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Queering care: Dissident Trans identities in health and social care settings

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Chapter 5. Queering care: Dissident trans identities in health and social care settings

Chrissy Alleyn and Rebecca L. Jones

'So God created man in his own image... male and female created he them' Genesis C1, v27

'If only we could all re-learn to speak out of our common suffering and need we would be surprised to find how close we are to one another' Laurens van der Post

Are you sitting comfortably? Then I'll begin.

Once upon a time, far far away, there lived a beautiful princess. Sadly she was trapped in the body of a fourteen stone bin-man from Crewe.

That is the fairy story that medical gender specialists and transsexual people developed to justify a pragmatic course of often life-saving treatment; 'gender reassignment'. It is a fairy story in the sense that it is a plausible simplification of a more complex truth, thought necessary because it is feared that the truth is unpalatable.

Who is speaking here?

This chapter draws on both academic literature and personal experience. Although both Rebecca Jones and Chrissy Alleyn contributed to this chapter, the 'I' that speaks in this chapter is Chrissy Alleyn, who combines academic knowledge with personal experience of the subject matter.

What then, are my credentials to talk about dissident trans identities in health and social care? My academic credentials include Masters level study of modern transgender, as part of which I reviewed in the region of a thousand relevant web-sites, blogs and message boards. My activist credentials are that I worked for two years as a union Equalities Officer for a County Council and am currently engaged in high-profile trans activism within Traveller communities. This means I have interviewed perhaps 100 trans people on varied aspects of their lives. My personal credentials are that I am a radical trans person, gender disidentified (don't identify as any gender), who has had genital surgery. After I transitioned to the social role of female I waited seven years for surgery, the first five of them without hormones, and finally received counselling nine months *after* my surgery. My experience is not unique. Although I have provided references wherever possible within this chapter, there are places where I have relied on my own extensive experience and research.

Introduction

Although most people have heard of transsexuality, relatively few know much about it. Individuals may use labels differently, but a transsexual person is generally one who has moved or is moving from one clearly defined sex/gender category to another through the vehicle of surgery; male to female or female to male, and is likely to identify as female or male (respectively). Genital surgery is one of many procedures they may undergo to cement this shift, and they may seek breast enlargement or reduction, brow or jaw reduction, vocal chord shortening, hair transplant or removal and, in some cases, forearm shortening.

Until the last decade or so transsexuals were likely to conceal their history, but now many transpeople are becoming more open about their histories and more likely to identify themselves in complex ways. It is common now for a range of people who may or may not be seeking surgery to use the prefix 'trans'. A Transman is usually a person who was ascribed female at birth, a Transwoman one who was ascribed male, but the crucial difference from the fairy story version is that they may not be seeking full (or any) gender reassignment surgery. Trans people, in this sense, are people whose gender identity has changed, but it may not have changed to a simple 'male' or 'female'.

A growing number of trans people are becoming increasingly dissatisfied with the fairy story, and the attendant diagnosis and prognosis, and are finding new ways of understanding and inhabiting their bodies. Some trans people are working out their own formulations of their identities, their own sets of gender-free pronouns, and their own understanding of their aetiology (causative factors) and diagnostic features. They may describe themselves as trans or transgender, or they may use other identity labels, such as 'genderqueer' or just 'queer'. These trans people have dissident trans identities, by which I mean that they do not identify unproblematically as one or another sex or gender.

In this sense, trans or transgender are terms that can be applied to people who haven't made a binary (either/or) shift, or who may move around within, between or outside the traditional sex/gender categories. This mobility is based on evidence that masculine or feminine sex and gender aren't exclusive categories but ends of a

continuum. Within this community of differently gendered people, sometimes referred to in the broadest sense by the term 'gender community', the 'traditional' transsexual can come to be viewed as relatively conservative

This chapter describes a minority movement emerging from within trans activism and writing. This movement is very influential and is having a profound and polarising impact on the gender community. It challenges the absolute validity of the traditional view of transsexuality and offers alternatives with wide-ranging implications.

The distinction between 'sex' and 'gender' (see Glossary) is important to understanding transsexuality and dissident trans identities. 'Sex' refers to a person's physical body, whereas 'gender' refers to their social behaviour. A transsexual person gains a surgical referral by claiming to be in the wrong *social* body (to 'really' be a woman trapped in a man's body, for example), but there is a growing body of evidence indicating that, for a sizeable proportion, the problem is less social than *physical*. Many trans people do not feel trapped in the wrong body; they feel they are in their own bodies which are the wrong shape. (Lawrence, 2006) The treatment protocols demand that one 'successfully' live in role (the 'Real Life Test') for one or two years before being approved for surgery, but for many it is the breasts or genitals that are the problem, not that they prefer coffee mornings to fixing the car (or *vice-versa*). In a striking parallel to Alien Limb Syndrome, perception of ones body, the mental image of self we all have, does not map onto the actual body, and the only sufficient and proven therapy is to modify the body (Prosser, 1998). Unfortunately the current diagnostic and referral process conceals this anomaly within the fairytale trope (Barratt, 2007).

In order to obtain medical treatment and recognition, trans people have to conform to current diagnostic protocols for transsexuality. These include clearly imagining oneself to be the 'opposite' gender and consistently and permanently behaving and living as the 'opposite' gender. The dissident trans movement is very critical of these protocols, claiming that people are being thrust from one ill-fitting and arbitrary category to another in order to satisfy social convention.

However not all trans people accept this critique. Instead, they argue that, on the whole, the current protocols work and improve people's lives, any change will inevitably be for the worse, and people who have what they want from medical services could at least have the decency not to rock the boat.

Transsexuals are rare, in the region of one in ten-thousand of the population. But imagine how many people you will see in the course of your life; at least one will be trans (seeing ten new people a day for three years should just about do it). If you work with a trans person as client or colleague, or know one as friend or family, you will already be aware that a little understanding of the issues surrounding trans lives makes interactions with trans people much easier. One's sex is a key classificatory category for state and social interactions and permeates every aspect of our lives; from passports to pensions to prisons, toilets to tennis-matches to dinner-party table settings. To somebody with a dissident view of their sex this is a constant, relentless irritation; people with a moderate knowledge of key concepts will find interactions with trans people far less stressful.

To this end, the rest of this chapter is a lightning tour of some of the key ideas within transgender, focusing particularly on the implications of dissident trans identities in health and social care settings. Having already introduced ‘the transsexual fairy-story’ and a number of key identity words, I start by describing the history of sex categories and their logic. I introduce an alternative logic that has come out of trans-activism and feminist study; that the bodies described as male and female are not two separate categories, but two ends of one continuum. Having introduced these key concepts, I briefly overview the state of the academic literature on trans issues. I then introduce key ideas that describe how identity is made and used and the impact this can have on relationships. The final sections of the chapter detail a representative (but not exhaustive) selection of issues faced by gender dissident people within health and social care settings, and suggest strategies for improving services.

Sexing the body

According to many traditions there were created two, and *only* two, sexes, and you were one or the other depending on what role you performed in the production of children. Although this was a reasonable view, it was by no means a universal one; other nations, tribes and cultures traditionally categorised people into at least three sexes/genders. These categorisations sometimes included intersex and transgender people as a supernumerary gender, sometimes as one of the three primary genders which appeared commonly enough to be assigned important ceremonial and social roles (Bullough & Bullough, 1993; Eliade, 2004; Herdt, 1998). Over time, however, the first story became very popular, to the degree that everyone in the world, pretty

much, now believes the Story of the Two Sexes (Conner, Sparks and Sparks, 1997; Feinberg, 1996).

This story, that there are two, and only two sexes, is a story we are told so often, and have been told for so long, that we all firmly believe it, *without critically examining the evidence*. Of course it doesn't help that the evidence has been 'Sexed Up' to reinforce the failing categories. Anyone who fails to meet the criteria – has an 'oversized' clitoris or 'undersized' penis, mixed sexual characteristics, a chromosomal or hormonal 'anomaly' – has, until recently, been surgically or hormonally rationalised upon diagnosis, often at birth (commonly by removal of the clitoris). The parents were left in no doubt by unimpeachable experts – doctors – about the serious social implications of this biological 'failure' and in the main felt they had no choice but to comply (Fausto-Sterling, 2000). This disquieting praxis is of modifying bodies to fit an elegant theory, rather than the more rigorous process of making a theory that fits the facts.

Determining someone's sex is not always as straightforward as we might assume.

Traditional binary understandings of sex are unable to answer the questions posed by real bodies:

- Is an impotent man a *real* man?
- Is a man with a tiny penis (a 'micro-phallus') a real man?
- Does it matter or not whether it works, whether he has children?
- Is a (potent) man who sleeps with men a real man?
- Is a man who lost his penis in an accident a real man?
- Is a man born with two working penises *more* of a man?

- Is a man born with no penis a real man?
- Is a man born with a clitoris a real man?
- Is a man who was born a woman a real man?

Look back at this list and see where you stopped saying 'Of course *he* is'. That may tell you something about how you personally define sex/gender.

Ask yourself why you chose that particular point, how on a sliding scale of real living bodies you could decide a quantitative, either/or, shift had been made.

How did you make that attribution, when you have no access to the relevant organs for verification?

Given your answers to the questions above, how do you think this will affect the way you respond to trans people?

Male and female genitals can be so similar that they are mistaken; the difference between the sexes isn't clear-cut (Fausto-Sterling, 2000). By any measure, hormonal, chromosomal, anatomical, social, behavioural, there is no absolute dividing line where one sex stops and the next starts (Nataf, 1995). In fact there is marked overlap, to the degree that the International Olympic Committee's sex testing programme has been under considerable criticism since the 1980s.

At the Beijing Olympics '1 in 500 gender tests were expected to reveal abnormalities' (Maccartney & Garlik, 2008). Biologist Alison Carlson states 'male and female are really a biological continuum. We're so much more alike than different. It is culture

that makes us see sex as black and white.' Ursula Mittwoch, Emeritus Professor of developmental biology, calls sex tests 'unscientific' and says she can think of no scientist who supports them. 'The binary male/female classification places insufficient emphasis on biological variation' (quoted in Vines, 1992). Whatever gender or sex determining test is used, some people will fail the test, some results will be inconclusive, and some people will get different results every time they test. Some women will test as men, some will test as neither, and some will test as both.

Academic literatures

This more nuanced understanding of the nature of sex and gender is not found throughout the academic literature on trans issues. Surgical or psychiatric texts usually focus on transsexuality and describe it in pathological terms as a series of conditions, (Barratt, 2007; Tully, 1992). Psychological literature tends to plead for acceptance through the rhetoric of normalcy overlying extreme distress, (Bloom, 2002; Moon, 2008). Social work texts look at damage limitation in difficult circumstances - the difficult circumstances usually being transgender (Israel and Tarver, 1997; Mallon, 1999).

In more sociological academic literature there is often a more radical understanding of sex/gender variability; Fausto-Sterling's (2000) *Sexing the Body* critically examines the medical and social construction of the sex categories, highlighting the practice of surgery to align troublesome intersex bodies to social standards. Radical trans and queer literature treat the fluidity of sex/gender/sexual orientation and the inadequacy of categories as a given (Bornstein, 1995; Feinberg, 1996; Hines, 2007).

In the second wave of trans biographies, particularly following the influence of Kate Bornstein, Leslie Feinberg and Sandy Stone, trans people looking to find themselves in print have discovered a problematisation of binary genders and an expanding cloud of fluid identities (Stone, 1991; Bornstein, 1995; Rothblatt, 1995; Feinberg, 1996; Webb, 1996; Griggs, 1998; O’Keefe & Fox, 2003) Trans people generally construct their identities from the materials at hand and the materials are getting a lot queerer. This is particularly noticeable in the fluid categories sometimes found amongst queer youth.

Now I have critically examined the evidence for the two-sex model I hope I have shown some of the ways it is inadequate. So we can abandon the model under certain circumstances. How far might we stretch those circumstances?

Identity labels

There are a number of people who cannot, or choose not to, fit the two-sex model. They might identify as trans, transgender, transsexual, queer, genderqueer, bi-gender, intersex or by another such term. These terms are how people identify themselves, or are identified by others. Identity words are a contextual and partial response to a specific question – who/what are you? In this context I self identify with the term TransDyke Queer; my *sex* is trans, my *sexual orientation* dyke, my *gender* queer. In the context of a builders yard I would probably identify as male, at a party I would most likely be found with the women.

When we use identity terms we use ones we believe will be understood or believed, which are appropriate within the context of the question, which we use to give *as specific* and *as truthful* an interpretation of ourselves as we can, or wish to. We may use these terms for short or long-term aims, we may use them inconsistently or fraudulently, discarding or modifying them as necessary, and they need not represent a definitive statement of our self-identity (Warnke, 2007).

If traditional identities do not describe us we are free to invent new ones (or revive old ones). The problem with identifying oneself by a new term is that few people understand it. By the time you've described what it means, time has passed, and the session you scheduled to sort out a problem has gone. Next time you might see a different practitioner and have to start all over again. Being trans is clearly a powerful motive for simplifying – telling fairytales.

Health and social care settings

When a person with a dissident sexual or gender identity engages with health or caring services we will frame the identity we project around; what we hope to gain in treatment, our reading of bias and level of understanding in that service, our reading of the beliefs of the practitioner, whether we are there voluntarily, and how voluntarily. When the practitioner engages with a gender dissident the tendency is to classify the person by binary sex/gender. This might be because of past experience, for diagnostic or treatment purposes, or more likely as a result of being embedded in a world where there are exactly two sexes. It may be that as a result both perpetuate the fairy story. It

may be that the dissident declines to engage further, or the practitioner terminates the contact, perhaps finding the client challenging or unsuited to their services.

For trans people obtaining a medical solution is dependant on behaviour, dress, employment status, physical fitness, attendance at appointments, and telling the right story, and it is never clear who is a gate-keeper and who a care-provider; who might give help, who could block treatment; who can safely be told the truth.

In the sections that follow I discuss issues commonly arising for trans people within health and social care settings. My particular focus is on the issues faced by people with dissident trans identities, but in order to elaborate these, I also cover some of the issues faced by trans people in general, including those with more traditional transsexual identities.

One general point is worth mention here; trans people are likely to experience severe challenges when they have changed their birth records. Their credit history will be erased, all government enquiries about tax or benefits need to be redirected to specially trained personnel, resulting in delays and unwanted attention, cases being lost in the system, and general unaccountability. Trans people may have problems with phone services, financial – using debit or credit cards – or services where confidentiality is an issue, when vocal range or appearance does not match personal details. Some dissident trans people have changed their birth records to make clear a break from their birth assigned gender. However that may not mean they align unproblematically, or at all, with the new gender. All these problems can be directly relevant or have knock-on effects in health and social care settings.

Specialist medical practitioners

Specialist medical practitioners – those working in gender clinics, or performing specialist surgery – tend to be more understanding of dissident trans identities in person than in print and to judge outcomes on patient satisfaction rather than convention. They are often under considerable pressure (from medical academia, the General Medical Council, and their managers) to represent outcomes in a normative medical framework (the fairy story). But if a client is well adjusted, happy, and willing to conform minimally to the conditions for referral, gender specialists may be willing to support their reassignment regardless of their evident dissidence.

Non-specialist health practitioners

However, before a trans person can see a specialist, they have to be referred on by non-specialist health practitioners, typically GPs. It has been widely reported that non-specialist health professionals tend to have stereotypical views of transsexuality and gender dysphoria, and ‘[s]ome professionals remain opposed to hormonal or surgical reassignment’ (Green, 1999). I also have found that although some GPs have attended specialist seminars, they were generally framed within the fairy story. The general lack of awareness of protocols combined with stereotypical views leads to confusion over hormone regimens or a flat refusal to prescribe. It can also lead to confusion over which procedures are cosmetic and which will be funded, and uneven referrals sometimes to unqualified or inexperienced specialists and surgeons. I have found

many GPs to be open and understanding of dissidence in person, yet unwilling to support or refer requests for funded treatments to managers or other departments.

Whether a trans person is able to access specialist services depends on the funding criteria in their particular area of the country. Funders' criteria vary; one area's non-essential cosmetic procedure is another's standard practice. Dr J Barratt is the current director of the UK's only state funded gender clinic at Charing Cross in London. It is Barratt's view that a trans person would not get funding for first referral to a gender clinic if they did not act like one or the other gender consistently enough (Barratt, 2008).

The limited numbers of specifically trained psychiatrists available to local mental health teams can lead to delays in the first referral from non-specialist services to a gender clinic. Non-specialist psychiatrists tend to have stereotypical views and are time consuming to brief, especially if they are on rotation. Non-stereotypical gender presentation might be diagnosed as a symptom of psychosis, genital dysphoria as generalised dissatisfaction or non-specific mental illness amenable to psychiatric intervention. (Barratt, 2007)

There appears to be no general awareness of guidelines on who should commission or provide which services, such as pre or post-surgical counselling, and when and in what order they should be provided. I know of several cases (75% of my surgical cohort, including myself) where the local psychiatric services assumed the gender clinic was providing counselling while they in turn expected local services to have put something

in place. One would think that pre-surgical counselling might be rather important for an elective procedure to remove ones penis.

At a more mundane level, neglecting the importance of something as simple as a pronoun can result in unwanted attention when prescriptions are collected or patients called. Practices may be slow or unwilling to change Mr to Ms or vice versa on their records, databases do not accommodate a third option, and that information is sometimes used to select for regular screening for gender specific conditions, so 'cannot be changed'. What exactly does that term *gender specific conditions* mean when faced with somebody who needs both breast and prostate examinations?

Social and caring services

Access to and custody of children is a commonly mentioned issue for many trans people. Strong evidence suggests that continuity of contact from the earliest age is likely to lead to the best outcomes for parents and children in trans families. Professor Richard Green, the previous director of Charing Cross Gender Identity Clinic and world-renowned expert was a frequent witness propounding this view. 'I am saddened at the number of cases in which I have testified as an expert witness where children and transsexual parent have been denied the opportunity to continue their parent-child relationship. From the many cases I have seen, a transsexual parent does not have a deleterious effect on the children' (Green, 1999).

Trans people have problems getting access to looked after children; ignorance or discrimination within social work settings can cause tensions with the foster or adoptive parents and children. This is even more the case for people with dissident

trans identities. Courts are more likely to be biased against the trans parent when being transgendered is seen by a case-worker to be problematic. This was certainly the case in my seven year struggle to see my daughter, and my experience is borne out by the three senior social work practitioner/trainers and a score of practitioners I corresponded with during my time as County Council Union Equalities Officer (2005-7).

Of concern are the widespread reports of transphobia by trans and non-trans staff within the social and caring services; these may implicate colleagues or indicate deeper institutionalised transphobic values. But there is continual improvement, and recent changes in the law (i.e. Gender Recognition Act 2004, Gender Equality Duty 2007, Sex Discrimination (Gender Reassignment) Regulations 1999) have made local government and public sector bodies such as the health service more responsible for ensuring systematic equalities training.

Solutions?

Most practitioners are working within the fairytale 'A trapped in B's body', while gender dissidents and some specialists are developing a sex/gender variance 'either/neither/both' model (Barratt, 2007). Trans people presenting at health or care settings may view themselves as 'either/neither/both', but will generally represent themselves as 'A trapped in B's body', just in case. They will then be under pressure to maintain this position through the referral process to maintain credibility. This distortion of data has contributed to the transsexual diagnosis and treatment remaining relatively unchanged for 80 years. Can you imagine if the same were true for lung

cancer, heart disease, HIV? There are ways to overcome this inertia - *by including trans people in significant processes.*

Employing transgendered professionals in specialist units has been productive, enabling the unit to benefit from informal advice and criticism, and the service users to feel they will be understood. (Green, 1999; Namaste, 2000) But there is a general trend amongst trans people to dislike working in non-specialist care settings, often citing institutional homophobia or transphobia. There is also a tendency to recruit 'traditional' transsexuals, which sends a very clear message to dissidents.

Support groups and organisations, commonly administered and funded by trans people and friends, could be mainstreamed by funded care providers. The providers would benefit from the training opportunities and data. Many would particularly benefit from some pronoun awareness. However the three largest UK advocacy and support groups (The Beaumont Society, The Gender Trust and Press For Change) are conservative in nature and their literature and advice cannot be applied uncritically (or in certain cases, at all) to dissident trans people.

Practitioners should consider the role of advocacy in their work with trans people.

Trans people may be at considerable risk, especially if they are housed in a problematic area. Most people do not understand the urgency of a transperson facing hate crime, which will probably end in violence and possibly death. This is particularly a concern for non-passing trans people and dissidents and may not apply to transsexuals who can pass as traditionally gendered (Namaste, 2000).

It is my view that a significant number of 'traditional' transsexuals are so because they do not know there are alternatives. Many pre-operative transsexuals aggressively defend the trope of 'girl trapped in boy's body' primarily because it is the only safe thing to say. Asking them open questions; 'So how do you describe your gender?' are more likely to elicit valuable responses than closed questions like 'so what makes you believe you are a woman?'

Working with trans people as researcher and transactivist I find it helpful to spot and respond to cues. When a person uses terms like Trans, Queer, Genderqueer, Transgender, TransDyke, Boi or Grrrl for instance, they are saying that they don't believe in the two-sex model, and they don't feel you should either, at least when dealing with them.

When a trans person asks you where the toilet is you may find it worthwhile to have thought through some options beforehand. What would you suggest for a male-bodied feminine gendered person? Male body – male loo? Are there unisex facilities, would a disabled loo be offensive, would other women be offended if they used the Ladies?

As a general rule of thumb do *not* initially suggest the sex that the person has *come from*, even if you cannot really say for certain which gender or sex they are *going to*.

Urinary segregation, the division of toilets into male or female, and the violent or confrontational penalties for non-conformity, raises issues for the majority of trans-people. Providing unisex facilities is a cheap response with a profound impact.

If you can't get the hang of the pronouns, try some gender free ones;

sie/ze - (s/he)

hir - (him/her)

hirs - (hers/his)

Mir – (Mr/Ms)

Or try using 'they' as a gender-neutral singular – this is increasingly acceptable in informal contexts. Making an effort to speak the language when you're abroad usually gets results. Finally, remember that the two-sex/gender model is excessively limiting and an inadequate description of reality.

Tale's end

Encountering gender dissidents for the first time can be disturbing and can arouse strong feelings. We can appear incomprehensible or contrary. It may help you to understand we are not doing this for your benefit but for ours, and we use the best tools and knowledge we have. It is likely we have a deeper understanding of sex and gender than you, which is hardly surprising, and we may be quite firm or belligerent about points that appear insignificant. They are not insignificant to us, we have been belaboured by sex and gender our whole lives, and may be desperately carving out a space where we can make sense of ourselves; we may be fighting for our very survival.

The surgical protocols we use are flawed, are premised on breeding but applied to sterile bodies. They are supported by an inflexible model that fails to accommodate reality. But they are the only protocols we have, and produce results. This is unsatisfactory, even though it worked for me; surgical risks for many transsexual

procedures are high and expected gains often illusory, surgically constructed genitals often turn out to lack some of the function or appearance that patients hoped for. The aftermath, of gender disorientation, of being in *another* wrong body, can be catastrophic, and terminal. The current protocol is inflexible and flows seamlessly from assessing gender to imposing sex and the gender clinics have an unenviable job navigating a fine line between clinical need and ideology.

Understanding transgender is often about unlearning habits of thought that have taken a lifetime to accumulate, realising that there are no clear answers and making a decision anyway. I hope that one day the screening for surgery becomes more nuanced, widening surgical options, enabling partial transition, creating a socially validated space for viable dissident identities. But that must happen hand in hand with society validating a space. Conversely I would hope a reassessment of gender options does not result in hardship to other trans-people by denying them existing, workable if flawed, solutions; that gender dissidence does not close the door on transsexual transition. But regardless of the risks I firmly believe that this debate needs to be had; for some of us at least, this fairytale must come to an end.