Sexual Risk Behaviors and Suicidal Ideations among *Hijras*: Role of Perceived Attitude and Anticipated Rejection

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Supervisor

Dedicated to

Mama who is the biggest role model in my life.
Everything I am, you helped me to be.

CONTENTS

List of Tables

List of Figures

List of Appendices

List of Abbreviations

FtMs	Female to Male
LGB	Lesbians, Gays, Bisexuals
LGBTs	Lesbians, Gays, Bisexuals, Transgenders
MtFs	Male to Female
MSM	Men who have sex with men
STIs	Sexually Transmitted Infections
TG	Transgender
TGNC	Transgender and gender nonconforming
Trans	Transgender/Transsexual

Glossary of Non-English Words

Words	
Dalal	Pimp
Girya	Boyfriend
Guru-Chela	Mentor-Disciple
Hajj	Pilgrimage
Khusras	Hijras by birth/TS
Mukhannas	Emasculate
Narbaan	Persian word meaning 'sacrificing man' or one who has undergone castration
Wadhaiyan	Alms
Zanana	Cross dresser

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ABSTRACT

In the present study aim was to explore the role of perceived attitude and anticipated rejection, in sexual risk behaviours, and suicidal ideations among *hijras*. Role of certain demographic variables in the proposed relationships of study variables was also studied. *Hijra's* Perception of Attitude towards *Hijra* Scale (Jami, 2012), Negative Expectations for Future Subscale (Gender Minority Stress and Resilience Measure (Testa et al., 2014)), Sexual Risk Behaviour Questionnaire (Jami, 2018), The Suicidal Behaviour Questionnaire-Revised (Osman et al., 1999), and a demographic variable sheet based on Biographical Interview Schedule (Jami, 2012) were used for the data collection from 105 *hijras* through convenience and snowball sampling in different areas of Islamabad and Rawalpindi. Results as assumed showed significant negative relationship between perceived attitude and anticipated rejection. Anticipated rejection showed significant positive correlation with sexual risk behaviours. Perceived attitude and suicidal ideations showed significant negative correlation. Sexual risk behaviours and suicidal ideations showed significant positive correlation. Hypotheses that anticipated rejection is a mediator for perceived attitude in effecting sexual risk behaviour and suicidal ideations among *hijras*, were rejected. Moderating role suicidal ideations, safe sex, and happy being a *hijra* were found for perceived attitude in predicting sexual risk behaviours among *hijras*. Implications, limitations and suggestions of the study had also been discussed.

INTRODUCTION

Chapter 1

INTRODUCTION

The *hijra* is most noticeable gender role in Pakistan, where men behave like women. They are also considered as "third gender". They do not fulfill the conventional beliefs of male and female gender but combine or comprise the both genders. This group of people as sexual minority, always face social exclusion by the cisgenders' community, in terms of consummation of opportunity for their productive life. Their weaknesses, insecurities, and exasperation is always looked over by the mainstream society. The society does not accept the people beyond the male-to-female gender norm. Being outside this dichotomy, they are restricted to have better status in greater society with human potential and security. They face discrimination, violence, physical and sexual abuse. Extreme social exclusion decreases their self-esteem, which, ultimately leads them to expect negative about their future. These behaviors and negative attitudes widely held by masses make them more vulnerable to suicidal ideations and risky sexual behaviors.

When a peculiar class is marked as 'normal'; that concurrently comes up with contrasting class marked as 'deviant' (Gupta, 2005); and things which are communally marked as 'deviant' are culpable to be thumped or to be disliked unless and until it gets 'normal' as per expectation of community. To boost up this evidence, those commanding communal postulates of masculinity and femininity follow up the concept of 'real men' and 'real women'. In this society, the traits like independent, non-emotional, belligerent, strong, competitive, skilled, active, self-reliant, and hard get related with stereotypical 'ideal men' and traits like dependent, emotional, dull, weak, nurturing, and soft get connected with 'ideal women'. In case of divergence from culturally anticipated gender identity, these stereotypes generate immense social pressure and this social pressure is based on person's biological sex (Bornstein, 1997). According to Gupta (2005), being as male or female or one's self-image or belief about one's gender is gender identity, is supposed to be persistent with one's biological sex.

It is not necessary that gender identity always coincides with biological sex. Some people who have female biology grow up confronting themselves to be male

and some with male biology confront themselves to be female. Others perceive themselves a mixture of both (androgynous), but do not perceive their gender to be either male or female and feel that they are neither female nor a male, as an unspecified "third" gender (Gupta, 2005). In this aspect, a *hijra* who is usually seen as neither male nor female feels such systematic pressure to an exceptional level (West, 2006).

Hijra are phenotypic men who dress up in women's clothes and, preferably, repudiate sexual need and practice by undertaking a sacrificial emasculation; that is, an excision of the penis and testicles (Reddy, 2005). *Hijras'* statements about themselves often take the form of expressing that they are neither man nor woman, but in-between. The term *hijra* itself is a manly noun, means a man that is less than a man (Nanda, 1998). This category of people usually lives and wants more preferably to live in contrasting gender role as of their biological sex. *Hijra* is taken as physically and mentally clashing and because of this inconsistency individuals think about them as monstrosities (concealing their sexual identity). That is the reason; they are underestimated/trashed community (Jami, 2005).

In mainstream society, *hijras* are considered as 'social misfits' as they are feared; tabooed, and excluded. They also state that prevailing society does not understand their culture, gender, and sexuality (Khan et al., 2009). In Pakistan, the attitude towards *hijra* is very biased and discriminatory in general. Because of the people's attitude towards *hijras,* they are underprivileged in having any possibility to take education. They are also refused to have any quota in employment on basis of their handicap (if it is there) (Jami, 2005). Discrimination against stigmatized/marginalized people restricts their approach to resources such as health care, housing, education, and employment (Miller & Major, 2000).

Transgender (TG) perceives that society views them as sexual deviants and suffering from mental illness. They develop a belief that their identity is "wrong" or "unwanted." They experience intense shame regarding their identity. They are labeled as freaks and unnatural individuals and inherently deceptive (Rood et al., 2017). Transgender people may join society's pessimistic assessments of transgender individuals into their self-idea; this proximal stressor is alluded to as internalized transphobia, and can prompt adverse self-evaluations (Hendricks & Testa, 2012; Testa et al., 2012).

Some transgender individuals conceal their gender identity and live full-time as their allotted sex to avoid discrimination and abuse related with uncovering or revealing, while the individuals who open up and uncover their gender identity face negative response ranging from subtle discrimination to overt violence. Transgender and gender non-conforming individuals anticipate rejection anytime they leave home enter a public place; they anticipate rejection in places where they need to interact with people in their clear gender identity (Rood et al., 2016).

Transgender people are often miscast in the role of an unscrupulous or sexual deviant, having mental health issues or as sex workers, and drag queens (Gupta, 2005). Violence and stigma has been related to the HIV vulnerability of transgender person (Wilson, Pant, Comfort, & Ekstrand, 2011). More HIV/ sexually transmitted infection (STIs) vulnerability and irregular use of condom among sex workers is associated with physical and sexual violence (Beattie et al., 2010), while adverse mental and physical health outcomes, and housing, healthcare and employment nepotism among transgender persons are associated with stigma (Hughto, Reisner, & Pachankis, 2015). When multiple stigmas cleave with socio-cultural injustice among transgender and other marginalized communities (Logie, James, Tharao, & Loutfy, 2011), it enlarges the vulnerability to violence, HIV, and negative health outcomes (Bockting, Miner, Swinburne, Hamilton, & Coleman, 2013; Poteat et al., 2015; Sugano, Nemoto, & Operario, 2006).

Transgender individuals who have reported physical or sexual violence were at higher risk of suicide ideation, suicide attempts, and substance abuse (Testa et al., 2012). There are several other risk factors which lead transgenders to suicide like lack of family and social supports, gender-based discrimination, transgender-based abuse and violence, gender dysphoria and body-related shame, difficulty while undergoing gender reassignment, and being a member of another or multiple minority groups (Williams, 2017). Therefore, the objective of the present study is to investigate how the attitude of cisgenders or heterosexual is perceived by the *hijras?* How these perceptions effect their future? What factors make them more prone towards sexual risk behaviors? And how all these factors lead to affect their mental health?

Hijras

Transgender is used for the people who live all or significant portion of their lives exhibiting the native sense of gender other than birth sex. This includes transsexuals, cross-dressers, and peoples who simply feel like their true gender is failed to reflect by their biological sex (Gupta, 2005). Transgender is, in fact, an umbrella term that refers to individuals who feel that in terms of their inner psyche, they are actually of another gender and they do not recognize with the gender that is communally attributed to them (Kugle, 2014). The umbrella term "transgender" also consists of people who are transsexual, intersex, and transvestites. Transgender people do not come under the traditional model of gender/sex. In general, "transgender" is an inclusive term (Chakrapani, 2010). The transgender community consists of a number of different groups of people with many different issues related to cross-gender. Gender commonly refers to a combination of characteristics, expectations and roles that are associated with biological sex (Gupta, 2005).

Hijra, the third gender means those people who do not come under the umbrella of male and female gender. In society, they are deviant in their sexual placement. *Hijra* strongly portray the identity as individuals who are born with sexual deformity (Sharma, 2000). *Hijra,* the icon of sex/gender non-conformism in South Asia, are "male-bodied" people who identify as female and sacrifice their male genitals to a goddess in return for spiritual prowess (Hossain, 2012). The *hijra* are identified as intersexed persons, "neither man nor woman", or "eunuchs", that is impotent men, who can, therefore, never fulfill their adult male roles as husband and fathers (Reddy, 2005). According to Nanda (1986), *hijra* is a third gender role; he is neither man nor woman, but contains the characteristic of both. He is powerless man, who is castrated.

In a society where being a *hijra* is seen as a malison, *hijras* are forced to go through dreadful situations and struggles to be announced as a self-identified *hijra.* For them, it is difficult to cross the circumference of male-female dichotomous gender norms and to find a safe, healthy, and peaceful space in this heteronormative society (Khan et al., 2009). *Hijra* community is organized in a hierarchy of *gurus* [literally, teachers] and *chelas* [literally, disciples]. Every *hijra* has a *guru* and beginning into the community occurs only when the *guru* sponsors the *chela.* When someone joins the *hijra* community, she is supposed to earn for her guru, as no *guru* needs a *chela*

who does not earn for her (Nanda, 1998). *Hijra* leads double-lives. At home, being a young feminine male, they pretend to be masculine and when they are with their peers, they pretend to be complete feminine for their mental relief (Khan et al., 2009). *Hijras* preferably dress up in female clothing and their female attire typically is followed by traditional feminine jewelry like nose rings, wrist bangles, and toe rings (Nanda, 1998). As they prefer to wear feminine clothes, they often face exclusion from family events, weddings, and funerals, because they are discouraged to show feminine attitude in front of relatives (Khan et al., 2009).

In 2009, the Supreme Court of Pakistan passed a judgment, calling upon the authorities to provide "eunuchs" with third-gender ID cards and to add their names in electoral rolls so they can participate in elections. Thus, NADRA started issuing ID cards to transgender community with the sex as male, *khawajasira*, female *khawajasira* or *mukhannas*. The explanation of these three new genders is ambivalent and vague. Same legal status as males is given with similar property share in first one; in the second likewise gives a status similar to females, while there is no legal clearness on the third. In some areas, the card requirements need to change the father's name with that of *guru's* name. Transgenders with third-gender identity card cannot perform *Hajj*, as third gender is not recognized in Kingdom of Saudi Arabia. Because of such issues many transgenders choose not to get the cards. The Supreme Court judgment doesn't allow savings, welfare and security of human rights to "eunuchs". Thus, many feels that the judgment has not delivered positive outcomes and just touched surface of an exceptionally real issue (NADRA, 2009).

On 7th March 2018, Senate passed a bill, The Transgender Persons (Protection Rights) Act for the transgenders of Pakistan. The bill ensures the protection, relief and rehabilitation of trangenders' rights and welfare. According to this bill, a transgender person has right to recognized and registers himself according to his self-perceived gender identity with NADRA on CNIC, driving license, and passport. The bill further includes the prohibition against transgender harassment and discrimination including discontinuation of educational institutions, employment, health care services, and denial of customary available to public, use of public facilities of transportation, holding public or private office. They have given the rights to inherit according to the gender they perceive, rights to education, employment, vote, hold public office, health, and property. It is the duty of government to ensure the fundamental rights of

transgender are protected and there is no discrimination for any person on the basis of their sex, and gender identity (Senate, 2018).

It is evident that transgender people belongs to high risk groups of having STI, HIV/AIDS infections. Stigma, discriminatory laws, social exclusion and a general lack of understanding about transgender issues make it extremely difficult for transgender people to protect themselves from HIV infection (Godwin, 2010). A basic right such as accommodation is also inaccessible for *hijra* community in the mainstream society. Even the death of *hijra* does not end their disgrace and different religions and social norms complicate the matter of burying the body and conducting the funeral (Habib,2013). While the *hijra* community is excluded from the mainstream social life, the civil society is not giving enough attention to this issue (Habib, 2013).

Attitude towards transgenders is discriminatory around the whole world (see Bryant & Schilt, 2008; Grant et al., 2011; King, Winter, & Webster, 2009). In Pakistan, *hijras* face very discriminatory and biased attitude (Jami, 2005). According to Miller and Major (2002), discrimination against marginalized/stigmatized people limits their access to facilities such as health care, housing, education, and employment. Same kind of attitude is faced by the *hijras* of Pakistan. They are denied of taking education and refused to have employment quota (Jami, 2005). They are also labeled as freaks and unnatural individuals that are inherently deceptive (Rood et al., 2017).

Perceived Attitude

Eagly and Chaiken (1998), define an attitude as "a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor." Most immediate perspectives on attitudes also allow that people can be opposed or unsettled toward an object by consecutively having both negative and positive attitudes toward the same object (Wood, 2000).

When people have deprecatory social attitudes or cognitive beliefs, the statement of negative effect, or the dispose of aggressive or discriminatory behavior towards members of a group, because of the portrayal of their membership of that group, then this prejudice (Brown, 1995). Discrimination, harassment and violence against LGBTs area affair of public attitudes and social acceptance (Weiss, 2007).

Those experiences in which transgender individuals face prejudice and discrimination are worse for them (Nagoshi et al., 2008). Lombardi, Wilchins, Priesing, and Malouf (2002) inspected the most strenuous situations of transgenders life and their day-to-day experiences of life. They concluded that over half of the transgenders, throughout their lifetime be a victim of either harassment or violence and almost 40% experiences some type of economic discrimination. Furthermore, evidences available from United States suggests that transgender people face global prejudice and discrimination (e.g., Bryant & Schilt, 2008; Grant et al., 2011) and this is, may be, because of their gender identities and expressions, and this also raises the risk for violence in them (e.g., Grant et al., 2011).

As a form of social control, labeling, stereotyping and rejecting human difference is a social process called stigma (Link & Phelan, 2001, Phelan et al., 2008). Stigma is a basal reason of inauspicious health in transgender population as it works undeviating to prompt stress (a key driver of morbidity and mortality) and secondarily by moderating the approach to health protective resources (e.g. knowledge, money, power) (Hatzenbuehler et al., 2013; Link & Phelan, 1995). Trans stigma is based on transperson's gender non-conformity. It represents the shared belief system through which transgenderism and transsexuality are delegitimized and established as irrational as compared to hetero-normativity. This stigma results from the perception of hetero-normative people about the individuals whose gender identity discordant with their birth sex as mentally ill, inferior, and mentally ill (King et al., 2009).

Since gender is conventionally seen as binary confining only male and female, so when transgender people thump people's projection of that binary, then they often face negative reactions (Gupta, 2005). The *hijra* proclaim that their gender, culture and sexuality are never understood by the mainstream society. In development sectors, aspects of their social privation and harassments have never received surveillance (Khan et al., 2009). They face paucity in conceivability to get employment, formal education and are often refused the rights to get general medical health services (Khan et al., 2009).

In Pakistan, the attitude towards *hijra* is very biased and discriminatory in general. Because of the people's attitude towards *hijras,* they are underprivileged in having any possibility to take education. They are also refused to have any quota in employment on basis of their handicap (if it is there). They are declined

psychological/ psychotherapeutic and health aid. Without any medical and psychological assistance, victims of gender identity problem perform castrations. They abandon themselves in self-remedy including hormone taking without prescription, using silicone injections and at extreme auto-castrations. No one is available for understanding them and deriving solutions to their problems. Only because of the fear to avoid their malison and get good wishes, people endow them (Jami, 2005).

An external stressor (e.g., a discriminatory event) is the starting point in a causal chain leading to psychological distress. This process may be mediated by the subsequent emotional and cognitive appraisals of the external stressor—for example, becoming more aware of stigma toward one's group (stigma awareness) and/or internalizing the anti-transgender prejudice that sparked the discriminatory event (internalized transphobia) (Breslow et al., 2015).

Perception and attitude are interconnected. When the individual explains and standardizes the impressions to establish a meaningful experience of the world, this process is perception (Lindsay & Norman, 1977). In other words, a person is challenged by a stimuli or situation. On the basis of her/ his prior experiences, the person interprets the situation or stimuli into something which seems meaningful to him/ her. However, there may be possibility that what the person perceives or interprets is significantly inconsistent with the reality (Pickens, 2005).

Internalized stigma is a person's own acknowledgment of sexual stigma as a piece of her or his own self-esteem and self-idea. It is showed by both sexual minorities and heterosexuals. To suggest the internalized sexual stigma among sexual minorities, the term self-stigma is used. He or she acknowledges society's negative assessment of homosexuality as justified and, subsequently, bears negative attitude toward the self and toward her or his own particular homosexuals wants (Herek, 2007).

According to Nadal, Rivera, and Corpus (2010), at the point when person's own realization and acknowledgment of sexual stigma turns into a piece of her or his own particular self-esteem, independence, and self-idea, then this is internalized stigma. For example, LGBT individual may recognize the ways that he or she has internalized negative messages about being LGBT. Transgender receives social

messages that denigrated and demonized their transgender/ gender non-conforming (TGNC) identity. They are labeled as freaks and unnatural individuals that are inherently deceptive. Transgender further perceives that society views TGNC individuals as sexual deviants and predators who are suffering for mental illness. They develop a conviction that their identity of TGNC is "wrong" or "undesirable." They encounter extreme disgrace with respect to their personality or identity (Rood et al., 2017).

Internalized homosexual stigma suggests that GBT people intermix the society's adverse perspectives of homosexuality into their own particular character (Herek, 2007). It might result in form of emotions, from self-doubt and disgrace to self-hatred (Szymanski, Kashubeck-West, & Meyer, 2008). Negative portrayals of TGNC people and reactions to problematic social structures are represented by the social stigma and the perceived internalization of the stigma (Rood et al., 2017).

Distal stressors such as prejudice and harassment (i.e., experiences of anti-transgender discrimination); are associated with the symptoms of psychological distress, including anxiety, depression, and suicidal ideations (Clements-Nolle, Marx, & Katz, 2006), and also with poor physical health outcome (Sugano, Nemoto, & Oper-ario, 2006). Transgender people may intermix society's adverse evaluations of transgender individuals into their self-idea; this proximal stressor is suggested as internalized transphobia, and can lead to negative self-evaluations (Hendricks & Testa, 2012; Testa et al., 2012). Stigma awareness and anticipated discrimination is promoted by the anti-transgender discrimination that is related with deficits in mental and physical health (Mizock & Fleming, 2011).

Anticipated Rejection

"Expectations of Rejection" depicts the manner in which transgender people can anticipate events of prejudice and become hyper-vigilant (Nadal, Davidoff, Davis, & Wong, 2014). Hyper-vigilance and concealment might be useful in warding off prejudice occasions; they are thought to have unfavorable consequences for psychological well-being (Hatzenbuehler, 2009; Meyer, 2003). "Concealment" suggests the way in which transgender people once in a while hide their minority status with a specific end goal to ignore events in which prejudice can occur (Zimman, 2009).

As indicated by the minority stress model, hiding one's sexual minority status is both a defensive factor and a reason for stress. Temporarily, camouflage or concealment might be protective factor, which makes a person escape from being a target of victimization and discrimination; as time goes on, it becomes stressful to maintain concealment, ultimately "costing" the person, in terms of increased levels of psychological distress (Meyer, 2003). Some transgender individuals hide their gender identity and live full-time in the gender that is assigned to them, because they want to avoid discrimination and abuse that are related with disclosing, while the individuals who open up and disclose their gender identity experience negative reaction from discrimination to obvious violence (Testa et al., 2012).

As pointed by Chrobot-Mason, Button, and DiClementi (2001) identity management is a specific approach or technique for displaying one's concealed identity in society, and exposure decision is certainly not a dichotomous decision between passing or bluntly distinguishing one's identity; rather, there are numerous ways related with disclosure choice, which include different identity management procedures that range from full revelation to hiding or concealment. People who have concealable attributes have the choice of not disclosing this reality to others to avoid the negative outcomes including verbal abuse or physical violence as compared to the individuals with exposed stigma, who want to diminish interpersonal tension in social interactions (Jones & King, 2014). Subsequently, the primary issue that is faced by these people with concealable stigmas is whether to disclose—frequently named coming out—or not that part of themselves to others in the workplace and society (Ragins, 2008). Transgender identity is additionally viewed as a concealable identity exactly as other concealed identity (e.g., religious convictions, ailment, sexual orientation) (Beemyn & Rankin, 2011). Transgender individuals who are living "covered" are unrecognizable as transgender to nearly everybody in their lives—relatives, bosses, companions—and rather living just as gender with which they are assigned.

A developing collection of evidence suggests that individuals from stigmatized groups are slandered, are undermined, experience relational criticism, and are targeted for discrimination (Bilgehan-Ozturk, 2011; Jaspal & Cinnirella, 2012; Wijngaarden, Schunter, & Iqbal, 2013). Some people have stigmatized identities that are easily noticeable, for example, racial identity, age, and physical disfigurement,

while a few people have hidden identities, for example, religious convictions, ailment, sex character, and sexual orientation (Goffman, 1963). More elevated amounts of prejudice events were related with more increased amounts of self-stigma and anticipated rejection (Timmins, Rimes, & Rahman, 2017).

Expectations of more discrimination have more negative outcomes than experiencing it (Bucher & Raess, 2007). Denton (2012) found that severity of physical health symptoms among gay men are predicted by internalized homophobia and expectations of rejection. Bockting et al. (2013) overviewed 1,093 transgender people and found that the expectation of rejection (i.e., felt stigma) was positively associated with psychological distress, and contrarily associated with levels of outness. Gamarel et al. (2014) analyzed relationship stigma—genuine or foreseen sentiments of negative judgment from others because of one's intimate relationship being socially depreciated—among couples involving cisgender men and transgender women. Their findings revealed that increased amounts of announced relationship stigma were related with higher chances (balanced chances ratio=1.13) of revealing clinically critical depressive distress. Transgender and gender nonconforming (TGNC) people may anticipate rejection particularly to their gender identity, and this information helps to develop a relationship between psychological distress and expecting rejection (Bockting et al., 2013).

Covering one's stigma is regularly used as coping technique, to avoid negative results of stigma, bit this coping technique can be failed and end up unpleasant (Miller & Major, 2000). Recent published studies have also explored varieties of expecting rejection among TGNC people. In a study, investigators analyzed particular circumstances or situations that TGNC people may avoid because of the fear of being outed against their desires. With a sample of 889 TGNC people, 38.8% detailed avoiding open bathrooms, 38.4% revealed that they ignore gyms, 29.8% reported ignoring apparel shops, and 24.0% detailed that they avoid public transportation (Ellis et al., 2014). In another study, investigators further analyzed the relationship between employment status, coping strategies, and internalized transphobia and transgender stigma among 55 TGNC people. The study revealed that higher amounts of coping techniques (e.g., adapting to work and mental health-related stigma) were related with lower levels of internal and external stigma (Mizock & Mueser, 2014).

Transgender people often noticed that they could decrease the pressure related with anticipating rejection by avoiding particular spots and situations. Their anticipated rejection frequently is related with dreadful feelings and stress for their own security. They experience anxiety and stress in relation to the expectation of rejection. While encountering the anticipated rejection, they some of the time, trust that they were not supported by others and disregarded. They feel excluded by the society (Rood et al., 2016).

In health care settings, transgender individual face discrimination and stigma, and this stigma impacts on their health care, access, and use (Poteat, German, & Kerrigan, 2013). The discrimination and stigma faced by transgender individuals have been related to increased risk for depression, suicide, and HIV (DeSantis, 2009; Lombardi et al., 2002). Being in transgender status, they encounter additional stigma that aggravates and bisects with particular vulnerabilities and characteristics found within a given ethnocultural context, for example, destitution, joblessness, homelessness, and high HIV prevalence. Sex laborers, including (MTF) sex workers, are helpless against unprotected forced sex through violence and assault (Hwahng & Nuttbrock, 2007).

Sexual Risk Behaviors

Sexual risk behavior is a term that researchers have had trouble defining due to the large array of behaviors and consequences associated with the construct (Turchik, 2007). The main variable that has been used in research to define and measure sexual risk behavior is condom use (Shapiro, Radecki, Charchian, & Josephson, 1999), number of sexual partners, age of first intercourse, participation in heterosexual or homosexual anal sex, and use of alcohol or drugs before sexual intercourse (Rosengard, Anderson, & Stein, 2004). Shapiro et al. (1999) pointed that someone is at high sexual risk if they have more than three sexual partners.

Sex work is normal, especially, among transgender women, attributed to business discrimination, financial hardship, and absence of medical services particularly related to transgender care (Nadal, Davidoff, & Fujii-Doe, 2014). *Hijras* regularly take part in homosexual prostitution. Their participation in prostitution might be their real source of income (Nanda, 1998). They do the sex work or traditional work, and often look for their sexual partners with whom they can spend

their entire life, but the most cruel reality is that they never get their loyal and faithful partner in the heterosexist community and are often used by the society, where they are compelled to have forced sex which is a risk of HIV tendency (Khan et al., 2009).

In Pakistan, *hijras* have been around for quite a while. Celebrations, weddings, dancing at birth, and singing are major sources of earning for their living. Their social acknowledgment in Pakistani society reduced as the time passes, which constrained them towards scrounging on streets and following earning through sex business (Altaf, Zahidie, & Agha, 2012). In Pakistan's HIV prevalence, *hijras* (male transgenders) are key group (Khan, Rehan, Qayyum, & Khan, 2008). According to Hawkes et al. (2009), elevated amounts of current STIs were found, primarily among transgender sex workers. Sex workers in Pakistan are second most leading threat for transmission of HIV. The government declines to acknowledge illicit sex in the country, in spite of the fact that prostitution centers in all significant urban cities of Pakistan are established, including brothel houses of female sex workers, houses of *hijra,* and 'red light' areas (Rai, Warraich, Ali, & Nerurkar, 2007).

Reports reflect approximately around 4% HIV prevalence among *hijras* in Karachi, a city of 13 million individuals in southern Pakistan (WHO, 2006). The situation is undoubtedly more terrible in the rural parts, especially, in the Pathan-ruled northern Pakistan, where homosexuality is socially endured. In Pakistan, HIV/AIDS awareness-raising intervention is more needed for men who engage in sexual relations with men as they are considered as more HIV vulnerable group (Khan & Hyder, 1998). *Hijra* sex workers are rising as second most HIV/AIDS prone group and high predominance was found in Larkana. Being unmarried, younger age and sex work as sole source of income and indulgence in sex business for longer period of time are related with HIV/AIDS prevalence in Larkana along drug use during anal intercourse and lack of awareness about precautionary measures that are also linked with AIDS (Altaf et al., 2012).

Among the Pakistani population, means of HIV transmission can be through sexual contact, infected blood and blood products, drug use through injection, and mother-to-infant transmission. Unsafe heterosexual contact is major source of sexual transmission of HIV along homosexual and bisexual contacts (Rajabali, Khan, Warraich, Khanani, & Ali, 2008). The HIV-related sexual risk practices among the male to female transgender (MtF) people were: Sex without utilizing a condom,

unprotected anal sex, and unprotected sex with various partners. Significant differences are found for age, pay, education, liquor propensity, and sex with more than two partners each day for these three distinctive HIV-related sexual risk practices. MtF transgender people who have secondary or higher level of education are three times more prone to have unprotected sex with different partners contrasted with those who have primary or no education (Bhatta, 2014).

Results of a study demonstrated that sexual risk practices depend upon partner type. Transgender women are less inclined to utilize condoms in course of receptive anal intercourse with their main partners and they are also less inclined to utilize condoms with main partner after substance abuse (Wilson, Garofalo, Harris, & Belzer, 2010). They have low levels of HIV risk perception and lack of knowledge about HIV risk (De Santis, Hauglum, Deleon, Provencio-Vasquez, & Rodriguez, 2017). A few investigations have demonstrated that partner type (classified as main, casual, or commercial) impacts the sexual risk practices of groups that are at high risk for HIV (Lightfoot, Song, Rotheram-Borus, & Newman 2005; Myers, Allman, Calzavara, & Morrison, 1999).

High risk sexual practices among MtF transgender women are related with elements, for example, social dialect hindrances, discrimination, stigma, high joblessness rates, destitution, and limited access to HIV education and medicine services (Nemoto, Sausa, Operario, & Keatley, 2006; Sevelius, Reznick, Hart, & Schwarcz, 2009). Unprotected anal sex has been associated with knowledge deficits, economic factors, forced sex or rape, use of drugs and/or alcohol before or during sex, educational level, and a prior history of incarceration (Brennan et al., 2012; Clements-Nolle, Guzman, & Harris, 2008; Nemoto, Operario, Keatley, Han, & Soma, 2004). Finally, sexual risk practices might be influenced by commercial sex work and is a source of HIV risk because of multiple sex partners, inconsistent condom use, sex in the context of alcohol/drugs, and higher payment for unprotected sex (Benotsch et al., 2016; Mimiaga, Reisner, Tinsley, Mayer, & Saffren, 2009).

A developing body of research braces the hypothesis that negative encounters because of LGBT stigma can direct to chronic stress that adds to emotional pain among Young and elderly LGBT (Bontempo & D'augelli, 2002; Clements-Nolle, Marx, & Katz, 2006). Physical victimization that is experienced as a result of one's gender identity and expression (Fields et al., 2013) are significant contemplations in

investigations of suicide risk. Targets of physical abuse have higher vulnerability for suicidal ideation, and suicidal practices (Mina &Gallop, 1998). This holds true for all individuals particularly for trans people (Grossman & D'augelli, 2006, Kenagy, 2005); physical victimization has been related with a four-fold increment in suicide risk among trans people (Testa et al., 2012).

Suicidal Ideations

Suicide is the demonstration of deliberately causing one's own death. The most often used technique for suicide differs by nation and is partly associated with accessibility. Normal techniques consist of hanging, pesticide, poisoning, and weapons, however this changes from locale to district (Ajdacic et al., 2008). The obsession with obtrusive notions of finishing one's own particular life is known as suicidal ideation, otherwise, called suicidal thought (Cole, Protinsky, & Cross, 1992; Harter, Marold, & Whitesell, 1992). Suicidal ideation is characterized as self-revealed wishes, ruminations, or wants to take one's own life (O"Carroll et al., 1996). Suicide is the completed procedure of a continuum that starts with suicidal ideation, trailed by an attempt of suicide, and lastly ended with suicide (Cole, Protinsky, & Cross, 1992).

Suicide rate and suicidal liability among transgender community have been accounted to be high contrasted with general population (Cochran & Mays, 2000; Proctor & Groze, 1994; Remafedi, Farrow, & Deisher, 1991). The high pervasiveness of depression and suicidal tendencies among transgender people are because of societal stigma, absence of social support, HIV status and violence related issues (Chakrapani, 2010). Rejection and absence of support from the families and society, gender dysphoria related with highly distressing encounters, sexual abuse in childhood, early end of tutoring, forced marriages, absence of job opportunities, sexual and money related abuse by the partner and police and rowdies, and absence of legal measures for security are few characteristics of transgender people (Virupaksha, Muralidhar, & Ramakrishna, 2016). All the transgender people are mostly placed into lower financial status (Chakrapani, Newman, Shunmugam, McLuckie, & Melwin, 2007) and have high level of perceived stigma (Virupaksha et al., 2016). There are a few risk factors which lead transgender to commit suicide like absence of family and social backings, discrimination based on gender, abuse based on transgender and violence, gender dysphoria and body-related disgrace, trouble while experiencing sex reassignment, and being an individual from another or different minority group

(Williams, 2017). High depressive symptomatology among LGBT people is represented by perceived discrimination, and represented a hoisted risk of self-hurt and suicidal ideation among LGBT men (Almeida et al., 2009).

Sexual minority status is a key risk factor for life-threatening practices among transgender youth (Grossman & D'augelli, 2007). Engagement in health-promoting lifestyle decreased with increase in the level of sexual minority stress which ultimately increases the physical health issues (Flenar, Tucker, & Williams, 2017).

The studies have distinguished various risk factors for the high rates of suicide and self-destructive practices among transgender people. The discrimination of the transgender people in the general public has kept them from getting education, employment, and lodging due to which they are living in ghettos or roads and need to turn to begging and sex work (DiStefano, 2008). These distressing conditions directed them to collapse further and end their life in suicide. Discrimination, stigma and violence against transgender people happen over different social and institutional settings; they are verbally abused, physical, and sexually manhandling (Testa et al., 2012) and coerced by the police and rowdies; rejection; hateredness; verbal and physical mishandle from loved ones; stigmatization; refusal of administrations; and disdainful naming from human service providers etc., lead them to lose enthusiasm in everyday errands. Further, the danger of HIV and HIV status increment their mental misery, and they express thoughts of conferring suicide (Chakrapani et al., 2007).

The suicidality among sexual minority is related with poor emotional health condition (Mustanski, Garofalo, & Emerson, 2010; Mustanski & Liu, 2013), mental agony, emotion fatigue, and low confidence. Life being hard, being confused about one's sexuality or trouble in tolerating it, not having the capacity to unveil one's sexuality, harassing experiences, history of constrained sex, sex based discrimination, and victimization (Clements et al., 2006) and isolation are alternate explanations behind suicide among this segment of population (DiStefano, 2008). Prejudice-motivated crimes against LGBT at their living area are secondary socio-contextual risk factors for suicidal ideation and related endeavors among young sexual-minority young (Duncan & Hatzenbuehler, 2014). Transgender people in adolescence and in their mid-20s and have history of suicide attempts (Mustanski & Liu, 2013). The individuals who work in the bars, amusement and sex industries, survivors of violence executed by intimate partners or relatives, are conceivably at higher risk for

suicidality (DiStefano, 2008). Sexual minorities do not share their thoughts of suicide and self-harm and not looking for help (DiStefano, 2008; Testa et al., 2012; Virupaksha et al., 2016).

Theoretical Perspective

Minority stress model. The idea of minority stress can be expressed as association between minority and dominant values and resultant clash with the social condition experienced by minority group individuals (Meyer, 1995; Pearlin, 1989). Minority stress theory recommends that sexual minority health varieties can be clarified in huge part by stressors incited by an antagonistic, homophobic culture, which frequently results in a lifetime experiences of molestation, discrimination, abuse, and exploitation (Marshal et al., 2008; Meyer, 2003) and may also effect access to care. The Meyer (2003) minority stress model depends on factors related with different stressors and ways of dealing with stress and their positive or negative effect on emotional well-being outcomes because of sexual minority status.

The latent idea of minority stress are presumptions that stressors are peculiar (not experienced by non-stigmatized populations), persistent (associated with social and cultural structures), and socially based (social procedures, establishments and structures) (Meyer, 2003). Experiences of concealing, hiding, anticipated rejection, prejudice experiences, internalized homophobia, and coping processes are described by this model. Homophobia or sexual stigma are kind of stressors which emerge from environment and are supposed to assimilate by the individual, but it is also a reason to cause stress, which eventually influence the mental and physical health (Dohrenwend et al., 1992). Stress theory gives a helpful structure to describe and inspect consistencies and the part of homophobia as a sociological paradigm that prospects social conditions as a reason of stress for individuals who belong to minority social groups, which thus can higher the chances for HIV (Aneshensel, Rutter, & Lachenbruch, 1991; Dressler, Oths, & Gravlee, 2005).

A developing research shows that exhibiting to distal stressors directs to proximal stressors in sexual minority people. While sexual minority stress and gender minority stress both are utilized by Meyer's minority stress model as a structure. The minority stress which is experienced by transgender, gender nonconforming, and gender non-binary people is discrete from sexual minority stress (Hendricks & Testa,

2012). For instance, LGB youth and adults sometimes choose to hide their sexual identity from other as they encountered prejudice about their sexual orientation (Croteau, 1996; D'Augelli & Grossman, 2001; Pachankis, 2007). Significant psychological distress occurs when such personal information is concealed by the individuals and the distress includes isolation from other individuals of minority group, guilt and blame, anxiety, and obtrusive thoughts about the secret (D'augelli & Grossman, 2001; Smart &Wegner, 1999). Internalized homophobia is another proximal stressor pervasive among LGBT people. It alludes to the internalization of negative social perspectives about homosexuality, which generates self-loathing and poor self-respect (Malyon, 1982; Meyer & Dean, 1998). As anticipated by minority stress theory, internalized homophobia is related with exhibiting distal stressors, seeing that it just happens because that LGB people are disclosed to adverse societal attitudes toward same-sex fascination.

LGBT people meet higher rates of psychopathology contrasted with their non LGBT peers. For instance, population based investigations have demonstrated that LGBT individuals have chances of higher rates of substance misuse, suicide attempts, anxiety, and depression over the life expectancy (Burgard et al., 2005; Cochran, Keenan, Schober, & Mays, 2000; Cochran & Mays, 2000; Gilman et al., 2001). Some investigations have connected these negative health results to distal stressors. For instance, in a national overview, LGBT adults shows higher rates of mental dismalness and furthermore describe altogether higher rates of discrimination and prejudice contrasted with their heterosexual peers; for LGBT respondents the link between psychiatric symptoms and sexual orientation is completely linked with discrimination and prejudice (Mays & Cochran, 2001). In another investigation, relationship between suicide risk and sexual orientation is partly described by the level of peer victimization (Russell & Joyner, 2001). For sexual minorities, negative health outcomes relate with proximal stressor. For instance, internalized homophobia has been connected to self-damage and dietary problems and in addition sexual risk-taking practices (Meyer & Dean, 1998; Williamson, 2000).

Based upon the theory following model is proposed.

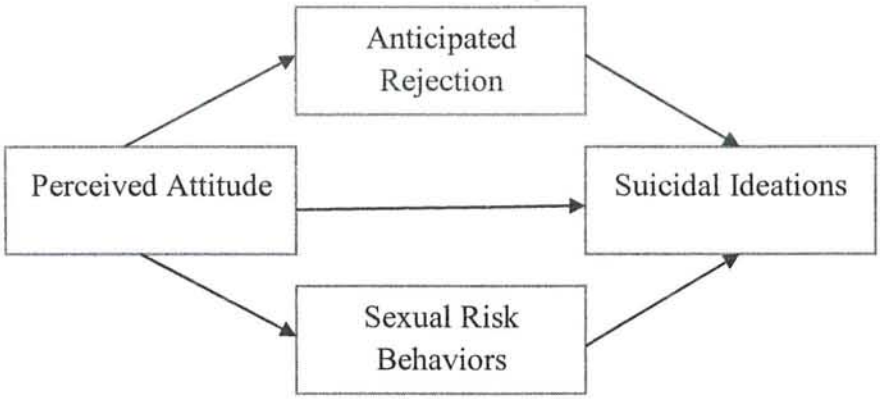

Figure 1. Proposed model

Relationship between Perceived Attitude, Anticipated Rejection, Sexual Risk Behaviors and Suicidal Ideations

Many researches describe the relation between perceived attitude, anticipating rejection, sexual risk behaviors and suicidal ideations. Some of them are given below:

A study was conducted by Abdullah et al., (2012) to investigate whether social exclusion leads *hijras* towards sex selling business which make them more prone to HIV. Qualitative research method was used. Four focus group discussions and eight in-depth interviews were supervised. The sample was taken from Rawalpindi and Islamabad. Multiples sessions were conducted with participants. Life histories were reported by the participants during interviews which showed that social exclusion at different levels of life and denial of educational and occupational opportunities leads them to enter in risky sex selling business.

A study was conducted by Yadegarfard, Meinhold-Bergmann, and Ho (2014) to inspect the impact of family rejection, social detachment, and isolation on negative wellbeing result in Thai MtF transgender adolescents. The sample included 260 male participants, in whom 129 were self-distinguished transgender and 131 were self-recognized cisgenders. Multivariate investigation demonstrated that transgender participants when contrasted with cisgender participants indicated essentially higher family rejection, lower social support, higher loneliness, higher depression, lower defensive factor and higher negative factors that are associated with suicidal behaviors and sexual risk practices. Numerous analyses demonstrated that exogenous factors of family rejection, social separation, and loneliness are noteworthy indicators

of detailed levels of melancholy, suicidal thinking, and sexual risk practices by both transgender and cisgender young people.

A study was done to investigate if the social environment around lesbian, gay, and bisexual youth may add to their higher rates of attempts to suicide, controlling for person's level risk factors. A sum of 31852 eleventh grade students (1413 [4.4%] lesbian, gay, and androgynous people) in Oregon finished the Oregon Healthy Teens Survey in 2006– 2008. LGB youth were fundamentally more inclined to attempt suicide in the past a year, contrasted with heterosexuals (21.5% versus 4.2%). Among lesbian, gay, and bisexual youth, the chances of suicide attempt were 20% more noteworthy in unsupportive conditions contrasted with supportive situations (Hatzenbuehler, 2011).

A study was conducted to explore one type of external stressor, expecting rejection to investigate the how and to what degree expectations of rejection work on daily basis for transgender and gender non-conformity individuals and to explore how they respond to expectations of rejection. Results showed four categories of expecting rejection. These categories were where to expect rejection (participants said that they expected rejection whenever they are in public places and left their homes), feelings and thoughts which are related with anticipated rejection (participants reported that they became fearful, and worried about being victim of discrimination and they reported fear and worry about their safety), adopting techniques used to deal with anticipated rejection (they avoid situations in which they expected rejections), and the convergence of ethnicity and race with expectation of rejection (participants reported that violence and discrimination depends upon color of person) (Rood et al., 2016).

A research was led to comprehend the issues around the suicide and self-destructive behavior among transgender people. The attempts to suicide rate among transgender people ranges from 32% to half over the nations. Victimization based on gender, discrimination, tormenting, violence, being rejected by the family, community, and friends; molestation by intimate partner, relatives, police and public; discrimination and abuse at health care system were the significant risk factors that impacted the suicidal behavior among transgender people (Virupaksha, Muralidhar, & Ramakrishna, 2016).

A study reported transgender sex laborers' encounters of stigma and violence, a key driver of the HIV prevalence, and investigated their adapting reactions in Maharashtra state, India. Results demonstrated that respondents met inescapable stigma and violence because of numerous criticized social identities (transgender status, sex work, gender non-conformity), which fortified and crossed with social imbalances (monetary and lodging insecurity, destitution and employment discrimination), powering HIV proneness at the smaller scale, meso, and large-scale levels. Some factors, for example, felt and internalized stigma related with psycho-social pain and low self-adequacy to challenge abuse and transact condom utilization; customers' capacity in sexual exchanges; building up trust in general affiliations through condom less sex; standards approving brutality against gender non-conforming people; absence of communal support; police molestation; discrimination by health providers and the sex workplace made a setting for HIV vulnerability (Ganju & Saggurti, 2017).

Literature on *Hijras* in Pakistan

In Pakistan, many researches have been conducted on *hijras* and their issues. Study conducted on the educational issues of transgender (Tabassum & Jamil, 2014) concluded that social prejudice towards the appearance of transgenders is very high and they had to stay out of institution despite the fact they want to take education. Results of another study (Ahmad, Yasin & Umair, 2014) showed that hostilities, detachments, and deprivations faced by eunuchs (*hijras)* are reason for their social exclusion. Study conducted on attitude towards *hijra* (Jami, 2012) revealed that *hijras* had more negative perceived attitude than actual attitude of people. Findings further revealed that *hijras* who were older, *zananas*, suffering from depression being *hijra*, had regret being *hijra*, had desire to leave *hijra* community, and those had not yet accepted their cross-gendered identity/ tendencies had more negative perceived attitude than their counterparts. Iram (2015) concluded that childhood gender dysphoria is prevalent among *hijras* (79.6%) and is related with suicidal ideations and high suicidal ideations were also prevalent 31%.

Furthermore, research on mental health of *hijras* was also done. Findings of an investigation revealed that in determining the mental health of *hijras,* perceived attitude of people and social support from their in-group (community) is important. Results also showed that factors including *hijra* as gender identity, physical/sexual

abuse, confusion being a part of *hijra* community, and police arrest was related to more mental health problems (Rafique, 2015). Another study was conducted on personality traits of transgender which concluded that transgenders need help and the ignorance they faced from their families and whole society directed them towards unhealthy life (Tasmeera, 2002). Another research was conducted on development of transgender, which revealed the role of socializing agent in transgender development. Results revealed that MtFs and female to male transgenders (FtMs) face many psychological problems consisting emotional problems, substance use and suicidal ideations and fathers, and brothers showed more accommodating behaviour for FtMs, TG and mothers, and sisters showed more helping behaviour towards MtFs (Bibi, 2009).

In Pakistan, studies on sexual health of *hijras* were also conducted. A study (Abdullah et al., 2012) showed that discriminatory attitude towards *hijras* force them to enter in sex selling business. According to Khanani et al. (2011), HIV/AIDS prevalence is spreaded by the men who have sex with men (MSM) to their female spouses and their offspring. The current study explores the association between perceived attitudes of people, sexual risk behaviors, and suicidal ideations and role of anticipated rejection among them, in *hijras*.

Rationale of the Study

Hijras are stigmatized, and excluded from the society. They face prejudice, discrimination, violence and rejection, because of their gender identity. Society's denial of their rights, giving them respect, considering them as sexually deviant, on giving them opportunities in different fields, show that basically society's attitude makes them socially excluded.

The arguments and discussion on *hijra* groups, related to the issues of their discrimination, violence, gender identity, equal rights, social support have been studied in many parts of the world and they are presented in academic and social welfare world. There is augmenting literature that focuses on sexual orientation, discrimination, mental health, sexual health, and that focuses on the challenges and problems faced by transgenders in their everyday life (see Bucher & Raess, 2007; Breslow et al., 2015; Clements-Nole et al., 2006; De Santis et al., 2017; Denton 2012).

According to Jami and Kamal (2015), there is a lot written about *hijras* in India (see, e.g., Nanda, 1998; Pande, 2004; Sharma, 2000; Talwar, 1999; Winter, 2002), but in Pakistan, limited researches are present on *hijras.* Those researches focus mostly on the attitude towards *hijras,* their issues related to education, occupation, employability, reasons for their social exclusion, and their struggle for their rights (see Abdullah et al., 2012; Abbas, Nawaz, Ali, Hussain, & Nawaz, 2014; Ahmed, Yasin & Umair, 2014; Jami, 2005; Jami & Kamal, 2015; Saeed, Mughal & Farooq, 2018; Nazir & Yasir, 2016; Tabassum & Jamil, 2014;). Very few researches focus on sexual health of *hijra* in Pakistan (see Akhtar et al., 2012; Altaf et al., 2012; Khanani et al., 2011).

The transgender people are still under researched, inspite of the fact that there is increase in academic interest to study LGBT (McFadden, 2015). There is need to recognize their third gender and need to work for their mainstreaming and mental health issues to make them productive member of society and also to work for their sexual risk behaviors, as they are high risk group for HIV (see Altaf et al., 2012; Ganju & Saggurti, 2017; Khan et al., 2008; Wilson et al., 2010). The present study aims to fill the gap in literature by exploring the effect of anticipated rejection on sexual risk behavior and suicidal ideations. Studies which describe the relationship between proximal stressors (anticipated rejection) and *hijra* mental health outcomes are very limited. So, present study will provide the account the risk factors in sexual and mental health of *hijras* that would be helpful in making intervention plans for them.

Rationale of the present study is to investigate the relationship of *hijras'* perceived attitude of people towards *hijras*, sexual risk behaviors and suicidal ideations among *hijras.* If this relationship is mediated by negative expectations about future, anticipated rejection is used as mediator, to see how people's perceived attitude make *hijras* to expect their future negative, how these negative expectations indulge them into risky sexual risk behaviors and how these factors lead suicidal ideations among them. The rationale of taking *hijras* as sample is because this community is seen as sexually deviant and they feel this pressure at extreme level. They are perceived socially misfit. Because of people's attitude (prejudice, discrimination, violence, abuse, and harassment) lack of rights, opportunities of education, and employment, they are forced to involve in sex business for their

survival. Their indulgence in prostitution makes them more vulnerable to have risky sexual behaviors. People's attitude, expectation of rejection, and having sexual risk behaviors affect their mental health. The kind of social exclusion they face as sexual minority makes them feel to die. The social climate, to which this minority group is exposed within stigmatization, makes them more vulnerable to high risk of developing negative health outcomes. This community is more vulnerable to suicide also. (see Bockting et al., 2013; Clements-Nolle, 2006; Duncan & Hatzenbuehler, 2014; Virupaksha et al., 2016). Placing context of sexual risk behavior, and suicidal ideations in perceived attitude and anticipated rejection may help to suggest health practitioners to plan intervention addressing attitude to reduce sexual risk behavior and suicidal ideations.

METHOD

Chapter 2

METHOD

Objectives

The objectives of study are to:

1. Investigate the relationship between perception of people's attitudes, anticipated rejection, sexual risk behaviours, and suicidal ideations among *hijras*.
2. Explore mediating role of anticipated rejection for perceived attitude in effecting sexual risk behaviours and suicidal ideations of *hijras*.
3. Study the role of demographic variables (age, *hijra* type, education, source of income, socio-economic status, status in community, etc.) in perception of attitudes, anticipated rejection, sexual risk behaviours, and suicidal ideations among *hijras*.

Hypotheses

The hypotheses of the study are:

1. There is negative relationship between positive perceived attitude and anticipated rejection in *hijras.*
2. There is negative relationship between positive perceived attitude and sexual risk behaviour in *hijras.*
3. There is negative relationship between positive perceived attitude and suicidal ideations in *hijras.*
4. There is positive relationship between anticipated rejection and sexual risk behaviours in *hijras.*
5. There is positive relationship between sexual risk behaviours and suicidal ideations.

6. Anticipated rejection is a mediator for positive perceived attitude in effecting sexual risk behaviours in *hijras* that is with increase in positive perception of attitude anticipated rejection decreases that decreases sexual risk behaviours.
7. Anticipated rejection is a negative mediator for positive perceived attitude in effecting suicidal ideations in *hijras* that is with the increase in positive perception of attitude anticipated rejection decreases that decreases suicidal ideations.

Conceptual and Operational Definitions of Variables

Perceived attitude. Perception of evaluative responses towards a group or members of the group (Herek, 2009; Stangor, 2009). For *hijras*, perceived attitude can be presented in three domains (Jami, 2012):

Rights and status. It includes the behavioural intentions of people towards providing the *hijras* their basic human rights (e.g., their rights for identity, health, occupation related, and right to be loved).

Social distance. It includes perception of general people that how much closeness they can accept in having different relationships with *hijras* (e.g., as a class mate, relative, colleague, neighbour, interacting to them etc.).

Sexual issues. It includes the perceptions of general people about the different sexual issues/ stigma related with *hijras* (e.g., homosexuality, prostitution, AIDS/ STDs etc.).

In the present study, high score on measure means more positive perception of attitudes and less score means negative perception of attitude.

Anticipated rejection. Experiences related to stigmatization, discrimination, and violence lead the victim to believe that they will always be a target of social exclusion (Rood et al., 2016). High scores on the measure show high level of anticipated rejection and low scores show low level of anticipated rejection among *hijras*.

Sexual risk behaviour. Sexual risk behaviour is an activity that increases one's chances of having unexpected pregnancies and sexually transmitted infections. It consists of sexual activities at very young age, having intercourse after taking drugs and alcohol, having multiple sexual partners, and having unprotected sexual

behaviours (Seth, Raiford, Robinson, Wingood, & DiClemente, 2010). In the study, high score on the measure show high risky sexual behaviours and low scores show less risky sexual behaviours.

Suicidal ideations. Suicidal ideations are obsession of unwanted thoughts about taking one's own life (Harter et al., 1992). High scores on the measure show high suicidal ideations and low scores show low suicidal ideations among participants.

Research Design

The current study is a quantitative; correlational research, using cross-sectional research design. The data is obtained from the respondents, using survey method through questionnaire.

Sample

Sample of the study are *hijras* (*khusra, zanana, moorat, narban, pedaeshi,* etc.). Sample was collected from different areas of Rawalpindi and Islamabad through convenient and snowball sampling. Sample of 105 *hijras* were taken, with the age range from 13-60 years (M =29.96, SD = 9.49); and monthly income ranges from 0-110000 (M = 23171.43, SD = 18354.65). For other demographic variables, frequencies and percentages are given in Table 1.

Table 1 shows that most of the participants are illiterate (43.8%). Majority of the participants reported that they registered themselves as male. Most of the participants (85.7%) reported their birth gender as male. All the participants were Muslim, except one who was Christian. Most of the participants reported that they are unmarried. Fifty-five participants reported their current status as *chela*, but many reported their current status as *guru* and *chela* both. Forty-eight participants reported their kind of transgender as *Khawajasara.* All *hijras* have different source of income, but mostly reported functions (71) followed by begging. This shows that *hijras* face employment discrimination which leads them to earn their living through begging.

Table 1

Frequencies and Percentages along Demographic Variables (N = 105)

Variables	*f (%)*	Variables	*f (%)*
Education		**Marital Status**	
Illiterate	46 (43.8)	Married	11 (10.5)
Primary	24 (22.9)	Unmarried	94 (89.5)
Matric	25 (23.8)		
Intermediate	7 (6.7)		
Graduation	3 (2.9)		
Registered Gender		**Current Status**	
Male	82 (78.1)	*Guru*	7 (6.7)
Transgender	14 (13.3)	*Chela*	55 (52.4)
No identity card	9 (8.6)	Both	43 (41.0)
Birth Gender		**Kind of Transgender**	
Male	90 (85.7)	*Zanana*	16 (15.2)
Female	3 (2.9)	*Khusra*	25 (23.8)
Transgender	12 (11.4)	*Khawajasara*	48 (45.7)
		Narbaan	6 (5.7)
		Pedaeshi	7 (6.7)
		Moorat	3 (2.9)
Religion		**Source of Income**[a]	
Muslim	104 (99.0)	*Wadhaiyan*	29 (27.6)
Non-Muslim	1 (1.0)	Begging	53 (50.5)
		Function	71 (67.6)
		Theatre	18 (17.1)
		Dance in fairs	21 (20.0)
		Sex business	51 (48.6)
		Others	2 (1.9)

Note. [a]Responses can be more than one.

Instruments

Following instruments were used in the study.

***Hijra's* Perception of Attitudes towards *Hijra* Scale (HPATHS).** It was used to measure perceived attitude (see Appendix C). First of all, permission from the author was taken (see Appendix C1). Jami (2012) developed this scale. The scale consisted of 32 items which measure the attitude of people perceived by *hijras*. The scale which further consists of 3 subscles. Rights and Status (R & S; 13 items, 7, 8, 9, 10, 22, 24, 25, 27, 28, 29, 30, 31, 32), is concerned with the perception of people's attitude towards providing basic human rights to *hijras* including mental and physical health facilities, right for identity, educational and occupational opportunities and

right to be loved etc. Social Distance (SD; 11 items 13, 14, 15, 16, 17, 18, 19, 20, 21, 23, 26), is concerned with the perceptions of closeness that general population accepts in having any relationships with *hijras* (e.g., as a neighbour, as a classmate, as a colleague, interacting or talking to them). Sexual Issues (SI; 8 items, 1, 2, 3, 4, 5, 6, 11, 12), is referred to the perception of people's attitudes towards different sexual stigmas/ issues related to the *hijras* (e.g., sex business, homosexuality etc.). Sixteen items of the scale are reversed scored (1, 2, 3, 4, 5, 6, 7, 11, 12, 16, 18, 19, 20, 23, 25, 26). It is a 5-point Likert scale with the response options ranging from *strongly disagree* to *strongly agree* (1-5). High scores on the scale show positive perceived attitude and low scores show negative attitude. Cronbach alpha reliability for total scale is .85, for Rights and Status .80, for Social Distance .81, and for Sexual Issues .73 (Jami, 2012).

Sexual Risk Behaviour Questionnaire. To measure the sexual risk behaviour among *hijras,* Sexual Risk Behaviour Questionnaire (see Appendix D) was used. It was developed in Urdu by Jami (2018). Questionnaire was based on the Sexual History Questionnaire (Davis, Yarber, Bauserman, Schreer, & Davis, 1998). It consists of 20 items, out of which 11 items are 5-point Likert scale, and other 9 items are open-ended indicator of sexual risk behaviour. Seven items of the scale were reversed score (4, 5, 6, 7, 9, 10, 13). Item 8 was excluded because it was not psychometrically sound as it has no inter-item correlation. Item 1 was not included in total score of items, used for correlation. To see the differences ANOVA was run on item 1. High scores on the scale show more risk behaviours and low scores show less risk behaviours.

Negative Expectations for Future Subscale. It was used to measure the anticipated rejection (see Appendix E1), which is a subscale of Gender Minority Stress and Resilience (Testa, Habarth, Peta, Balsam, & Bockting, 2015). It consisted of 9 items. It is a 5-point Likert scale with the response options ranging from *strongly disagree* to *strongly agree* (0-4). High scores on the scale show more negative expectations about future on the disclosure of gender identity and low score show less negative expectations about future. Cronbach alpha reliability for the scale is .89.

As the scale was in English language, which is not understandable to the target sample, hence, there was a need to translate the instrument into Urdu language to make it understandable, adaptable, and easier for the sample. For this purpose, first of

all the permission (see Appendix E2) from the corresponding author was taken to use, and translate the scale to make it adaptable according to the Pakistani culture (see Appendix E5).

Translation and adaptation of the measure. In this phase, Negative Expectations for Future was translated and adapted in Urdu language, so that it could easily be understandable by the sample. For translation and adaption, standard guidelines were followed (Sousa & Rojjanasrirat, 2010). Following steps are followed:

Step 1: Forward translation of the original Instrument into Urdu language.

Step 2: Comparison of the received translated versions in a committee.

Step 3: Back-translation of Urdu selected items into English.

Step 4: Comparison of received back-translated versions for the final selection in a committee.

Step 1 involved the translation of original instrument into target language (Urdu) from the source language (English). For this purpose, 5 bilingual experts were requested to translate the instrument. The translators had Mphil or PhD degree in Psychology and they were faculty members of a university. The translators already knew the process, but they were instructed to translate the scale in a manner that makes the meaning of items understandable and easy for the targeted community.

In Step 2 the items of forward-translated version were compared with the original version of Negative Expectations for Future in a committee. For committee, three bilingual subject matter experts including supervisor, a faculty member (PhD scholar) and PhD scholar were approached with researcher, to assess the discrepancies, and ambiguity in sentences, words and meanings supplementing with each other (Urdu translated version) and with original version. All discrepancies and ambiguities were resolved in the committee. Dictionaries (Oxford and Urdu) were consulted when the ambiguity occurred. The best items were selected from five translated version with 100% consensus of the experts on the basis of understandability and equivalence with the original items. For few item, two or three statements were merged into one item to get the exact meaning of the original version (see Appendix E3).

Then, the items which are selected by the committee members were translated back into the source language (English) in step 3. For this purpose, three different bilingual experts (M.Phil and PhD scholars) were approached. Any of the translator was not aware and had not seen the original version of the scale, this is an essential feature of back translation. They were guided to translate the instrument as genuinely as possible without losing original meanings of the items.

In Step 4 the items of the back translation were compared in the committee, with the item of original English version for wording, grammatical structure of the sentences, similarity in the meaning and relevance. The committee consisted of three subject matter experts (two PhD and one M. Phil scholar) and one researcher. Any kind of ambiguity was not found. After discussion, consensus was made among committee members to derive final version of the instrument (see Appendix E4).

Suicidal Behaviour Questionnaire-Revised (SBQ-R). To investigate the suicidal ideations among *hijras*, Suicidal Behaviour Questionnaire-Revised (see Appendix F1) was used. It was developed by Osman et al (2001). It has four items, each of them is tapping different dimension of suicidality. Item 1 taps the lifetime suicide ideations or suicide attempts. Item 2 assess the frequency of suicidal ideations over the past 12 months. Item 3 taps the threat of suicide attempts. Item 4 evaluates self-reported likelihood of suicidal behaviour in the future. Every item has different response options and is given some points. Participant must respond only on one option. At the end, all scores are added. The total score should range from 3-18, to evident the suicidal behaviour.

The scale was in English language, so there was a need to translate this instrument too in Urdu language to make it understandable and easier for the sample. As the permission for use was granted from the author so the process of translation was started. Only forward translation (Maneesriwongul, & Dixon, 2004) was used.

To translate the scale with response options from source language English to the target language Urdu. The scale was given to the three bilingual experts (M.Phil and PhD scholar) for translation. Translators were instructed about the translation and requested to translate the scale as appropriate as possible. Then, the items were compared with the original version of instrument in a committee of experts (M.Phil and PhD) to evaluate the all three versions of translated scale and to ensure the

compatibility and equivalence. Urdu dictionary was consulted for the ambiguities. The best items were considered and few statements from all three translated versions were merged into one item to gain the equivalence (see Appendix F2). The order of response options of item 4 was changed to make it more understandable. Based upon mutual agreement of the committee members, items and response options were finalized (see Appendix F3). Then, the scale was used for the data collection.

Demographic sheet. To get the information of demographic characteristics of the sample, a demographic sheet (see Appendix B) was used. It was based on Biographical Interview Schedule developed by Jami (2012). The general questions included in the sheet were their age, education, gender which is registered on their Computerized National Identity Card (CNIC), birth gender, monthly income, religion, marital status, current status, working place, residence area, kind of *hijra*, source of income etc.

Some specific questions were asked in demographic sheet to assess their perception about themselves, and to evaluate their sexual risk behaviours that is, what they think of themselves? What does their family call them? Are they happy being a *hijra*? relationship with *guru*, relationship with boyfriend, whether they take drugs, when do they take drugs? Have they done their HIV/ AIDS test? If yes, then what are the results? etc. (see Appendix B).

Procedure

Data collection was started when a *hijra* was approached from the market, which further helped to arrange the most of his community members. He was paid for the help (4000-8000). The academic purpose of the study was clearly explained to the *hijras,* most of them agreed to participate. Before participation they are clearly told about ethical considerations that their information will be kept confidential and used only for academic purpose, anonymity was ensured, they were told that they have right to quit at any time. Participants were also requested to give honest answers as possible to get the genuine results. They had a long list of complaints against people's attitude towards them. Some *hijras* also denied helping, as they do not want to share their sexual life histories. When they are offered money, few of them agreed. Those who voluntarily participated, were educated and interested in the study, but did not ask to share the findings.

Most of the *hijras* were living with their *gurus*, therefore, before participating they also got permissions from them. Some whose guru did not give them permission, did not participate. Few of them participate on the condition if they get more money. Questionnaires were given to those only who were educated. Instructions to fill the questionnaires were clearly explained to them. All the uncertainties were handled properly. Participants co-operated very well, they respond on all items very quickly and bluntly. As the data were collected during the month of Ramazan, group of 12-18 members were mostly approached at the dinner. The data were collected in structured interview format. It took 18-20 minutes to fill the questionnaire. Most of the questionnaires were completed by the researcher, but for some research assistants were also employed. Both research assistants had Mphil degree, though they had not graduated in Psychology, but they handled the interviews very well. Before interviews, they are instructed to be careful about ethical considerations and ensured that they could not force participants to participate and could not do anything which hurt the feelings of participant. Hundred questionnaires were expected to be filled, but with the help of research assistants, 117 questionnaires had been filled. Twelve questionnaires were discarded because they are incomplete as some of elderly participants were not interested in helping.

RESULTS

Chapter 3

RESULTS

The current study was aimed to explore the relationship between perceived attitude, anticipated rejection, sexual risk behaviors, and suicidal ideations among *hijras*. Beside this, mediating role of anticipated rejection for perceived attitude in predicting sexual risk behaviors and suicidal ideations was also studied. The role of demographic variables (age, monthly income, source of income, relationship with guru etc.) in study variables was studied. For the appropriate statistical analyses, the IBM SPSS Statistics Version 21 has been used. The internal consistency of the scales was measured through Chronbach alpha's reliability coefficient. Descriptive statistics was computed including mean, standard deviation, skewness, and kurtosis. Pearson Product Moment Correlation was computed to investigate the relationship among variables and also with certain demographic variables. Independent Sample *t*-test and One-Way Analysis of Variance (ANOVA) were executed to study the group differences on study variables along certain demographic variables (having boyfriend, having done HIV/ AIDS test etc.). Step-wise regression was done to explore the strongest predictor for sexual risk behaviors and suicidal ideations. Mediation and moderation was done through process Macro.

Reliabilities and Descriptive Statistics

In order to calculate the descriptive statistics, alpha reliability coefficients of the *Hijra's* Perception of Attitude towards *Hijra* Scale, Negative Expectation for Future Scale, Sexual Risk Behavior Questionnaire, and Suicidal Behavior Questionnaire-Revised were computed. The analyses were run on raw scores; however, these are converted into transformed scores to study magnitude/tendency based on mean and standard deviation as shown in Table 2. It is attained by dividing the sum of each scale and subscale by their respective number of items.

Table 2 shows that the internal consistencies of all the measures are good and acceptable. Mean values of transformed scores of HPATHS, and its subscale R & S, shows mean lies at right side of the curve, showing that participants scored on low scores. This means participants perceive people's attitude more negative. The mean

values of other subscales of HPATHS (SD & SI) lie on the left side of the curve, showing that participants scored on high values, which means participants perceive that people accept to have relationships with them and do not consider them as sexual deviant. Transformed scores of NEFFS shows that mean value lies on right side of the curve, showing that participants are expecting rejection in future. Mean values of transformed scores of SRBQ and SBQR show that participants scored on high scores. Participants have more sexual risk behaviors and suicidal ideations. Normal univariate distribution of the data is depicted through the values, the values for skewness (asymmetry) and kurtosis that lie between -2 and +2, which are considered acceptable (Gravetter & Wallnau, 2014). Hence, parametric tests are used for further analyses.

Table 2

Descriptive Statistics and Cronbach Alpha of Hijra's Perception of Attitude towards Hijra Scale, Negative Expectations for Future Scale, Sexual Risk Behavior Questionnaire and Suicidal Behavior Questionnaire-Revised (N = 105)

			Raw data	Transform	Range			
Variables	*K*	α	*M (SD)*	*M (SD)*	Actual	Potential	Skew	Kurt
HPATHS	32	.91	64 (13.41)	2 (.41)	1.28-2.97	1-5	.04	-1.20
RS	13	.80	30.22 (7.06)	2.32 (.54)	1.38-3.92	1-5	.42	-.05
SD	11	.77	20.65 (4.45)	1.87 (.40)	1.09-2.73	1-5	-.01	-1.27
SI	8	.91	13.11 (3.74)	1.63 (.46)	1-2.50	1-5	-.29	-1.48
NEFFS	9	.93	29.97 (3.79)	3.33 (.42)	2.56-4	0-4	.46	-1.23
SRBQ	9	.83	32.60 (6.73)	3.62 (.74)	1.89-5	1-5	-.11	-.90
SBQR	4	.80	12.83 (3.64)	3.20 (.91)	.75-4.50	1-7	-1.12	.39

Note. k = no. of items; HPATHS = *Hijra's* Perception of Attitude towards *Hijra* Scale; RS = Rights and Status; SD = Social Distance; SI = Sexual Issues; NEFFS = Negative Expectations for Future Scale; SRBQ = Sexual Risk Behavior Questionnaire; and SBQR = Suicidal Behavior Questionnaire-Revised.

Correlation among Study Variables

To study the relationship between perceived attitude of people, their anticipated rejection, sexual risk behavior and suicidal ideations among participants, Pearson Product Moment Correlation was executed.

Table 3

Correlation among Perceived Attitude, Anticipated Rejection, Sexual Risk Behaviors, and Suicidal Ideations (N = 105)

Sr No.	Variables	1	2	3	4	5	6	7
1.	Perceived Attitude	-	.92**	.92**	.73**	-.28**	-.67**	-.45**
2.	Rights & Status		-	.80**	.47**	-.12	-.60**	-.41**
3.	Social Distance			-	.61**	-.26**	-.64**	-.43**
4.	Sexual Issues				-	-.48**	-.51**	-.32**
5.	Anticipated Rejection					-	.31**	.09
6.	Sexual Risk Behaviours						-	.35**
7.	Suicidal Ideations							-

$^{**}p < .01$. $^{*}p < .05$.

Table 3 shows perceived attitude is significantly negatively correlated with anticipated rejection showing that more the *hijras* have positive perception of people's attitude towards them lesser they are expecting rejection in future. This also proves Hypothesis no. 1 that there is significant negative correlation between perceived attitude and anticipated rejection. Same relationship is observed for social distance and sexual issues domains of perceived attitude showing significant negative relationship with anticipated rejection, showing social distance meaning more they perceive that people can accept them for having a relationship for example, as a colleague, neighbor, class-fellow, interacting with etc. the less they have negative expectations about their future; and the more they perceive that people do not take them as sexual deviant and accept them, lesser they are expecting rejection in future. Rights and Status domain of perceived attitude shows nonsignificant relationship with anticipated rejection. Perceived attitude of people towards *hijras*, and it's all domains show significant negative correlation with sexual risk behaviors. This finding proves Hypothesis no. 2 that is more *hijras* perceive that people are in their support to provide them basic needs, accept to have relationships with them, and do not consider them as sexual deviant, the less they have risky sexual behaviors. Suicidal ideations are significantly negatively correlated with perceived attitude and its domains that means as *hijras* perceive attitude of people more positive about their rights and acceptance, the lesser they have thoughts of suicide. This finding proves the

Hypothesis no. 3 that there is negative relationship between perceived attitude and suicidal ideations.

Table 3 also shows that anticipated rejection is positively correlated with sexual risk behaviors, conveying that more *hijras* expect their future as negative, more chances of their having risky sexual behaviors. This also proves Hypothesis no. 4 that there is positive correlation between anticipated rejection and sexual risk behaviors. Suicidal ideations show non-significant correlation with anticipated rejection. Table 3 further shows that suicidal ideations are significantly positively correlated with sexual risk behaviors, indicating that more the *hijras* are in risky sexual behaviors, more they have suicidal thoughts. This finding proves Hypothesis no. 5, that there is positive correlation between sexual risk behaviors and suicidal ideations.

Analyses along Demographic Variables

Frequencies and percentages were computed for the information taken on demographic variables related to study variables. This was done to have better understanding of stressors which can play the role in sexual risk behaviors and suicidal ideations. Some of these variables were used in further analyses.

Table 4 shows that majority of the participants (48.6%) are confused about being happy as a *hijra* showing that they are still in conflict with perception of people's attitude. Most of the participants want to be female (35.2%), but no one reported their registered gender as female. Eighty-eight participants reported that they have a boyfriend and most of them (28.6%) reported that they have good relationships with their boyfriend, indicating involvement in more sexual behavior. Majority of the participants (41.9%) reported they liked to be called themselves *moorat* showing the desire or wish of femininity. Fifty-two participants reported bad relationship with *guru*, as *guru* is an important source of support system, but when the support system gets weak, it causes suicidal ideations among participants. Majority of the participants (47.6%) think themselves as female, as they also desired to be a female, showing dissatisfaction with the gender.

Table 4

Variables related to Sexual Risk Behaviors and Suicidal Ideations among Hijras (N = 105)

Variables	*f (%)*	Variables	*f (%)*
Happy as transgender		**Family call you**	
Yes	23 (21.9)	Female	9 (8.6)
No	31 (29.5)	Male	73 (69.5)
Do not know	51 (48.6)	*Hijra*	16 (15.2)
		Moorat	7 (6.7)
Actually, want to be		**Offer prayers**	
Male	15 (14.3)	Yes	38 (36.2)
Female	37 (35.2)	No	48 (45.7)
Hijra	20 (19.0)	Sometimes	19 (18.1)
Moorat	33 (31.4)		
Boyfriend		**Prayers in a day**[a]	
Yes	88 (83.8)	Two in a day	11 (10.5)
No	17 (16.2)	Three in a day	13 (12.4)
		Four in a day	22 (21.0)
		Five in a day	2 (1.9)
Relation with boyfriend		**Take drugs**	
Very good	12 (11.4)	Yes	29 (27.6)
Good	30 (28.6)	No	28 (26.7)
Normal	25 (23.8)	Only cigarettes	43 (41.0)
Bad	18 (17.1)	Others	5 (4.8)
Very bad	3 (2.9)		
Like to call you		**Use drugs**	
Zanana	15 (14.3)	Parties	5 (4.8)
Khusra	10 (9.5)	Depends on mood	21 (20.0)
Khawajasara	26 (24.8)	Functions	46 (43.8)
Narbaan	1 (1.0)		
Moorat	44 (41.9)		
Others (male, female)	9 (8.6)		
Relationship with guru		**HIV/ AIDS**	
Very good	8 (7.6)	Yes	50 (47.6)
Good	35 (33.3)	No	55 (52.4)
Normal	6 (5.7)		
Bad	52 (49.5)		
Very bad	4 (3.8)		
Think of yourself		**Results of HIV/ AIDS test**	
Male	9 (8.6)	Positive	23 (21.9)
Female	50 (47.6)	Negative	28 (26.7)
Hijra	27 (25.7)		
Moorat	19 (18.1)		

Note. [a]Those who reported that they sometime offer prayers, some of them also reported how many they offer in a day?

Seventy-three participants reported that their family calls them male, showing that their family rejects their gender identity as *hijra*. Most of participants (45.7%) reported that they do not offer prayers and 36.2% participants reported that they offer

prayers and 18.1% reported that they offer prayers sometimes. Some of them also reported number of prayers they offer in a day. Forty-three participants reported that they smoke cigarettes and twenty-nine reported that they take drugs. Drug before sexual contact is also an indicator of sexual risk behaviors. Most of them (43.8) reported that they take drugs in functions, increasing the chances of sexual contacts. Fifty-five participants reported that they have not done their HIV/AIDS test, as they have fear of being a HIV+. Only 21.9% participants reporting being HIV positive, indication of having risky sexual behaviors.

Correlation of Study Variables with Demographic Variables

To study the relationship of perceived attitude, anticipated rejection, sexual risk behaviors, and suicidal ideations with demographic variables, Pearson Product Moment correlation was executed. With demographic variables that are age in years, monthly income in Pakistani rupee, relationship with guru, and relationship with boyfriend, both are 5-point (Likert type), and religiosity is taken as dichotomous variable that is whether they offer prayers or not.

Table 5 shows significant positive correlation between perceived attitude, and its domain social distance and religiosity, which was the only indicator of religiosity. Results show that perceiving people's attitude as more positive about their acceptance in relationships as neighbor, class-mate, etc. is positively related to offering the prayers more. Anticipated rejection is significantly positively correlated with age and negatively correlated with religiosity; showing that as the age of *hijras* increases, their negative expectations about future also increases and expecting their future negative is linked with offering prayers.

Results further shows that sexual risk behaviors are significantly positively correlated with age and relationship with guru, showing that as the age of *hijras* increases, the chances of risky sexual behaviors also increases and positive relationship with guru also increases the chances of risky sexual behaviors.

Table 5

Correlation of Demographic Variables with Study Variables (N = 105)

Variables	Age	Monthly Income	Relationship with Guru	Relationship with Boyfriend.	Do you offer prayers?
Perceived Attitude	-.08	-.10	-.13	.02	.20*
Rights & Status	-.05	-.09	-.15	.07	.19
Social Distance	-.08	-.09	-.11	.01	.20*
Sexual Issues	-.09	-.07	-.06	-.07	.12
Anticipated Rejection	.22*	.04	.11	.00	-.20*
Sexual Risk Behaviours	.23*	.19	.26**	.14	-.09
Suicidal Ideations	.04	-.12	-.08	.14	-.17

Note. Do you offer prayers scored yes as 1 and No as 0.
$^{**}p < .01$. $^{*}p < .05$.

Correlation of Study Variables with Other Indicators of Sexual Risk Behaviors

Pearson Moment Product Correlation was executed to figure out the relationship between study variables and other indicators of sexual risk behavior like age of first sexual contact, no. of sexual contacts with safe sex, earning through sex business per month etc.

Table 6 shows that perception of attitude gets more negative with age at which first sexual contact was made; number of people participants had sexual contact month; number of people with whom they had sexual contacted more than once; with the number of sexual contacts with regular partners or clients; and the number of sexual abuse they experienced last month. Results also show that perceived attitude is significantly positively correlated with taking precautionary measures during sexual contact and having many places for sexual contact. Same relationship has been observed for rights and status, domain of perceived attitude. However, sexual issues domain shows same relationship with respect to the sexual behaviors during which they take precautionary measures but nonsignificant on other risk behaviors.

Table 6

Correlation of Indicators of Sexual Risk Behavior Questionnaire with Study Variables (N = 105)

Variables	PA	R & S	SD	SI	AR	SRB	SIdea
Age at first sexual contact	-.23*	-.23*	-.25**	-.08	-.05	.33**	.07
No. of sexual contacts in last month	-.20*	-.24*	-.15	-.08	-.09	.24*	.13
With how many sexual contact more than once	-.23*	-.28**	-.15	-.13	-.00	.20*	-.00
No. of sexual contact with regular partner/ client	-.21*	-.24*	-.18	-.07	.02	.22*	.08
No. of sexual contacts with safe sex	.23*	.22*	.14	.24*	-.12	-.25**	-.13
Money received per sexual contact	.05	.10	.03	-.04	-.09	-.15	-.12
Earning through sex business per month	.17	.17	.19*	.07	.13	.05	-.09
No. of sexual abuse last month	-.22*	-.24*	-.17	-.15	.05	.14	.25**
No. of places of sexual contact	.22*	.20*	.21*	.17	-.18	-.20*	.12

Note. PA = Perceived Attitude; R & S = Rights and status; SI = Sexual Issues; AR = Anticipated Rejection; SRB = Sexual Risk behaviors; SIdea = Suicidal Ideations.
$^{**}p < .01$. $^{*}p < .05$.

Social distance domain shows the same direction of relationship with reference to age of first sexual relationship and different areas for sexual activities, but it also shows positive relationship with earnings from sex business. This shows *hijras'* perceived attitude about their acceptance in different relationships become more positive with the increase in their earnings from sex business. Sexual risk behaviors show positive correlation with age in which they had first sexual contact, number of people they had sexual contact last month, with number of people they had sexual contact more than once, with the number of sexual contacts with regular partners or clients and negative correlation with the sexual behaviors during which they use contraceptives and different places for sexual activities. Results further revealed that suicidal ideations significantly positively related with the sexual abuse last month. This finding evidence that thoughts of suicide increase with the increase in participants' experience of sexual abuse last month.

Predictors of Sexual Risk Behaviors

In order to explore the predictors of sexual risk behaviors, Step-wise linear regression was conducted along perceived attitude, anticipated rejection, certain demographic and some indicators of sexual risk behaviors.

Table 7

Perceived Attitude and Anticipated Rejection as Predictors of Sexual Risk Behavior (N = 105)

						95% *CI*	
Predictors	*B*	*β*	R^2	ΔR^2	*F*	*LL*	*UL*
Model 1							
Constant	55.11		.46	.45	49.14***	48.60	61.63
Perceived Attitude	-.34	-.68				-.44	-.24
Model 2							
Constant	40.95		.52	.06	29.90***	27.91	53.99
Perceived Attitude	-.31	-.62				-.41	-.21
Anticipated Rejection	.41	.23				.07	.74

Note. CI = Confidence Interval; *UL* = Upper Limit; *LL* = Lower Limit.
*** $p < .001$. * $p < .05$.

To explore the predictors of sexual risk behaviors, perceived attitude, anticipated rejection, certain demographic variables (age, relationship with *guru*, relationship with boyfriend etc) were taken as predictors. Only significant models are reported. According to results (see Table 7), Model 1 shows 45% variance that is caused by perceived attitude in sexual risk behaviors. β value shows positive perceived attitude is significantly negatively predicting sexual risk behaviors. This represents that positive perceived attitude increases with the decrease in sexual risk behaviors. Model 2 shows that overall 50% variance is cause by perceived attitude and anticipated rejection. Out of which, 45% variance is explained by perceived attitude only and 6% of anticipated rejection for sexual risk behaviors. β value of model 2 shows that anticipated rejection is significantly positively predicting sexual risk behaviors, showing as the participants expect more rejection on disclosure of their identity, their sexual risk behavior also increases.

Mediation Analyses

Mediation analysis was run through the process Macro. It was computed taking perceived attitude as independent variable, sexual risk behavior as outcome variable and anticipated rejection as mediator.

Table 8

Mediating Role of Anticipated Rejection between Perceived Attitude and Sexual Risk Behaviors (N = 105)

	Model 1	Model 2	*95% CI*	
Variables	*B*	*B*	*LL*	*UL*
Constant	35.20***	46.00	35.61	56.39
Perceived Attitude (IV)	-.34***	-.32***	-.39	-.24
Anticipated Rejection (M)		.24	-.02	.50
R^2	.46	.48		
ΔR^2		.02		
F	87.30***	46.18		
ΔF		41.12		

Note. z = -1.48; *CI* = Confidence Interval; *UL* = Upper Limit; LL = Lower Limit.
*** $p < .001$. ** $p < .01$. * $p < .05$.

In Table 8, results explain the mediating role of anticipated rejection between perceived attitude and sexual risk behaviors among *hijras*. According to Model 1, positive perceived attitude negatively predicts sexual risk behaviors, but Model 2 shows that positive perceived attitude significantly negatively affects anticipated rejection (β = -.08, p = .00), but anticipated rejection shows nonsignificant effect on sexual risk behaviors. Only 2% nonsignificant variance is caused by anticipated rejection. This shows that participants who perceive people's attitude more positive, have less sexual risk behaviors and anticipated rejection does not affect sexual risk behaviors. Sobel test value (z = -1.48, p = .07), that is non significant, which shows that anticipated rejections does not work as mediator between perceived attitude and sexual risk behavior. This finding rejects Hypothesis no.5 that anticipated rejection is mediator for positive perceived attitude in effecting sexual risk behaviors in *hijras*.

Next Table 9 shows the mediating effect of anticipated rejection on suicidal ideations.

Table 9

Mediating Role of Anticipated Rejection between Perceived Attitude and Suicidal Ideations (N = 105)

	Model 1	Model 2	*95% CI*	
Variables	*B*	*B*	*LL*	*UL*
Constant	35.20***	21.96	15.05	28.87
Perceived Attitude (IV)	-.12***	-.12***	-.17	-.07
Anticipated Rejection (M)		-.03	-.20	.14
R^2	.20	.20		
ΔR^2		.00		
F	26.92***	13.42		
ΔF		13.50		

Note. $z = .36$; *CI* = Confidence Interval; *UL* = Upper Limit; *LL* = Lower Limit.
*** $p < .001$. ** $p < .01$. * $p < .05$.

In Table 9, results explain the mediating role of anticipated rejection in *hijras* between perceived attitude and suicidal ideations among *hijras*. According to Model 1, perceived attitude negatively effects suicidal ideations, as the positive perceived attitude increases, the negative expectations for future decrease. But Model 2 shows significant negative effect of positive perceived attitude on anticipated rejection ($\beta = -.08, p = .00$). Table 9 further represents that anticipated rejection shows nonsignificant effect on suicidal ideations. This shows that participants who perceive people's attitude more positive, have less suicidal ideations and anticipated rejection does not affect suicidal ideations. Sobel test value ($z = .36$, $p = .71$), that is non significant, which shows that anticipated rejection does not work as mediator for perceived attitude in predicting suicidal ideations. This finding rejects Hypothesis no.6 that anticipated rejection is a mediator for positive perceived attitude in effecting suicidal ideations in *hijras*.

Moderation Analyses

Moderation analyses were executed through the process Macro. It was run between perceived attitude as independent variable, and sexual risk behavior as outcome variable. Suicidal ideations, safe sex (precautionary measure taken during sexual contact), and a demographic variable happy as a *hijra,* were taken as moderators one by one.

Table 10

Moderating Role of Suicidal Ideations between Perceived Attitude and Sexual Risk Behaviors (N = 105)

		95% *CI*	
Predictors	*B*	*LL*	*UL*
Constant	31.82***	30.70	32.95
Perceived Attitude	-.29***	-.37	-.20
Suicidal Ideations	.36*	.01	.72
PA X SI	-.03**	-.06	-.00
R^2	.49		
ΔR^2	.03		
F	32.79***		
ΔF	6.38		

Note. CI = Confidence Interval; *UL* = Upper Limit; *LL* = Lower Limit. PA = Perceived Attitude; SI = Suicidal Ideations.
*** $p < .001$. ** $p < .01$. * $p < .05$.

According to the results in Table 10, the increase in *hijra's* positive perceived attitude of people results in decrease of sexual risk behaviors among them. The significant interaction is shown in Table 10. *Figure* 2 shows that positive perceived attitude increases, the sexual risk behaviors decrease, in those *hijras* who have more suicidal ideations ($t = -2.16$, $p = .00$). The same effect of suicidal ideations is also seen for those who have moderate level of suicidal ideations ($t = -6.95$, $p = .00$), and who have less suicidal ideations ($t = -7.6$, $p = .00$). As compared to moderate level and low level of suicidal ideations the trend is more sharp for those who have more suicidal ideations.

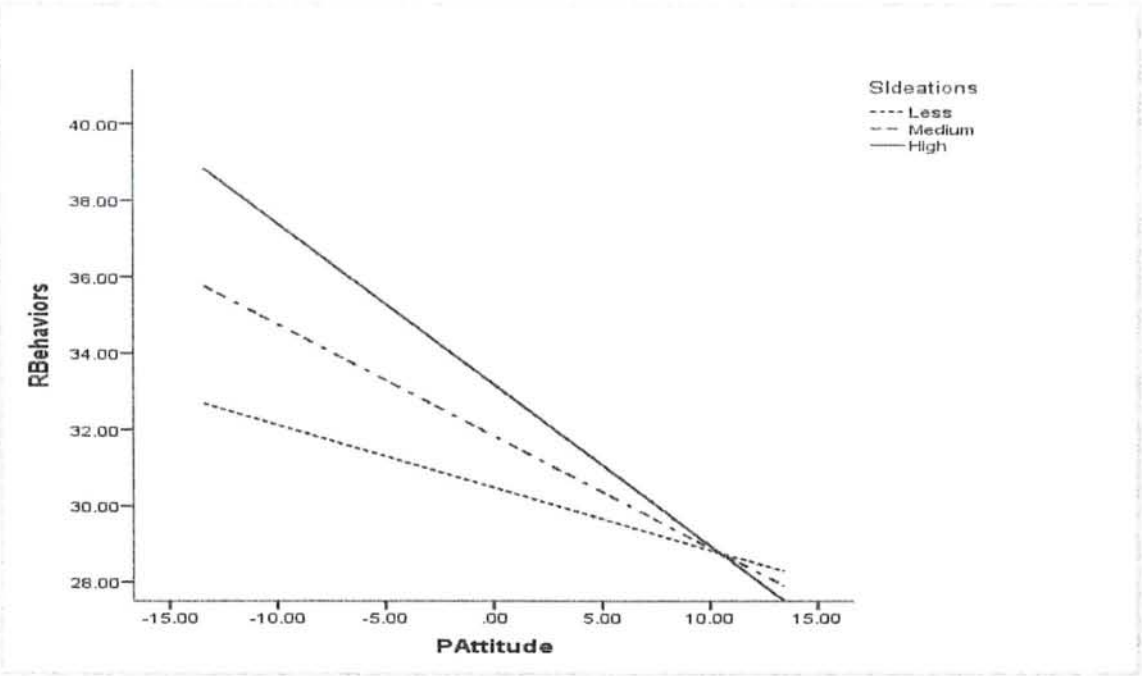

Figure 2. Modgraph representing the moderating effect of suicidal ideations.

Table 11 shows the moderating effect of use of contraceptives between perceived attitude and sexual risk behavior.

Table 11

Moderating Role of Safe Sex between Perceived Attitude and Sexual Risk Behaviors (N = 105)

		95% *CI*	
Predictors	*B*	*LL*	*UL*
Constant	32.29***	31.31	33.28
Perceived Attitude	-.31***	-.39	-.24
Use of Contraceptives	-.41*	-.78	-.03
PA X UoC	.03*	.00	.06
R^2	.49		
ΔR^2	.02		
F	32.67***		
ΔF	4.65		

Note. CI = Confidence Interval; *UL* = Upper Limit; *LL* = Lower Limit. PA = Perceived Attitude; UoC = Use of Contraceptives.
*** $p < .001$. ** $p < .01$. * $p < .05$.

Results show that as the positive perceived attitude increases, the sexual risk behavior decreases. The significant interaction is also shown in Table 11. The result in *Figure* 3 shows that for those who do not have safe sex (t = -8.57, p = .00), their

positive perceived attitude sharply increases with the decrease in sexual risk behaviors. Same effect is seen for those, who have moderate level of safe sex (t = -8.61, p = .00) and for those who have safe sex (t = -3.51, p = .00), but the effect is weak for those who have safe sex.

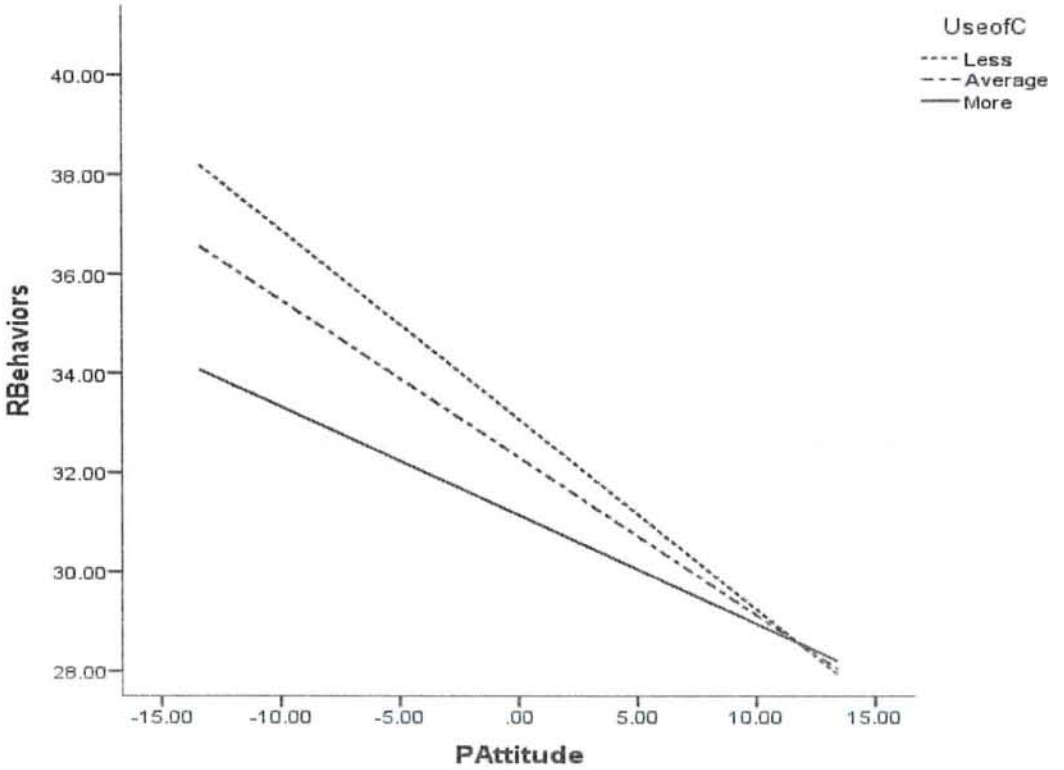

Figure 3. Modgraph showing the moderating effect of use of contraceptives

Table 12 shows the moderating effect of happy as *hijra* between perceived attitude and sexual risk behaviors.

Table 12

Moderating Role of Happiness being a Hijra between Perceived Attitude and Sexual Risk Behaviors (N = 105)

		95% *CI*	
Predictors	*B*	*LL*	*UL*
Constant	32.47***	31.53	33.41
Perceived Attitude	-.33***	-.41	-.26
Happy as *hijra*	.87	-.34	2.09
PA X HaH	.13**	.03	.22
R^2	.50		
ΔR^2	.03		
F	33.66***		
ΔF	7.76		

Note. CI = Confidence Interval; *UL* = Upper Limit; *LL* = Lower Limit; PA = Perceived Attitude; HaH = Happy as *hijra*.
*** $p < .001$. ** $p < .01$. * $p < .05$.

Results show that perceived attitude shows non-significant prediction for happiness as *hijra*. When the moderator came in interaction with the predictor which is perceived attitude, this effect of predictor on outcome which is sexual risk behaviors get significant. Mod graph further explains this effect.

The mod graph shows that perceiving people's attitude more positive, decreases sexual risk behaviors in those *hijra* who are not happy being a *hijra* (t = -8.68, p = .00). The same trend is seen in *hijras* who are confused and do not know whether they are happy or not (t = -9.57, p = .00) and in *hijras* who are happy being a *hijra* (t = -4.78, p = .00). The effect is stronger for those who are not happy as compared to those who are confused and happy.

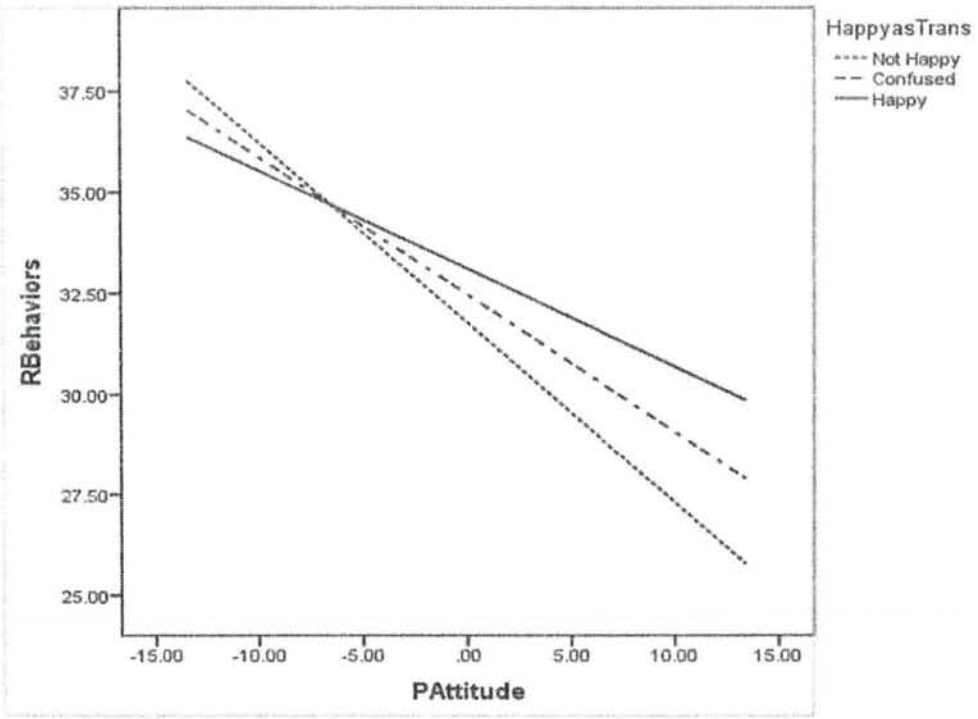

Figure 4. Modgraph showing the interaction effect of perceived attitude and happy as *hijra* on sexual risk behavior.

Differences on Study Variables Along Having Boyfriend

Independent Sample *t*-test was conducted to study the differences on study variables, along those *hijras* who have boyfriend (n = 88) or those who have not (n = 17).

On perceived attitude and its domains social distance and sexual issues, result (Table 13) shows the significant differences. Those *hijras* who have boyfriends have significantly more positive perception of people's attitude about their acceptance in having them in different relationships and do not considering them as sexual deviants, as compared to the *hijras* who have no boyfriend. The effect size for total perceived attitude, social distance, and sexual issues is .63, .72, and .56 respectively, showing the larger effect of mean difference. This means 63% variance in total perceived attitude, 72% in social distance, and 56% in sexual issues is explained by having boyfriend.

Table 13

Differences on Study Variables along having Boyfriend (N = 105)

Variables	Boyfriend (n = 88) M (SD)	No boyfriend (n =17) M (SD)	t (103)	95%CI UL	95%CI LL	Cohen's d
Perceived Attitude	65.40 (12.74)	56.70 (14.82)	2.51*	16.69	.70	.63
Rights & Status	30.80 (6.69)	27.23 (8.31)	1.93	8.03	-.88	.47
Social Distance	21.14 (4.38)	18.11 (4.07)	2.63*	5.28	.77	.72
Sexual Issues	13.45 (3.65)	11.35 (3.83)	2.15*	4.19	.00	.56
Anticipated Rejection	29.86 (3.76)	30.52 (4.01)	-.66	1.33	-2.66	.17
Sexual Risk Behaviors	32.03 (6.52)	35.58 (7.20)	-2.02*	.35	-7.46	.52
Suicidal Ideations	12.64 (3.71)	13.82 (3.18)	-1.2	.73	-3.08	.34

Note. CI = Confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit.
$^{**}p < .01$. $^{*}p < .05$.

Significant differences are also observed on sexual risk behaviors. Those *hijras* who have no boyfriend, has low chances of having risky sexual behaviors in comparison to those who have boyfriends. The effect size for sexual risk behavior is large (.52); showing 52% variance in sexual risk behavior is given by having no boyfriend. Results show nonsignificant differences on anticipated rejection and suicidal ideations.

Differences on Study Variables along having Done HIV/AIDS Test

Independent Sample *t*-test was conducted to compute differences on study variables along those *hijras* who have done their HIV/AIDS test ($n = 50$) and those who have not done their test ($n = 55$).

On perceived attitude and its domain Social Distance and Sexual Issues, result (Table 14) shows significant differences. *Hijras* who have done their HIV/AIDS test perceive people's attitude more positive about their acceptance as compared to those who have not done their test. The effect size for perceived attitude and its domain social distance and sexual issues is .59, .58 and .72 respectively, showing mean difference has larger effect. This shows that 59% variance in perceived attitude, 58% variance in social distance, and 72% in sexual issues is predicted by those who have done their HIV/AIDS test.

Table 14

Differences on Study Variables along HIV/AIDS Test (N = 105)

Variables	Test Yes (n=50) M (SD)	No Test (n=55) M (SD)	t (103)	95%CI UL	95%CI LL	Cohen's d
Perceived Attitude	68 (12.68)	60.36 (13.12)	3.02**	12.63	2.63	.59
Rights & Status	31.60 (6.57)	28.98 (7.31)	1.92	5.30	-.07	.37
Social Distance	21.96 (4.11)	19.47 (4.46)	2.95**	4.14	.82	.58
Sexual Issues	14.44 (3.41)	11.90 (3.65)	3.65**	3.89	1.16	.72
Anticipated Rejection	28.42 (2.94)	31.38 (3.95)	-4.37**	-1.61	-4.30	.85
Sexual Risk Behaviors	30.72 (6.62)	34.32 (6.41)	-2.83**	-1.07	-6.13	.55
Suicidal Ideations	12.44 (3.65)	13.20 (3.63)	-1.06	.65	-2.17	.21

Note. CI = Confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit.
$^{**}p < .01$. $^{*}p < .05$.

Result also shows significant differences on anticipated rejection and sexual risk behaviors. *Hijras* who have not done their HIV/AIDS test expect their future being more negative and have more risky sexual behaviors as compare to the *hijras* who have done their test. The effect size value for anticipated rejection and sexual risk behavior reflects larger effect (.85 and .55). This represents that 85% variance in anticipated rejection and 55% in sexual risk behavior is explained by those who have not done their HIV/AIDS test. Nonsignificant differences are shown on suicidal ideations and tilt to significant relationship is shown on the domain rights and status of perceived attitude.

Differences on Study Variables along Happy being a *Hijra*

One-Way ANOVA was conducted to compute differences along study variables among *hijras*; those who are happy, those who are not happy and those who do not know whether they are happy or not being *hijra*. Bonferroni post-hoc analysis was executed for the significant differences.

Result (Table 15) from post-hoc analysis shows differences on total perceived attitude and its domain rights and status. *Hijras* those are not happy being a *hijra* perceive the attitude of people more negative about themselves, their rights and status in comparison to those who are happy being a *hijra*. The tilt to significance is also

seen in other domains of perceived attitude, social distance and sexual issues, and anticipated rejection. Nonsignificant differences are seen on sexual risk behaviors and suicidal ideations.

Table 15

Comparing One Way Analysis along Happy being a Hijra (N = 105)

	Yes	No	Do not know					
	(n = 23)	*(n = 31)*	*(n = 51)*				*95%CI*	
Variables	*M(SD)*	*M(SD)*	*M(SD)*	*F*	*i-j*	*D(i-j)*	*LL*	*UL*
Perceived Attitude	58.26 (11.89)	69.03 (14.07)	63.52 (12.73)	4.61*	1 < 2	-10.77*	-19.46	-2.08
Rights & Status	27.04 (5.04)	33.09 (8.22)	29.92 (6.48)	5.35**	1 <2	-6.05**	-10.59	-1.50
Social Distance	19.52 (4.58)	22.06 (4.03)	20.31 (4.51)	2.51				
Sexual Issues	11.69 (3.78)	13.87 (3.87)	13.29 (3.54)	2.40				
Anticipated Rejection	31.56 (4.19)	29.48 (3.58)	29.54 (3.60)	2.68				
Sexual Risk Behaviors	33.65 (8.65)	31.29 (6.02)	32.94 (6.15)	.93				
Suicidal Ideations	12.60 (4.01)	12.67 (3.99)	13.03 (3.30)	.15				

Note. CI = Confidence Interval; *UL* = Upper Limit; *LL* = Lower Limit.
$^{**}p < .01$. $^{*}p < .05$.

Differences on Study Variables along Registered Gender

One-Way ANOVA was computed to figure out differences on study variables among *hijras* who have registered their gender as male, female, transgender or have no identity cards. The category of female was skipped because no one in the sample was reportedly registered as female.

On domains of perceived attitude, social distance and sexual issues, result (Table 16) shows significant differences. Games-Howell post-hoc analysis (used for unequal sample size) shows that *hijras* who registered their gender as male perceive people's attitude more positive about their acceptance and perceive that people do not consider them as sexual deviant and in having different relationships in comparison to *hijras* who have registered themselves as transgender and have no identity card, respectively. Bonferroni post-hoc analysis also shows significant differences on anticipated rejection and sexual risk behaviors. *Hijras* who have no identity card, are significantly expecting their future more negative as compared to the *hijras* who registered themselves as male. Result shows the significant difference on sexual risk behavior too. *Hijras* who have registered themselves as transgender have more sexual risk behavior as compared to the hijras who have registered themselves as male. Nonsignificant differences are shown on total perceived attitude and its domain rights and status and suicidal ideations.

Table 16

Comparing One Way Analysis along Registered Gender (N = 105)

	Male	Transgender	No identity card					
	(n = 82)	*(n = 14)*	*(n = 9)*				*95%CI*	
Variables	*M(SD)*	*M(SD)*	*M(SD)*	*F*	*i-j*	*D(i-j)*	*LL*	*UL*
Perceived Attitude	65.65 (13.07)	58 (12.50)	58.22 (14.99)	2.97				
Rights & Status	30.80 (6.80)	27.21 (6.39)	29.66 (9.65)	1.59				
Social Distance	21.39 (4.34)	17.78 (3.92)	18.44 (4.09)	5.56**	1 >2	3.60*	.59	6.61
Sexual Issues	13.46 (3.70)	13 (3.74)	10.11 (3.05)	3.40*	1 > 3	3.35*	.22	6.48
Anticipated Rejection	29.53 (3.61)	29.64 (3.49)	34.44 (3.24)	7.72**	1< 3	-4.90*	-7.96	-1.85
					2<3	-4.80*		
Sexual Risk Behaviors	31.53 (6.50)	37.07 (4.93)	35.44 (8.12)	5.31**	1 <2	-5.53*	-10.08	-.97
Suicidal Ideations	12.60 (3.85)	13.64 (2.73)	13.66 (2.78)	.73				

Note. CI = Confidence Interval; *UL* = Upper Limit; *LL* = Lower Limit.
**$p < .01$. *$p < .05$.

DISCUSSION

Chapter 4

DISCUSSION

The present study was aimed to find the relationship between perceived attitude, anticipated rejection, sexual risk behaviors and suicidal ideations among *hijras.* For data collection, convenient and snowball sampling technique was used. The predictors for sexual risk behaviors were also tested. Mediation analysis was run to see the effect of anticipated rejection as a mediator, on sexual risk behaviors and suicidal ideations. Further, moderating role of different variables in predicting sexual risk behaviors was also analyzed. Finally, role of demographic variables (e.g., age, monthly income, relationship with guru, relationship with boyfriend, religiosity etc.) on study variables among *hijras* were also investigated.

To develop the better understanding of the sample characteristics on study variables, first of all frequencies and percentages were obtained (see Table 2). Analyses were computed on few demographic variables; age, monthly income, registered gender, happy being a *hijra,* relationship with *guru*, having boyfriend, relationship with boyfriend, religiosity, and having done HIV/AIDS test. For others, only frequencies and percentages were computed to give detailed context of characteristics of a *hijra.* Alpha reliabilities of the instruments used in the study showed that measures had good reliabilities.

The mean of *Hijra's* Perception of Attitude towards *Hijra* Scale and its subscales lied on the left side of the curve which showed that participants scored on high values. Transformed scores of NEFFS shows that mean value lies on right side of the curve. This shows that participants are expecting more rejection. Mean values of transformed scores of SRBQ and SBQR show that participants scored on high scores. Participants have more sexual risk behaviors and suicidal ideations. Overall descriptive statistics showed that all the variables were normally distributed as all values of skewness and kurtosis lied in acceptable range which is between -2 and +2 (Gravetter & Wallnau, 2014). Hence, parametric tests were used for the analysis.

Correlation between Study Variables

The results of bivariate correlation analyses showed that there was significant negative correlation between perceived attitude (i.e., perception of attitude of people about *hijra's* rights and status, their acceptance in close relationships, and their acceptance as sexual deviant), and anticipated rejection. This showed that rejection which *hijras* were expecting about their future was related with their perception of people's attitude towards them. So, Hypothesis 1 that there is negative correlation between positive perceived attitude and anticipated rejection is accepted. This might be because *hijra* identity is not accepted in Pakistan yet. *Hijras* face violence, discrimination and anger, abuse, and lack of support, when they disclose their identity and interests. These things make them feel that they have dark future and are expecting discrimination in future because of their identity and might be that is reason for their negative perceived attitude of people towards them or vice versa. Experiences of discrimination which are faced by transgender magnify the expectation of discrimination in future (Mizock & Fleming, 2011). Transgender people may assimilate negative appraisals of society into their self-concept, which leads to negative self-evaluation (Hendricks & Testa, 2012; Testa et al., 2012).

Results showed that positive perceived attitude was negatively correlated with sexual risk behaviors among *hijras*. Thus, Hypothesis 2 that there is negative correlation between positive perceived attitude and sexual risk behaviors is accepted. The reason could be the trans stigma, which makes them a marginalized community. The lack of opportunities for employment restricts their approach to essential necessities of life, which ultimately leads them to survive on sex business. According to Hughto et al. (2015), adverse mental and physical health outcomes, and housing, healthcare and employment nepotism among transgender persons are associated with stigma. Stigma and violence has been related to vulnerability of HIV/ AIDS (Wison et al., 2011). In Pakistan, transgender earns their living by weddings, festivals, singing, and dancing in functions. The decrease in their social acceptance pushes them towards begging on streets and successive commercial sex (Altaf et al., 2012). Physical and sexual violence is related to the irregular condom use among sex workers (Beattie et al., 2010).

Table 3 further showed that positive perceived attitude was correlated with suicidal ideations among *hijras*. Hypothesis 3 that there is negative correlation

between positive perceive attitude and suicidal ideations is accepted. This might be because when *hijras* perceived that people including their families consider them as sexual deviant, do not accept to have relationships with them, and do not give them support, then they naturally want to die. Among transgenders, sexual minority status itself is a main factor for life-threatening behaviors (Grossman & D'augelli, 2007). According to Chakrapani (2010), societal stigma, lack of social support, violence-related issues highly regulate the suicidal tendencies among transgender persons.

Finding revealed that anticipated rejection was positively correlated with sexual risk behaviors among *hijras*. Hypothesis 4 that there is positive correlation between anticipated rejection and sexual risk behaviors is accepted. The possible reason could be *hijras* face prejudice, discrimination, anger in their past and in present so they also expect rejection in future on the disclosure of their identity. So, the fear of discrimination pushes them to risky sexual behavior. Expectation of rejection and transgender-related discrimination are connected with sexual risk behaviors. Anticipated rejection is positively related with sexual risk behaviors (Rood, Kochaver, McConnell, Ott, & Pantalone, 2018). According a theory, there is possibility that LGB and men who have sex with men (MSM) anticipating rejection may guide them to take their sexual partners to the places where they expect least chances of rejection (Holloway, Pulsipher, Gibbs, Barman-Adhikari, & Rice, 2015).

Table 3 further revealed that sexual risk behaviors were positively correlated with suicidal ideations. Hence, Hypothesis 5 that there is positive correlation between sexual risk behaviors and suicidal ideations is accepted. This might be because *hijras* normally indulge in sex business, whether in prostitution or survival sex, which make them more prone to sexual risk behaviors. There is also possibility of feeling of guilty in them because of their indulgence in sexual activities, which leads to suicidal ideations. Another reason could be *hijras* face sexual violence, and sexual abuse, which also increase their chances of having risky sexual behaviors, the pain related to those events ultimately leads suicidal ideation among them. Another study is consistent with the present findings transgenders who experiences sexual violence are at high risk of having suicidal ideations, suicidal attempts (Testa et al., 2012). As homosexuality is consider as shameful sin Islam and in Pakistani culture this could be a reason for suicidal ideations among *hijras* (Kulge, 2010).

Qualitative Analyses of Demographics

Analyses of demographics showed that most of *hijras* are confused about being *hijra*, as they do not know whether they are happy or not about having *hijra* their gender identity. Most of them reported that they are confused because they are in conflict created by the negative attitude of people and supportive attitude of their community members. Most of the *hijras* reported that they actually wanted to be female. This shows that they are happy with their gender identity, which can lead them to suicidal ideations. According to Blosnich et al., (2013), transgenders who do not happy with their gender have more chances of having suicidal ideations and suicidal attempts. Majority of the participants have boyfriend and out of which most of the *hijra*s have good relationship with their boyfriends. This shows that they do have more sexual contacts, which can be a reason for risky sexual behavior among them. This finding is consistent with previous literature which shows that having more sexual contacts with different sexual partners is source of transmission of HIV/AIDS (Bhatta, 2014). Most of them want to call themselves *moorat.*

Majority has good relationship with their *gurus*. Good relationship with *guru* shows that *gurus* can be their support system. According to Jami (2012), *gurus* play very important role in the community as they provide social and emotional support to their *chelas.* Good relationship with *guru* also shows high sexual risk behaviors. *Guru* controls over the life of her *chela* and takes a portion of income of her *chela.* Major source of income of *hijras* is sex business, so to fulfill the demands of *guru* and own self, *hijras* work as prostitutes which increases their sexual risk behaviors (Nanda, 1998; see Table 5). Most of them, think themselves as female but majority of the *hijras* have registered them as male. This shows the conflict in their gender identity and can be a reason for suicidal ideation as discussed above. Families of majority of *hijras* call them male. This could be because biological families of *hijras* show rejection and lack of social support because of their gender identity (Rafique, 2015), so they call them with the gender identity they birth with.

Most of the *hijras* reported that they did not offer prayers and few who offer prayers sometimes also reported how many they do offer in a day? This shows that they are dissatisfied with themselves and that is why they are far from religion. Results (see Table 4) further reported that *hijras* smoked cigarettes and some also took drugs mostly in functions. This could be because of the social exclusion they

face. Prior literature also suggests that social exclusion and discrimination leads transgender to drug abuse (Scheim, Bauer, & Shokoohi, 2017). More than half of the *hijras* had not done their HIV/AIDS test and some of them reported that they are HIV positive. To avoid the stigma of HIV positive could be reason for those who had not done their HIV test and having different sexual partners, involvement in sex business, anticipated rejection makes them more vulnerable to HIV/AIDS (Bhatta, 2014; Nanda, 1998; Shankle, 2006).

Predictors of Sexual Risk Behavior

Table 7 showed that positive perceived attitude significantly negatively predicted sexual risk behaviors. The reason could be when *hijras* perceive people accept them in different relationships, so they indulge in risky sexual behavior less. A study shows that condom is sign of love and protection and a barrier to HIV/AIDS risk in relationships (Harrison, Xaba & Kunene, 2001). Anticipated rejection significantly positively predicted sexual risk behaviors among *hijras*. The possible reason could be *hijras* expect negative reaction on their identity disclosure, that is why they conceal their identity and indulge in sexual risk behaviors. Anticipation of more discrimination has more negative outcomes than experiencing it (Bucher & Raess, 2007). According to Kopetz et al., (2014), experiencing social rejection is related to greater number of sexual partners, which ultimately leads to high sexual risk behavior. Rejection based on disclosure of sexual orientation is barrier to safe sex and leads to HIV/AIDS risk (Wang & Pachankis, 2016).

Correlation along Demographic Variables

Results in Table 5 showed positive perceived attitude and its domain, social distance was positively correlated with religiosity. The reason could be *hijras* who perceive that people accept them as they are and accept to have relationship with them practices religion (offer prayers) or vice versa. Those who have intrinsic motivation to follow religion have better relationship that may be the reason that *hijras* perceive people's attitude as positive. They may also indulge less in deviant social behaviors being religious. Hence, may perceive positive attitude and satisfied with their lives. According to Myers (2008), people who are actively religious are far happier and satisfied with their lives as compared to their other counterparts.

Results further revealed that anticipated rejection is positively correlated with age, but negatively correlated with religiosity. Most of the participants of study were above 25 of age; may be their experiences of discrimination, prejudice, and violence increase with their ages that's why they are expecting the same in future. Another reason could be as their age increases, their sources for earning become less which makes them to expect their future negative. Existing literature also supports this finding, that there is more probability that older transgenders are unemployed and they receive very little household income (Conron, Scott, Stowell, & Landers, 2012; Rosser, Oakes, Bockting, & Miner, 2007). According to Fredriksen-Goldsen et al. (2013), transgender people who are aged that is 50 and more are at higher risk of disability, poor physical health, depression, and perceived stress. Transgender adults often are victims of hate crimes and are experience violence and abuse (Witten & Eyler, 2012). Fear of rejection, discrimination, violence on disclosure of identity may be make them dissatisfied with their own selves and have feeling of guilt that is why they do not offer prayers.

Table 5 also showed that sexual risk behaviors were positively correlated with age and relationship with guru. The reason could be as the age increases number of sexual activities with different sexual partner also increases, which make the *hijras* more vulnerable for HIV/AIDS. According to Sales et al., (2011), older people are more vulnerable to HIV as they have more unsafe sex with different sexual partners. Since earning reduce with age, and to sustain oneself *hijras* may increase their sexual contact to earn living. Financially *hijras* support *gurus* and *gurus* act *dalal* for them, which may lead to more sexual risk behaviors to increase earning. It may be possible that having good relationship with guru increases the number of sexual activities which further leads to chances of having HIV/ AIDS. Another reason can be to what extent a *hijra* has control over her life. If her life is under-control of *guru,* having safe sex also depends on *guru.* According to Nanda (1998), *gurus* play an important role in the lives of *hijras*. They support economically their *gurus*. *Gurus* have control over the lives of *chelas,* as they provide social support to *chelas* that is why *chelas* have to do what *gurus* want from them. Most of *hijras* work as prostitutes and a portion of the money earned from prostitution is used by *guru.*

Correlation along Other Indicators of Sexual Risk Behaviors

Results in Table 6 showed that age of first sexual contact was negatively correlated with perceived attitude and its domains, rights and status and social distance but positively correlated with sexual risk behaviors. *Hijras* who experiences sexual contact at very young age might be perceive that people are not in favor of their basic rights, and does not want to have relationships with them and consider them as sexual deviant. Same relationship was noticed with reference to perceived attitude and its domain rights and status and sexual risk behavior for number of people with which *hijras* have sexual contacted last month, with the number of people they had sexual contact more than once, and number of sexual contacts *hijras* had with regular partners or client. Number of safe sex is significantly negatively correlated with sexual risk behaviors. Being a victim of parental physical abuse is an amplified reason for homelessness of LGBT youth (Cochran, Stewart, Ginzler, & Cauce, 2002). Homeless youth is more pregnable to any kind of victimization that is rape, robbery, and assault. According to Cochran et al. (2002), since LGBTs first become homeless, they are often sexually victimized. LGBTs have their first voluntary intercourse at younger age as compared to heterosexuals (Cochran et al., 2002). *Hijras* who experience sexual contact at very young age can be more vulnerable to HIV/ AIDS as that sexual contact can be a sexual abuse or violence. According to Hawkes et al. (2009) experience of forced first sex is a factor to vulnerability of HIV/AIDS. Hawkes et al. (2009) found that STIs are more in transgender sex workers. According to Shankle (2006), transgender often have multiple sex partners or unprotected sex. This makes them more vulnerable to HIV/AIDS. LGBT youth have more number of sexual partners than heterosexuals and they overlook the protection during sex "all of the time" (Cochran et al., 2002), making them more prone to risky behaviors. In the mainstream society *hijras* are usually pressurized to have unsafe sex, as they are misused by cisgenders (Khan et al, 2009).

Results further revealed that number of safe sex is significantly positively correlated with perceived attitude and its domain rights and status but negatively correlated with sexual risk behavior. This might be when *hijras* perceive that people accept them as they are, and are satisfied with themselves then they have safe sex which ultimately decreases their sexual risk behaviors. A study shows that condom is sign of love and protection and a barrier to HIV/AIDS risk in relationships (Harrison

et al., 2001). Same relationship is observed in case of number of places sexual contact was made that is number of places of sexual contact is positively correlated with perceived attitude and its domains, rights and status and social distance. The reason could be as *hijras* perceive people attitude more positive about themselves they want to have sexual contact at different places because they perceive that people accept them. Results further revealed that number of places sexual contact was made is negatively correlated with sexual risk behaviors.

Table 6 further revealed that earning through sexual contact is positively correlated with social distance. *Hijras* who perceive that people accept to have relationships with them might have more sexual contact with their same community or cisgenders. *Hijras* having more sexual contact may perceive other people as their client, "*tamashbeen*" who love them or want to meet them. That may be a reason for perceiving people's attitude more positive (Jami, 2012). Number of sexual abuse was negatively correlated with perceived attitude and rights and status but positively correlated with suicidal ideations. The reason could be when *hijras* experience sexual abuse or rape or force sex; they perceive people's attitude towards them and their rights negative. The discrimination, violence, abuse ultimately leads to suicide ideations among them. According to Clements-Nolle, Marx, and Katz (2006), the exposure of discrimination and harassment to transgenders, lead them to suicidal ideations.

Mediation Analysis for Sexual Risk Behaviors and Suicidal Ideations

Hypothesis 6 suggests that anticipated rejection is mediator for positive perceived attitude in effecting in effecting sexual risk behaviors among *hijras*. Results showed that there was significant direct effect of perceived attitude on sexual risk behavior but anticipated rejection showed nonsignificant effect. Hypothesis 7 proposes that anticipating rejection is mediator for positive perceived attitude in effecting the suicidal ideations in *hijras*. Table 9 showed that perceived attitude directly affected the suicidal ideations in *hijras* when anticipated rejection was entered as mediator, it did not affect suicidal ideations. Hence, both hypotheses are rejected.

Both hypotheses were based on minority stress model. This model suggests that variations in health of sexual minority are explained by stressors instigated by the

homophobic and hostile culture which ultimately results in discrimination, maltreatment, victimization and harassment in lifetime (Marshal et al., 2008; Meyer, 2003).Stress theory provides a useful framework to explain and examine health disparities and the role of homophobia as a sociological paradigm that views social conditions as a cause of stress for members of disadvantaged social groups, which in turn can increase risk for HIV, among other risk factors (Aneshensel, Rutter, & Lachenbruch, 1991; Dressler, Oths, & Gravlee, 2005). The possible reason for finding of current study could be that *hijras* are anyways so open to cisgenders that their concealment in future does not really affect their sexual risk behaviors and suicidal ideations.

According to fourteen stages of transsexual identity formation of Devor (2004), by the time people reach at stage 9 "Acceptance of Transsexual or Transgendered Identity", they collected required information and worked enough on their emotional anxieties about the concern that they can tell others and themselves and at this stage they fully accept themselves as transsexual or transgender. In last stages (11-14) of this model, individual lives as identified gender successfully, learns to deal with stigma, desegregate the different features of identity, and adopts the transsexed or transgendered identity, sometimes through the participation in activism. According to Heidi and Maria (2014), transgenders reach to their identities through stabilizing a desire for validity with demands of necessity that is with the concern about their present resources, coping skills, and consequences of gender transitions, they appraise their internal gender experience.

Stigma is insidious and continued for all transgenders even for those who have transitioned themselves to live as a member of other sex. Transgender and transsexual people see support and association among themselves, they endorse their rights, respect and acceptance, declare their distinct identity and experience, provocate the stigma and this makes "Transgender" an identity now (Bockting, 2014). According to Lev (2004), considering transgender identity a pride, significantly comes as outcome resulting from subjugating social stigma and shame authorizing by the institutions and societies. In relation between minority stress and negative mental health outcomes pride is taken as mitigating effect (Bockting et al., 2013).

Moderation Analyses for Sexual Risk Behaviors

Results (see Table 10) showed that for more suicidal ideations, positive perceived attitude increases sharply with the decrease in sexual risk behaviors and same effect was seen for medium level and low level suicidal ideations. The reason could be that those who have more suicidal ideations may have feeling of shame that people think positive about their rights and their acceptance but they indulge in multiple sexual activities. Another reason could be suicidal ideations act as coping strategy or protective factor for their guilt. According to Kaufman (1996), shame occurs when one criticizes or condemns own-self. When the person has evaluated the difference as a deficiency, then the shame is generated by perceived difference. Fullagar's (2003, 2005) work suggests that to understand the young people's subjectivities, it is important to understand the social dynamics of shame. She links shame to shamed or failed self and proposes that to escape from those pressures which make them feel failed or unworthy one has suicidal ideations.

Moderation results (Table 11) further showed that participants who did not have safe sex, their sexual risk behavior decreased with the increase in positive perceived attitude of people. Same effect was seen for who had medium level safe sex. The possible reason could be that positive perceived attitude plays role of protective factor as they perceive people accept them as they are, so they are indulging in risky behaviors less. For those who had safe sex, their sexual risk behaviors decrease less with the increase in positive perception of people's attitude. The reason might be they have good relations with their sexual partners, so they perceive people's attitude more positive and because of the love and acceptance of their partners they do not care about using contraceptives all the time. Love and trust relationship with intimate partner provides secure base. That is why condom use is less frequent with such intimate partners (Stoebenau, Hindin, Nathanson, Rakotoarison, & Razafintsalama, 2009).

Results (Table 12) further showed that the increase in positive perceived people's attitude decreased the sexual risk behaviors more sharply in those who are not happy being a *hijra* as compared to those who are confused and happy being a *hijra*. The reason could be when *hijras* are not happy with their gender identity and they are experiencing rejection then they are not willing to indulge in safe sex practices. Experiences of rejection and careless behaviors from parents, and whole

community make transgender youth feel shame and unworthiness (Herek et al., 1998) and these experiences lead them to have more sexual partners and make them more vulnerable HIV/AIDS (Kopetz et al., 2014).

Differences on Study Variables along Demographic Variables

Results showed that significant differences occurred on perceived attitude and its domains, social distance and sexual issues, and sexual risk behaviors. Table 13 showed that those participants, who had boyfriend, had more positive perception of people's attitude as compared to those who did not have boyfriend. The possible reason could be *hijras* are happy for having boyfriend or in relationship that may affect their perception in general. *Hijras* feel acceptance and love; perceive themselves as female while in relationship that strengthen their gender identity, hence perceive people's attitude positively. According to Hazen and Shaver (1987), romantic relationships prove safe haven and secure base. The increase in social acceptance, level of self-esteem, and feelings of competence is related with having good intimate relationship (Grover, Nangle, & Zeff, 2005). Those participants who had no boyfriend showed less chances of risky sexual behaviors as they might be less sexual contacts with others as compared to those who had boyfriends. This finding is consistent with the observation of researcher that *hijras* who had boyfriends, indulge more in sexual contacts, as compared to those who had no boyfriends.

Differences on study variables along having done HIV/ AIDS test (see Table 14) showed that participants who had done their HIV/ AIDS test perceived people's attitude more positive towards them as compared to the participants who had not done. Participants who had not done their HIV/AIDS test expect their future more negative as compared to the participants who had done their tests. The possible reason could be that *hijras* who had not done their HIV/AIDS test, have not disclose their identity and have more fear of being a victim of violence, so that they are more anticipating rejection in future. According to Grossman and D' Augelli (2006) most important concerns of transgenders are safety issues which are related to being victim of violence on the disclosure of their gender identity. So, they perceive that their selfhood and uniqueness can hide only if their gender and sexual identities remain non disclose. So, they learn to rely on avoidance coping skills. Another reason could be *hijras* are already stigmatized, so they do not want to be double stigmatized or do not want to be rejected, as they know they are at high risk for HIV/AIDS that is why they

had not done their HIV/AIDS test. People who are suffering from HIV/AIDS face social exclusion or rejection, discrimination and stereotyping. To avoid the rejection by the families, providers and general public, such people conceal their status which ultimately leads them to delay or cut off from medical services they needed (Herek et al., 1998).

Comparison along registered gender showed that *hijras* who had registered themselves as males perceived people's attitude more positive towards themselves as compared to those who registered themselves as transgender or had no identity cards. The reason could be male is taken as dominant gender in Pakistan, therefore, *hijras* who present themselves as male have more positive perception of attitude as compared to those who presents themselves as transgender, which is already taken sexual minority status. Some *hijras* may be *zananas,* who take *hijras* as a professional category for earning money rather than gender category. They are contended with their gender identity they are born with. Hence, there is no fear of disclosure of secret identity. They may be married and earn money (Cohens, 1995). Hence, they may perceive people's attitude positively. Results further showed that *hijras* who had no identity card expected more rejection on their disclosure as compared to those who had registered themselves as male or transgender. *Hijras* who registered themselves as transgender had more sexual risk behavior compared to those who had registered them as male.

Implications

The present study fills the gap in literature by studying the role of anticipated rejection between perceived attitude, sexual risk behaviors and suicidal ideations among *hijras.* In the current study, the Negative Expectations for Future subscale, was also translated in Urdu which was found to be a valid measure for Pakistani culture, hence, it would be useful for future studies to study the role of expecting rejection in the lives of transgender or other sexual minorities. Suicidal Behavior Questionnaire-Revised was also translated for tapping different dimensions of suicidality. It was also found to be psychometrically sound to be used in future studies. A new to measure sexual risk behaviors, Sexual Risk Behavior Questionnaire (Jami, 2018) was used. It had been used for the first time. The findings on the scale showed that scale is reliable and can be useful in future as no such measure was available in Pakistani context.

Current study reveals the role of people's perceived attitudes and negative anticipation of future as linked to sexual risk behaviors and suicidal ideation. This suggests mental health practitioners to address these while offering health services to them as *hijras* are high risk group for AIDS/HIV; by addressing underlying cause for sexual risk behaviors the health of *hijras* can be promoted.

Government can run awareness and attitude change programs to change attitude of masses that will help in mainstreaming of *hijras* as they are now declared as third gender in Pakistan. Government declaration about their rights to inherit, education, vote, and employment can also help them to opt other profession except sex business which also reduces their risky sexual behavior.

Limitations and Suggestions

1. The sample was limited and was taken only from Rawalpindi and Islamabad; therefore, the findings cannot be generalized overall *hijra* community of Pakistan. Further studies should consider the community from different cities, so that findings can be generalized over all the country.
2. Participants reported that questionnaires were lengthy. Some reported that they got bore while answering the questions. For the researcher also, it was a big task to take information from each of them. It was very time-consuming. It was in interview format so it took 18-20 minutes, to fill each questionnaire. For future, research should be conducted in qualitative structure to get the detailed information.
3. The researcher was female, but for few questionnaires, the research assistants were employed, who were male. It was noticed that *hijras* were more open to male as compared to the female researcher, especially, when they were supposed to give their personal information regarding their sexual life history; they were more responsive to male research assistant. There should be male research assistant employed for future studies for the whole period, to get the genuine information about the sensitive issues.
4. The subscale Negative Expectations about the Future, used to measure anticipated rejection, was only translated and adapted. In future studies, the validity of the subscale should be measured.

Conclusion

The findings of present study are consistent with the earlier efforts to understand how perceived people's attitude affects the lives of *hijra* community. The findings contribute to dearth of scientific research by highlighting how perceptions of people's attitude by *hijras* affect *hijras'* sexual behaviors and mental health. The present study revealed that *hijras* perceived people attitude more negative. The violence, discrimination, and abuse, they are facing in past, present make them to anticipate rejection in future. The employment discrimination leads them to involve in sex selling business, which ultimately lead them to sexual risk behaviors. *Hijras* face physical as well as sexual abuse, which is also another indicator of sexual risk behavior. People's biased attitude towards them, denial of their rights, and on the opportunities, that comes their way gives them psychological distress including suicidal ideations. The current study gives us the information about the stressor which effects the sexual and mental health of *hijras*.

Findings of the study further revealed that anticipated rejection is non-significant mediator of perceived attitude in predicting sexual risk behaviors and suicidal ideations. Significant role of suicidal ideations, safe sex and happiness being a *hijra* as moderator between perceived attitude and sexual risk behavior was also found. Positive perceived attitude was significantly negatively predicted sexual risk behaviors while anticipated rejection significantly positively predicted sexual risk behaviors. Significant role of demographic variables (age, religiosity, having boyfriend, relationship with *guru*, having done HIV/AIDS test, registered gender etc.) was also seen.

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APPENDICES

Appendix-A

Informed Consent

میں قومی ادارہ نفسیات "قائداعظم یونیورسٹی" اسلام آباد میں ایم۔ایس۔سی کی طالبہ ہوں۔ یہ تحقیق میری ایم۔ایس۔سی ڈگری کے حصول کا حصہ ہے۔ جس میں مجھے آپ کی مدد درکار ہے۔ خواجہ سرا (ہیجڑا، کھسرا، زنانہ، وغیرہ) ہمارے معاشرے کا اہم حصہ ہیں۔ جو تیسری جنس مانے جانے کے باوجود بہت سے مسائل سے دوچار ہیں۔ میری تحقیق کا مقصد یہ جاننا ہے کہ آپ دُنیادار/لوگوں کے رویوں کو کس طرح محسوس کرتے ہیں۔ اور یہ رویے آپ کی زندگی پر کیا اثرات مرتب کر رہے ہیں۔ یہ تحقیق خواجہ سرا (ہیجڑا، کھسرا، زنانہ، وغیرہ) کے معاشرتی نظام میں برابری کی بنیاد پر بحیثیت ایک آزاد شہری کے طور پر شمولیت میں اہم کردار ادا کر سکتی ہے۔

اگر آپ اس تحقیق کا حصہ بننا چاہتے ہیں تو نیچے دیئے گئے راضی نامے پر دستخط کریں۔ پھر آپ کو سوالنامے دیئے جائیں گئے۔ آپ کو سوال نامے میں دی گئی ہدایات کے مطابق سوال پوچھے جائیں گئے اور آپ سے گزارش ہے کہ اپنے تجربات کے پیش نظر سوالات کا ایماندارانہ جواب دیں۔ آپ کو سوال نامہ پُر کرتے وقت کچھ پوچھنا ہو تو بلا جھجک پوچھ سکتے ہیں۔ ہمارے لیے آپ کے صحیح جوابات بہت اہم ہیں۔ آپ کی معلومات سے اجتماعی نتیجے اخذ کیے جائیں گے۔ آپ کو اس بات کی گارنٹی دی جاتی ہے کہ:

1- آپ کا نام یا شناخت ظاہر نہیں کی جائے گی۔

2- سوال نامے پُر کرتے ہوئے اگر آپ چھوڑ کر جانا چاہیں گے، تو چھوڑ کر جا سکتے ہیں۔

3- آپ کی دی گئی معلومات کو مکمل طور پر صیغہ راز رکھا جائے گا اور صرف تعلیمی مقاصد کے لیے استعمال کیا جائے گا۔

آپ کے وقت اور تعاون کا شکریہ!

دستخط: _____

خدیجہ مظفر

نیشنل انسٹیٹیوٹ آف سائیکالوجی، شاہدرہ روڈ، قائداعظم یونیورسٹی، اسلام آباد۔

Appendix-B

ذاتی کوائف

عمر: _____ پیدائشی جنس: _____

رجسٹرڈ جنس: _____ موجودہ مقام: (گرو ، چیلا ، دونوں)

تعلیم: _____ ماہانہ آمدنی: _____

ازدواجی حیثیت: _____ رہائشی علاقہ: _____

کام کا علاقہ: _____

ہیجڑے کی قسم: (زنانہ / کھسرا / خواجہ سرا / نربان / پیدائشی / کوئی اور _____)

کیا کہلوانہ پسند کرتے ہیں؟ _____

روزگار کا ذریعہ (ایک سے زیادہ ہوسکتے ہیں): (ودھائیاں / بھیک مانگنا / فنکشن کرنا / تھیٹر / میلے میں ناچنا / جنسی کاروبار / کوئی اور _____)

اپنے آپ کو کیا سمجھتے ہیں؟ مرد / عورت / ہیجڑا

گھر والے آپ کو کیا کہتے ہیں؟ لڑکی / لڑکا / ہیجڑا

کیا آپ ہیجڑا بن کر خوش ہیں؟ ہاں / نہیں / معلوم نہیں

آپ دراصل کیا بننا چاہتے ہیں؟ مرد / عورت / ہیجڑا

گرو سے تعلقات:

ا) بہت اچھے ب) اچھے ج) درمیانے د) بُرے ہ) بہت بُرے

کیا آپ کا گریا (boyfriend) ہے؟ _____

آپ کے گریا سے تعلقات:

ا) بہت اچھے ب) اچھے ج) درمیانے د) بُرے ہ) بہت بُرے

کیا آپ نماز پڑھتے ہیں؟ ہاں / نہیں / کبھی کبھار

اگر ہاں! دن میں کتنی نمازیں پڑھتے ہیں؟ _____

کیا آپ نشہ کرتے ہیں؟ ہاں / نہیں / صرف سیگریٹ / یا کچھ اور

اگر نشہ آور چیز (مثلاً شراب، آئس وغیرہ) استعمال کرتے ہیں تو کب؟ _____

کیا آپ نے HIV\AIDS کا ٹیسٹ کروایا ہے؟ ہاں / نہیں

اگر ہاں تو کیا نتیجہ نکلا؟ _____

Appendix-C

Hijra's Perception of Attitute towards Hijra Scale

اس سوالنامے کے ذریعے ہم یہ معلوم کرنا چاہتے ہیں کہ آپ لوگوں کے رویوں کو کس طرح محسوس کرتے ہیں۔ سوالنامے میں دیئے گئے بیانات کا کوئی غلط یا صحیح جواب نہیں ہے۔ آپ سے صرف یہ مقصود ہے کہ آپ دیئے گئے بیانات کو غور سے پڑھ کر یہ نشان دہی کریں کہ آپ کس حد تک متفق یا غیر متفق ہیں۔

نمبر شمار	بیانات	مکمل طور پر متفق	متفق	معلوم نہیں	غیر متفق	مکمل طور پر غیر متفق
1	دُنیادار سمجھتے ہیں چونکہ ہمیں بغیر کسی محنت و مشقت کے پیسے مل جاتے ہیں اس لیے ہم کوئی بھی عزت دار پیشہ اختیار کرنے پر راضی نہیں ہوتے۔					
2	دنیاداروں کے مطابق ہم جنسی کاروبار میں ملوث ہوتے ہیں۔					
3	دُنیاداروں کو ہم سے گھن آتی ہے۔					
4	دُنیادار سمجھتے ہیں کہ ہماری وجہ سے معاشرے میں بُرائی پھیل رہی ہے۔					
5	دُنیادار سمجھتے ہیں کہ ہم کسی بھی وقت کائی بھی نازیبا اور شرمندہ کر دینے والی حرکت کر سکتے ہیں۔					
6	دُنیادار سمجھتے ہیں کہ ہماری وجہ سے ایڈز/جنسی بیماریاں پھیل رہی ہیں۔					
7	دُنیادار ہمیں منحوس سمجھتے ہیں۔					
8	دُنیاداروں کو احساس ہے کہ ہم صنفی شناخت نہ ہونیکی وجہ سے الجھن اور پریشانی کا شکار ہوتے ہیں۔					
9	دُنیادار ہمارے لیے جسمانی اور نفسیاتی علاج کی خصوصی سہولتوں کے حق میں ہیں۔					
10	دُنیادار ہمیں تیسری صنف (جنس) مان لینے کے حق میں ہیں۔					
11	دُنیاداروں کے مطابق ہم پر خدا کی لعنت ہے کیونکہ ہم اپنی مرضی سے صنف بدل کر فطرت کی خلاف ورزی کرتے ہیں۔					
12	دُنیادار سمجھتے ہیں ہم جنسی پرستی ہماری وجہ سے پھیل رہی ہے۔					
13	دُنیادار ہمارے ہاتھ کا پکا ہوا کھانا کھا لیتے ہیں۔					
14	دُنیاداروں کو ہمارے ساتھ کام کرنے پر کوئی اعتراض نہیں ہوتا۔					
15	سفر کے دوران دُنیاداروں کو ہمارے ساتھ بیٹھنے پر کوئی اعتراض نہیں ہوتا۔					
16	دُنیادار سمجھتے ہیں کہ ہمیں نوکری دینے سے اُس جگہ کام کرنے والے باقی لوگوں پر منفی اثر پڑے گا۔					
17	دُنیاداروں کو ہم سے دوستی کرنے پر کوئی اعتراض نہیں ہوتا۔					
18	دُنیاداروں کے مطابق ہمیں ہمسایہ بنانے سے ماحول خراب ہونے کا اندیشہ ہوتا ہے۔					
19	اس خوف سے کہ کہیں دوسرے لوگ اُن پر شک نہ کریں دُنیادار ہم سے کوئی بھی تعلق رکھنا پسند نہیں کرتے۔					
20	دُنیادار ہم سے کسی بھی قسم کی رشتہ داری رکھنا پسند نہیں کرتے۔					
21	اگر ہم سے کوئی الیکشن میں کھڑا ہو تو دُنیادار اُسے ووٹ دیں گے۔					
22	دُنیاداروں کو احساس ہے کہ ہم اُن کے بیجا مذاق اور تنقید کا نشانہ بنتے ہیں۔					
23	دنیادار کسی بھی صورتحال میں ہم سے بات کرنا / ملنا آسان نہیں سمجھتے۔					

نمبر شمار	بیانات	مکمل طور پر متفق	متفق	معلوم نہیں	غیر متفق	مکمل طور پر غیر متفق
24	دُنیادار ہماری مدد کر کے خوشی محسوس کرتے ہیں۔					
25	ہمیں معاشرے سے الگ کر کے ایک مخصوص کردار ادا کرنے کی توقع کی جاتی ہے۔					
26	دُنیادار ہمیں اپنے گھروں میں موضوع گفتگو بنانا معیوب سمجھتے ہیں۔					
27	دُنیادار سمجھتے ہیں کہ حکومت کو ہمارے لیے وظیفے مختص کرنے چاہئیں تا کہ ہم بُرائی کی طرف مائل نہ ہوں					
28	دُنیاداروں کا خیال ہے ہم صرف محبت اور اپنائیت کے حصول کے لیے اپنی جماعت میں رہنا پسند کرتے ہیں۔					
29	دُنیاداراس چیز کے حق میں ہیں کہ ہمارے لیے تعلیم اور نوکری کی خصوصی سہولیات ہونی چاہئیں۔					
30	دُنیادار سمجھتے ہیں کہ اُنکے منفی رویے ہمارے لیے تعلیم اور نوکری چھوڑنے کا موجب بنتے ہیں۔					
31	دُنیاداروں کے مطابق ہمیں مرد یا عورت میں سے جس حیثیت میں پالا جائے اُسی لحاظ سے وراثت کا حق دینا چاہیے۔					
32	اگر ہم اپنے حقوق حاصل کرنے کے لیے تحریک چلائیں گے تو دُنیادار ہماری حمایت کریں گے۔					

Appendix-C1

Student Copy

PERMISSION FORM
(For Research Only)

Applicant's Name Khadeeja Muzaffar Supervisor's Name Dr. Humaira Jami

Applicant's Email jazzmzfr52@gmail.com

Institution/ Department National Institute of Psychology, QAU, Islamabad.

Topic of Research Sexual risk behavior and Suicidal ideations among Hijras: role of perceived attitude and anticipated rejection.

M.Sc. / M.Phil / M.S / Ph.D / Diploma

Test Required: (scale title, year, author) Hijra's perception of attitude scale. (Jami,

Undertaking

- This is hereby specified that the above mentioned information is correct.
- I applied for the above mentioned scale after consultation with my supervisor.
- I also understand that I have to follow the copy rights requirements of the National Institute of Psychology.
- This test / scale is the intellectual property of the National Institute of Psychology. No part of this test / scale may be reproduced or photocopied or disseminate or to republish without written permission from the National Institute of Psychology.
- I am also under obligation to share my data and research findings with the TRC of National Institute of Psychology.

Research Supervisor

Khadeeja
Student

Permission granted for the above mentioned research only.

You are not allowed to share this scale /test with other students.

25/4/16

Incharge TRC (Signature)
Test Resource Centre,
National Institute of Psychology, Quaid-i-Azam University

Appendix-D

Sexual Risk Behavior Questionnaire

نیچے دیے گئے سوالات آپ کے جنسی تجربات سے متعلق ہیں۔ برائے مہربانی پڑھ کے یا سُن کے جواب دیں۔

1- آپ کس کے ساتھ جنسی تعلق رکھتے ہیں؟

ا) صرف مرد ب) زیادہ تر مرد ج) مرد عورت دونوں د) زیادہ تر عورت ہ) صرف عورت

2- جنسی ملاپ کے دوران کیا آپ احتیاطی تدابیر (مثلاً کونڈوم وغیرہ) استعمال کرتے ہیں؟

ا) ہمیشہ ب) اکثر ج) کبھی کبھار د) بہت کم ہ) کبھی نہیں

3- جنسی ملاپ کے دوران آپ تماش بین/کلائنٹ/ پارٹنر سے احتیاطی تدابیر استعمال کرنے کے لیے کتنا اصرار کرتے ہیں؟

ا) ہمیشہ ب) اکثر ج) کبھی کبھار د) بہت کم ہ) کبھی نہیں

4- اگر آپکا تماش بین/کلائنٹ/ پارٹنر آپ سے بغیر احتیاطی تدابیر استعمال کیے جنسی ملاپ قائم کرنے پر اصرار کرے تو آپ _____ مان جاتے ہیں؟

ا) ہمیشہ ب) اکثر ج) کبھی کبھار د) بہت کم ہ) کبھی نہیں

5- جنسی ملاپ میں آپ کے احتیاطی تدابیر استعمال کرنے کا انحصار تماش بین/کلائنٹ/ پارٹنر پر منحصر ہوتا ہے؟

ا) ہمیشہ ب) اکثر ج) کبھی کبھار د) بہت کم ہ) کبھی نہیں

6- آپ کی جنسی زندگی دوسروں (گُرو، تماش بین وغیرہ) کے اختیار میں ہے/ رہی ہے؟

ا) ہمیشہ ب) اکثر ج) کبھی کبھار د) بہت کم ہ) کبھی نہیں

7- جنسی ملاپ کے دوران آپ وہ سب کرنے کو تیار ہوتے ہیں جس کی ڈیمانڈ تماش بین/کلائنٹ/ پارٹنر کرتا ہے۔

ا) ہمیشہ ب) اکثر ج) کبھی کبھار د) بہت کم ہ) کبھی نہیں

8- جنسی ملاپ کے دوران آپ وہی کرتے ہیں جو آپ چاہتے ہیں؟

ا) ہمیشہ ب) اکثر ج) کبھی کبھار د) بہت کم ہ) کبھی نہیں

9- جنسی ملاپ سے پہلے یا اُس کے دوران کیا آپ کوئی نشہ آور چیزیں (مثلاً شراب، آئس وغیرہ) استعمال کرتے ہیں؟

ا) ہمیشہ ب) اکثر ج) کبھی کبھار د) بہت کم ہ) کبھی نہیں

10- جنسی ملاپ سے پہلے یا اُس کے دوران کیا آپ کے تماش بین/کلائنٹ/ پارٹنر آپ کو نشہ آور چیز (مثلاً شراب، آئس وغیرہ) استعمال کرنے پر اصرار کرتے ہیں؟

ا) ہمیشہ ب) اکثر ج) کبھی کبھار د) بہت کم ہ) کبھی نہیں

11- آپ اپنے لیے AIDS / یا دوسری جنسی بیماریوں کے لیے کتنا خطرہ محسوس کرتے ہیں؟

ا) بہت زیادہ ب) زیادہ ج) درمیانہ د) کم ہ) بہت کم

12- کس عمر میں آپکا سب سے پہلے جنسی ملاپ ہوا؟ _____

13- پچھلے یک مہینے میں آپ نے کتنے افراد کے ساتھ جنسی ملاپ کیا؟ _____

14- ان میں سے کتنوں کے ساتھ آپ نے ایک سے زیادہ مرتبہ جنسی فعل قائم کیا؟ _____

15. جنسی ملاپ کی کل تعداد کتنی ہوگی جو کہ آپ نے ریگولر پارٹنر/ کلائنٹ/ تماش بین کے ساتھ کیا؟ _____

16 - ان میں سے کتنے جنسی ملاپ کے دوران آپ نے احتیاطی تدابیر (مثلاً کونڈوم وغیرہ) اختیار کیں؟ _____

17 - آپ اپنے تماش بین/ کلائنٹ/ پارٹنر سے ایک مرتبہ جنسی ملاپ قائم کرنے کے کتنے پیسے وصول کرتے ہیں؟ _____

18 - آپ ایک مہینے میں جنسی کاروبار سے کتنا پیسہ کما لیتے ہیں؟ _____

19 - میں پچھلے ایک مہینے میں _____ مرتبہ زیادتی کا شکار ہو چکا ہوں؟

20 - پچھلے ایک مہینے میں آپ کتنی مختلف جگہوں پر جنسی تعلق قائم کرنے کے لیے راضی ہوئے؟

☐ اپنے گھر میں
☐ ہوٹل کمرے میں
☐ پارک میں
☐ کسی گاڑی میں
☐ کسی پبلک ایریا میں
☐ کوئی اور _____

Appendix-E1

Negative Expectations for the Future (Original Version)

Response options: 5-point scale from *strongly disagree* to *strongly agree.*

1. If I ever express my gender IDENTITY/HISTORY, other would not accept me.
2. If I ever express my gender IDENTITY/HISTORY, employers would not hire me.
3. If I ever express my gender IDENTITY/HISTORY, people would think I am mentally ill or "crazy."
4. If I ever express my gender IDENTITY/HISTORY, people would think I am disgusting or sinful.
5. If I ever express my gender IDENTITY/HISTORY, most people would think less of me.
6. If I ever express my gender IDENTITY/HISTORY, most people would look down on me.
7. If I ever express my gender IDENTITY/HISTORY, I could be a victim of crime or violence.
8. If I ever express my gender IDENTITY/HISTORY, I could be arrested or harassed by police.
9. If I ever express my gender IDENTITY/HISTORY, I could be denied good medical care.

Appendix-E2

Ry Testa <testa.ry@gmail.com> Apr 23, 2018, 11:14 AM
o bcc: me

Hello,

There are 3 of you blind cc'd on this email. You are all researchers in Pakistan who at one point or another have asked me to translate and use the GMSR measure. You are alll welcome to do so. However, it strikes me that you might all benefit from being in touch. Some of you have already done thorough work to achieve a solid translation, and others are just starting.
I didn't want to share your emails with each other without permission. But if you would be open to me connecting you to the others, please reply so and I will forward your information to the others.

Best,
Rylan Jay Testa, PhD
P.S. I am no longer at Rhodes College, so you should correspond with me here.

Appendix-E3

Negative Expectations for the Future (Forward Translation)

نمبر شمار	بیانات	مکمل طور پر متفق	متفق	غیر جانبدار	غیر متفق	مکمل طور پر غیر متفق
1	اگر میں اپنی صنفی شناخت/ ماضی کو ظاہر کروں ،تو دوسرے لوگ مجھے قبول نہیں کریں گے۔					
2	اگر میں اپنی صنفی شناخت/ ماضی کو ظاہر کروں، تو ملازمت دینے والے مجھے ملازمت پر نہیں رکھیں گے۔					
3	اگر میں اپنی صنفی شناخت/ ماضی کو ظاہر کروں، تو لوگ سوچیں گے میں ذہنی طور پر بیمار یا پاگل ہوں۔					
4	اگر میں اپنی صنفی شناخت/ ماضی کو ظاہر کروں، تو لوگ سوچیں گے کہ میں قابل نفرت یا گناہ گار ہوں۔					
5	اگر میں اپنی صنفی شناخت/ ماضی کو ظاہر کروں، تو زیادہ تر لوگ مجھے کم تر/ گھٹیا سمجھیں گے۔					
6	اگر میں اپنی صنفی شناخت/ ماضی کو ظاہر کروں، تو زیادہ تر لوگ مجھے حقارت کی نگاہ سے دیکھیں گے۔					
7	اگر میں اپنی صنفی شناخت/ ماضی کو ظاہر کروں، تو میں تشدد یا جرم کا شکار ہو سکتا ہوں۔					
8	اگر میں اپنی صنفی شناخت/ ماضی کو ظاہر کروں، تو میں پولیس کے ہاتھوں ہراساں یا گرفتار کیا جا سکتا ہوں۔					
9	اگر میں اپنی صنفی شناخت/ ماضی کو ظاہر کروں، تو مجھے اپنی طبی خدمات دینے/ پہنچانے سے انکار کر دیا جائے گا۔					

Appendix-E4

Negative Expectations for the Future (Backward Translation)

Response options: 5-point scale from *strongly disagree* to *strongly agree.*

1. If I express/reveal my gender IDENTITY/PAST, others will not accept me.
2. If I express/reveal my gender IDENTITY/PAST, employers will not hire me.
3. If I express/reveal my gender IDENTITY/PAST, people will think that I am mentally ill or insane/mad.
4. If I express/reveal my gender IDENTITY/PAST, people will think that I am sinful.
5. If I express/reveal my gender IDENTITY/PAST, people will consider me inferior/worthless.
6. If I express/reveal my gender IDENTITY/PAST, most people will look down upon me.
7. If I express/reveal my gender IDENTITY/PAST, I could become a victim of violence or crime.
8. If I express/reveal my gender IDENTITY/PAST, I could be harassed or arrested by the police.
9. If I express/reveal my gender IDENTITY/PAST, I will be refused the provision of good medical services.

Appendix-E5

Negative Expections for the Future (Final Urdu Version)

اپنی موجودہ صنفی شناخت شاید آپ نے اپنے خاندان کے لوگوں/ رشتہ داروں/ یا کچھ لوگوں میں ظاہر نہ کی ہو۔ مثلاً شاید اُن کو نہ معلوم ہو کے آپ خواجہ سر/ ہیجڑا کے طو
رہ رہے ہیں۔ یا کچھ کوگ جن سے آپ روزمرہ ملتے ہوں شاید آپکے ماضی کے بارے میں نہ جانتے ہوں۔ ان صورتحال کو ذہن میں رکھتے ہوئے مندرجہ ذیل سوالات کے جوابا
دیں۔ اس کے لیے دیئے گئے پیمانے پر اپنے جوابات مرتب کریں۔

نمبر شمار	بیانات	مکمل طور پر متفق	متفق	غیر جانبدار	غیر متفق	مکمل طو پر غیر متفق
1	اگر میں اپنی صنفی شناخت/ ماضی کو ظاہر کروں ،تو دوسرے لوگ مجھے قبول نہیں کریں گے۔					
2	اگر میں اپنی صنفی شناخت/ ماضی کو ظاہر کروں، تو ملازمت دینے والے مجھے ملازمت پر نہیں رکھیں گے۔					
3	اگر میں اپنی صنفی شناخت/ ماضی کو ظاہر کروں، تو لوگ سوچیں گے میں ذہنی طور پر بیمار یا پاگل ہوں۔					
4	اگر میں اپنی صنفی شناخت/ ماضی کو ظاہر کروں، تو لوگ سوچیں گے کہ میں قابل نفرت یا گناہ گار ہوں۔					
5	اگر میں اپنی صنفی شناخت/ ماضی کو ظاہر کروں، تو زیادہ تر لوگ مجھے کم تر/ گھٹیا سمجھیں گے۔					
6	اگر میں اپنی صنفی شناخت/ ماضی کو ظاہر کروں، تو زیادہ تر لوگ مجھے حقارت کی نگاہ سے دیکھیں گے۔					
7	اگر میں اپنی صنفی شناخت/ ماضی کو ظاہر کروں، تو میں تشدد یا جرم کا شکار ہوسکتا ہوں۔					
8	اگر میں اپنی صنفی شناخت/ ماضی کو ظاہر کروں، تو میں پولیس کے ہاتھوں ہراساں یا گرفتار کیا جا سکتا ہوں۔					
9	اگر میں اپنی صنفی شناخت/ ماضی کو ظاہر کروں، تو مجھے اپنی طبی خدمات دینے/ پہنچانے سے انکار کر دیا جائے گا۔					

Appendix-F1

Suicidal Behaviour Questionnaire-Revised (Original Version)

Please check the number beside the statement or phrase the best applies to you.

1. Have you ever thought about or attempted to kill yourself?

- o 1. Never
- o 2. It was just a brief passing thought.
- o 3a. I have had a plan at least once to kill myself but did not try to do it.
- o 3b. I have had a plan at least once to kill myself and really wanted to die.
- o 4a. I have attempted to kill myself, but did not want to die.
- o 4b. I have attempted to kill myself, and really hoped to die.

2. How often have you thought about killing yourself in the past year?

- o 1. Never
- o 2. Rarely (1 time)
- o 3. Sometimes (2 times)
- o 4. Often (3-4 times)
- o 5. Very often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might, do it?

- o 1. No
- o 2a. Yes, at one time, but did not really want to die.
- o 2b. Yes, at one time, and really wanted to die.
- o 3a. Yes, more than once, but did not want to do it.
- o 3b. Yes, more than once, and really wanted to do it.

4. How likely is it that you will attempt suicide someday?

- o 1. Never
- o 2. No chance at all
- o 3. Rather unlikely
- o 4. Unlikely
- o 5. Likely
- o 6. Rather Likely
- o 7. Very Likely

Appendix-F2

Suicidal Behavior Questionnaire-Revised (Forward Translation)

1- کیا آپ نے کبھی اپنی جان لینے کے بارے میں سوچا یا کوشش کی؟

1) کبھی نہیں

2) وہ محض ایک وقتی سوچ تھی۔

3a.) میں نے کم از کم ایک مرتبہ اپنی جان لینے کا منصوبہ بنایا تھا پر اس پر عمل نہیں کیا۔

3b.) میں نے کم از کم ایک مرتبہ اپنی جان لینے کا منصوبہ بنایا تھا اور میں واقعی میں مرنا چاہتا/ چاہتی تھی۔

4a.) میں نے اپنی جان لینے کی کوشش کی ہے لیکن میں مرنا نہیں چاہتی تھی/ چاہتا تھا۔

4b.) میں نے اپنی جان لینے کی کوشش کی ہے اور واقعی مرنے کی اُمید بھی تھی۔

2- پچھلے ایک سال میں آپ نے اپنی جان لینے کے بارے میں کتنی مرتبہ سوچا ہے؟

1) کبھی نہیں

2) بہت کم (ایک بار)

3) کبھی کبھار (دو بار)

4) اکثر (تین-چار بار)

5) کئی مرتبہ (پانچ یا اس سے زیادہ بار)

3- کیا آپ نے کبھی کسی کو بتایا ہے کہ آپ خودکشی کرنے والے ہیں یا کر سکتے ہیں؟

1) نہیں

2a.) جی، ایک مرتبہ، مگر میں حقیقت میں مرنا نہیں چاہتا تھا/ چاہتی تھی۔

2b.) جی، ایک بار اور میں حقیقت میں مرنا چاہتا تھا/ چاہتی تھی۔

3a.) جی، ایک سے زیادہ دفعہ، لیکن میں مرنا نہیں چاہتا تھا/ چاہتی تھی۔

3b.) جی، ایک سے زیادہ مرتبہ، اور میں واقعی میں یہ کرنا چاہتا تھا/ چاہتی تھی۔

4- یہ کتنا ممکن ہے کہ آپ کسی دن خودکشی کی کوشش کریں گے؟

0) کبھی نہیں

1) کوئی امکان نہیں

2) کافی حد تک نہ ممکن

3) نہ ممکن

4) ممکن ہے

5) کسی حد تک ممکن

6) کافی حد تک ممکن

Appendix-F3

Suicidal Behavior Questionnaire-Revised (Final Urdu Version)

نیچے دیئے گئے سوالات زندگی موت سے متعلق ہیں۔ برائے مہربانی پڑھ کے یا سُن کے جواب دیں۔

1- کیا آپ نے کبھی اپنی جان لینے کے بارے میں سوچا یا کوشش کی؟

1) کبھی نہیں

2) وہ محض ایک وقتی سوچ تھی۔

3a.) میں نے کم از کم ایک مرتبہ اپنی جان لینے کا منصوبہ بنایا تھا پر اس پر عمل نہیں کیا۔

3b.) میں نے کم از کم ایک مرتبہ اپنی جان لینے کا منصوبہ بنایا تھا اور میں واقعی میں مرنا چاہتا/ چاہتی تھی۔

4a.) میں نے اپنی جان لینے کی کوشش کی ہے لیکن میں مرنا نہیں چاہتی تھی/ چاہتا تھا۔

4b.) میں نے اپنی جان لینے کی کوشش کی ہے اور واقعی مرنے کی اُمید بھی تھی۔

2- پچھلے ایک سال میں آپ نے اپنی جان لینے کے بارے میں کتنی مرتبہ سوچا ہے؟

1) کبھی نہیں

2) بہت کم (ایک بار)

3) کبھی کبھار (دو بار)

4) اکثر (تین- چار بار)

5) کئی مرتبہ (پانچ یا اس سے زیادہ بار)

3- کیا آپ نے کبھی کسی کو بتایا ہے کہ آپ خودکشی کرنے والے ہیں یا کر سکتے ہیں؟

1) نہیں

2a.) جی، ایک مرتبہ، مگر میں حقیقت میں مرنا نہیں چاہتا تھا/ چاہتی تھی۔

2b.) جی، ایک بار اور میں حقیقت میں مرنا چاہتا تھا/ چاہتی تھی۔

3a.) جی، ایک سے زیادہ دفعہ، لیکن میں مرنا نہیں چاہتا تھا/ چاہتی تھی۔

3b.) جی، ایک سے زیادہ مرتبہ، اور میں واقعی میں یہ کرنا چاہتا تھا/ چاہتی تھی۔

4- یہ کتنا ممکن ہے کہ آپ کسی دن خودکشی کی کوشش کریں گے؟

0) کبھی نہیں

1) ناممکن

2) کوئی امکان نہیں

3) کافی حد تک ناممکن

4) کافی حد تک ممکن

5) ممکن ہے

6) بہت ممکن ہے