

“Trans*, Intersex, and Gender-Variant Justice: The Persistent Battle”

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We, as a society, have been deepening our conceptual understanding of sex and gender, and are discovering that these concepts are more complex than originally assumed. In turn, we have been adapting and changing – our language, policies, practices, theories, etc. – along with that understanding, arguably not fast enough. Sex and gender are not simply concepts that consist of an either-or, man-woman, or male-female binary system – a “rigidly bifurcated mode of thinking indicative of Western epistemology” (Irving, 2013, p.323). As we begin to look more closely and unpack the essentialized and rigid conceptions of sex and gender it becomes clear that we have pressed limitations upon humanity, particularly within our Western, “first world” context. These limitations impact our personal expression, our ability to self-actualize, our self-determination and, therefore, our well-being as global citizens. Relaxing these rigid conceptions exposes the incredible diversity that undeniably exists within our sphere of humanity. This paper will explore this diversity, highlighting the intersection where sex and gender variation – particularly Trans*, Intersex and Gender-Variant (TIGV) individuals – meets and interacts with society. Through decades – arguably centuries – TIGV people have faced erasure (Irving, 2013; Bauer *et al*, 2009) and today more than ever these individuals and communities are embracing a fight for justice and equal citizenship in many facets of their lives. This fight is gaining steam and becoming a focal point of present day, diversity-based and anti-oppressive narratives. Progress is being made in regards to TIGV justice, and it is important to make that acknowledgement, but at the same time, the landscape is riddled with injustice – a lot of work still needs to be done.

The challenges that people who identify as TIGV encounter span across all stages of life, through infancy, adolescence, adulthood and end of life – the battle is persistent. There are myriad points throughout one’s life where barriers to self-actualization and full citizenship are

erected, areas where abuse, injustice and oppression are the norm. This paper, using a lens of social justice, brings attention to several – but certainly not all – of these systemic barriers, highlighting their impact upon the health and wellness of these TIGV individuals.

Lens and Self-Location

I host a gay, gender-fluid identity within an able, white body. My life experience does not include living as Intersex or Trans*, but it does include a passion for social justice and a keen attention to and academic study of TIGV experiences. While I cannot speak from a place of having had some of the lived experiences presented in this paper, I can speak from a place of navigating an oppressive heteronormative and cisnormative world that seeks to oppress outlying variations (*cis-* implying a congruence between designated sex and core gender identity).

It is important to first express the lens through which I am approaching this work. Drawing upon a Citizenship Theory of social justice, I explore how personalization can be utilized and integrated into the care of TIGV people. Personalization allows individuals to be at the heart of services as well as be active participants in the design and delivery of those services; it gives choice, control and power over any received supports and services. Furthermore, it calls into question the impersonal, inflexible and insensitive nature of many failing public services (Duffy, 2010). This approach is paramount in conversations involving TIGV health care. These individuals, when given the chance, come to know their bodies, what they want, and what treatments are needed to self-actualize; they exist on a spectrum in terms of sex and gender, and their care must reflect that spectrum and not be presumed by anyone other than themselves.

Citizenship Theory reveres human variation and makes a claim that “in all its forms, [diversity] is essentially a good thing” (Duffy, 2010, p.261). Regardless of the degree of

difference, be it in gender, body, mind, etc., everyone is of equal worth and dignity and should be ensured inclusion within society and equal treatment as fellow citizens. (Duffy, 2012).

Citizenship, in this context, goes beyond nationality and patriotism, it relates to the reality that everyone should be valued, dignified and respected as global citizens. This is an ideal of justice, something towards which society is invited to strive and something that rings true for many discriminated and oppressed groups such as TIGV communities.

Many of the challenges these communities face are in relation to the social world, in navigating oppressive and exclusionary systems. When considering the health of people who are TIGV, it can be easy to become engulfed by a biomedical perspective, which is understandable since much of the conversation about Trans* and Intersex peoples involves a highly medicalized component – that is, Sex Reassignment Surgeries (SRS) and other medical interventions. However, what I want to address in this paper is that there are various ways that a person's health is impacted, much of which is social, i.e. access to education, social exclusion, childhood development, employment, housing, etc. For this reason, a Social Determinants of Health (SDoH) lens will be maintained.

TIGV populations come into contact with health professions numerous times throughout their lives, arguably a lot more than most, and these interactions are not always helpful, supportive or caring. When justice is boiled down to its most raw of manifestations, it can be observable in the one-to-one interactions between health professionals and service users. The transition to a just and rights-based reality for people who are TIGV includes a drastic shift in how health professionals and service providers support them; this is where an Ethic of Care as a measure of justice-based practice becomes increasingly important. Integrating virtues such as responsiveness, attentiveness and respect in caring for others, as suggested by Engster (2014)

moves socially just health *care* towards “helping individuals to meet their basic physical and emotional needs so that they can survive... and mitigate unnecessary pain and suffering” (p.157).

To illustrate non-attentiveness and stress the need for care ethics, Bauer *et al* (2009) state that “trans issues” and “mental health issues” are often blurred, leading to a discarding of important trans* experiences. The authors argue:

“[p]roviders rarely receive information presented in a way that allows them to see a person’s mental health issues as separate from trans status and tend to discount one from the other... this blurring or binding may result in inadequate or inappropriate care” (p.353).

Much of the tension that exists in society in regards to people who identify as TIGV is in relation to entrenched social constructions that influence how we organize and interpret sex and gender. For this reason, this paper draws upon a social constructivist lens and aims to explore how these constructions lead to lives that are haunted by oppression, violence, and copious determinants of ill health – essentially, injustice. It is argued by Duffy (2010) that “such injustices are rooted in the socially constructed categories that are applied to natural human differences, which then harden into damaging stereotypes” (p.258), and these misinformed stereotypes influence the demarcation of normalcy. What is perceived as “normal” (or “abnormal” for that matter) within society often becomes the foundation from which policy and legislation is constituted. In the context of sex and gender normalization, TIGV individuals face frequent marginalization.

Miller (2015) writes that these social constructions influence our identity, and we “are dependent on norms and external forces for our social acceptance and worth” and that these norms “maintain status quo beliefs and make identities legible and readable” (p.38). This says that one cannot exist without the influences of predetermined social norms that were present

before our birth and that norms make it easier to exist socially – the more legible one is, the more accepted one becomes. It is true that the norm-based information that we accumulate within our environments helps to inform our social interactions; but in contradiction, norms “create uneven social realities, and one’s sense of internal safety – one’s ability to be a self-determined autonomous agent who determines how to live one’s life – is often at odds with competing societal norms” (Miller, 2015, p.38). While helpful for social navigation, norms can become, in and of themselves, determinants of health.

Language and Terminology

The use of the acronym “TIGV” is not to imply that each of these experiences are indistinct from one another, because they most certainly are distinct. The intention is to bring attention to the similar struggles these people encounter in finding social- and self-acceptance within a society that maintains strict social norms around sex and gender. Before moving ahead, it is important that the reader understands what I am referring to when these words are used.

“Trans*” is a way of expressing the wide range of identities that imply some transition from one sex or gender to some other variation, or even to traverse that line throughout one’s lifespan. Trans with an asterisk provides the necessary space and invitation for self-identification. We cannot presume how people identify; saying that someone is “Transsexual” because they are presenting as the opposite sex makes a claim that may in fact be illegitimate. Trans* is more inclusive in that it represents people who may identify as transgender, transsexual, transvestite, trans-man, trans-woman, and so on. While it can be argued that “Trans*” encompasses gender-variance, I argue that they are different camps that deserve different respect. It would do a disservice to diversity to be too all-inclusive.

“Gender-Variant” refers to people who do not subscribe to the male-female binary; for example, people who identify as genderqueer, gender-fluid, (a)gender, gender-nonconforming, etc. These people are not necessarily interested in biomedical interventions, but are instead invested in intervening with the socially constructed and oppressive regime within which they walk on a daily basis. A political drive and an activist standpoint often ignites these people to bend the binary and work towards a neutralization of gender. However, because people who are gender-variant fall outside of the binary, and their outward expression commonly reflects this, they become targets of oppression and, in effect, ill health.

“Intersex” refers to people who are “born with a reproductive or sexual anatomy that doesn’t seem to fit the typical definitions of male or female” (Intersex Society of North America, 2008). Historically, the term to describe this phenomenon was *hermaphroditism*, which is now seen as outdated, medically stigmatizing and misleading; it actually implies that a person “is both fully male and fully female... [which] is a physiological impossibility” (ISNA, 2008). Further evolution in terminology is occurring, but not without contention. In the DSM-5 it was decided that “Intersex” evolve to “Disorder of Sexual Development (DSD)” but it is argued that the use of the label “disorder” would lead to further stigmatization (Kraus, 2015; Coleman *et al*, 2011). The Intersex Society of North America (ISNA) surprisingly uses the language of DSD to make their “message to patient-centred care much more accessible to parents and doctors” and to move towards language that is “much less charged” (ISNA, 2008, para. 2).

Since language itself is socially constructed, it shapes how we make sense of and keep order within the multitude of evolving phenomena that exist within the human experience. Words make worlds, so to speak, and without unpacking the words we use, we have the potential to perpetuate worlds of oppression and injustice. One of the major critiques involving Trans*

rights and progress, for example, is the use of the words “transgendered” – with an extraneous “ed” attached to the end. “Transgender” is an adjective, not a verb. It appears to be appropriate in regards to the rules of English, but once explored it becomes clear that it is problematic for the transgender community. Steinmetz (2014) published in TIME magazine an article on moving away from this language, and argues that “[m]oving away from the ‘ed’ – which sounds like a past-tense, completed verb that marks a distinct time before and after – helps move away from some common misconceptions about what it means to be transgender” (para.8). A main misconception is that an individual isn’t truly transgender until they have had surgery – the past-tense, completed event. What we know, though, is that people who are transgender face their gender struggle in some fashion or another throughout their entire lives. Terminology can be weighted in unintentional oppression and, as expressed by Coleman *et al* (2011), “is culturally- and time-dependent and is rapidly evolving. It is important to use respectful language in different places and times and among different people” (p.167). Honouring this sentiment, we as citizens can enact social justice by using the pronouns chosen by the trans* individuals themselves, i.e. gender-neutral, Spivak or other preferred pronouns.

Prevalence

It can be quite complicated to get a concrete epidemiological picture of the prevalence of Trans* individuals, but attempts should be continued. While it is clear that this is a real human phenomenon that already deserves just attention, learning more about the prevalence has implications for the development of support services, inclusive policies, and funding options. The literature speaks to some estimates but achieving realistic estimates is a mission fraught with difficulty (Coleman *et al*, 2011; Conway, 2002; Fausto-Sterling, 2000; Scheim, A. & Bauer, G.,

2015). Variation in culture partially accounts for such difficulty. It has been researched and reported that “cultural differences from one country to another would alter both the behavioural expressions of different gender identities and the extend to which gender dysphoria ...is actually occurring in a population,” and in fact, “certain cultures of gender-nonconforming behaviours (e.g., in spiritual leaders) that are less stigmatized and even revered” (Coleman, *et al*, 2011, p.169). The World Health Organization (WHO) acknowledges sex and gender cultural diversity and sheds light on various cultures around the world: “the *Berdache* in North America, the *fa’afafine* (Samoan for ‘the way of a woman’) in the Pacific, and the *kathoey* of Thailand are all examples of gender categories that differ from the Western division of people” (WHO, 2015). From a SDoH perspective, one’s “race” or nationality plays a role on the level of social acceptance or exclusion. Being trans* in Thailand or Iran, for example, two countries with the most SRSs globally, allows for easier access to treatment. It would seem that gender-variance is part of the human condition, and as such, requires scrutiny in regards to human rights and justice.

A problem with recent prevalence research is that numbers are being extracted from gender clinics and not everyone who identifies as Trans* and Gender-Variant feels the need, or, rather, is too hesitant, to reach out to these services so a proportion of individuals are overlooked and face exclusion from academic research (Coleman *et al*, 2011). Furthermore, through necessity of survival, many people do not disclose their gender-variant aspects of themselves, which further weakens any obtainable estimates. According to Conway (2002), the prevalence of “untreated” male-to-female (MtF) transsexualism in the Unites States is upwards of 1:500, a drastic increase in estimate from the decades-old data that has taken root throughout the literature.

The prevalence of individuals born intersex is also challenging to estimate “because there are no concrete parameters to the definition of intersex (WHO, 2015), however they draw from estimates made by ISNA (2008) who states that 1:2000 children, or 5 infants per day, are born intersex. What complicates estimation even further is that wide variation exists within diagnoses of atypical births, and these sex anatomy variations can occur approximately every 1:66 up to 1:150,000, depending on the particular condition. When we overlay this steep prevalence with the ideological and sociological pressures of sex and gender conformity, it is understandable why there is a perceived need for Sex Reassignment Surgeries, which comes with its own wealth of human rights issues, which will be discussed later.

A Health Snapshot

Health is holistic; it includes physical, mental, spiritual emotional and social spheres; a purely biomedical approach is insufficient when working towards TIGV well-being. Because TIGV individuals are often at odds with what is socially constituted as normal and acceptable they face a multitude of health-related concerns that must be addressed. Many TIGV individuals hit barriers to housing and employment (therefore income) and encounter rampant transphobic harassment, (in)direct discrimination, and violence; moreover, “there are few jurisdictions where basic human rights protections exist and even fewer where they are enforced” (Bauer *et al*, 2009. P. 349). Selvaggi & Giordano (2014) highlight that “transsexual people are among the most violated, humiliated and abused of all minorities: some of the most violent and atrocious crimes are those perpetrated against them” (p.1179). These crimes are listed on the Transgender Day of Remembrance (TDOR) website which aims to honour and bring justice to the unsolved murders of gender-variant individuals around the world (TDOR, 2015). It is no surprise that TIGV

people, facing such adversity, often have coexisting mental health diagnoses such as anxiety, bipolar disorder, and major depression (Rotondi *et al*, 2013). Viewed through a SDoH lens, this form of excluded and marginalized existence has grave implications; in fact, Xavier *et al* (2007) reported 65% of the 350 study participants considered suicide, and 41% of that 65% made attempts. These are unacceptably high numbers.

Trans* communities have higher prevalence rates of and are at greater risk for HIV infection than many other social groups (Bauer *et al*, 2009). Sevelius (2013) reports that Trans* women are 49 times more likely to contract HIV compared to other groups; furthermore, these women also face higher rates of HIV-related mortality and morbidity and have less successful treatment results. Reporting on HIV incidence in trans* men is minimal as there are few studies, but those studies completed “have found high levels of reported risk behaviour, but lower levels of HIV prevalence” (Sevelius, 2013, p.31). Also, it is known that hormone treatments can be injected with syringes, which can increase the risk for HIV, depending on one’s level of risk-mitigation and access to information and prescribed hormone medication (Rotondi, 2013).

Engster (2014) argues that good health “is important because it plays a pivotal role in determining the range of opportunities individuals have available to them to pursue their life plans” (p.150) and, in addition, to attain full citizenship within society. While this seems rather obvious, accessing health care services to combat these various health concerns is not always easy for TIGV patients. These patients require trans*- and intersex-specific healthcare, from professionals who know how to – and want to – engage and support these populations through good care ethics. Unfortunately, the present landscape of care is far from this ideal. TIGV communities face endemic *erasure*, a term coined by Namaste (2000) which describes “a defining condition of how transsexuality is managed in culture and institutions, a condition that

ultimately inscribes transsexuality as impossible” (qtd. in Bauer *et al*, 2009, p. 350). Erasure manifests in a lack of interest or knowledge regarding TIGV issues, a surplus of erroneous presumptions, a complete disregard or ignorance, inaccurate perceptions of trans* rarity, and/or the frequent movement of these patients between care providers, colloquially referred to within some trans* communities as “passing the tranny” (Bauer *et al*, 2009). While it should not be the case, it is not unusual that TIGV patients feel that the onus is on them to educate the doctors, care staff and social workers (Siverskog, 2014). Over time, this erasure leads to distrust and learned helplessness in relation to service providers, which has serious health implications, particularly as these people age and cease to access care all together out of well-founded fears of being mistreated. From a care ethics standpoint, the delivery of care must be responsive to the needs of the patients; otherwise patients’ confidence will continue to decline along with their health.

The World Professional Association for Transgender Health (WPATH) holds a vision of a world wherein “transsexual, transgender and gender-nonconforming people benefit from access to evidence-based health care, social services, justice and equality” (Coleman *et al*, 2011, p. 166). WPATH aims to counter TIGV invisibility and erasure through its promotion of care standards and a provision of guidance for health professionals to assist TIGV people; their publication of *Standards of Care* (SOC) provides a wealth of well-articulated, detailed and specific information. Furthermore, the SOC are “flexible to meet the diverse health care needs of trans* people, resulting from their unique, social, or psychological situations” (Rotondi *et al*, 2013, p. 1830.). The dissemination and implementation of the SOC, though, is something that could stand to be investigated.

The Self-Determined Power to Decide

One of the most vulnerable points in the lives of Intersex individuals is in infancy. People who are intersex inherently destabilize the notions of sex and gender, and this causes great social distress. In many cases, infants born into intersex bodies receive SRSs in infancy, often referred to as infantile genital reassignment. Therefore, people born intersex can be thrust into a life of transsexuality without themselves having given consent – the parents make the choice for them. Beyond surgery, many are socialized or “normalized” as children to become a gender chosen by the parents to match the genitals (Pesc, 2015). This can have serious health implications in adolescence and adulthood if the prescribed gender is incongruent with one’s core, authentic gender. Gender identity exists in the mind, not on the body and is simply not observable in infancy. Of course it must be stated that not all people who are Intersex have faced infant SRS or normalization tactics, nor should they have to in a society that relaxes its sex and gender constructs.

An important name in the TIGV field is that of Dr. John Money. Money was a controversial physician and pioneer in the field of sexual development and was undeniably influential in regards to the treatment of intersex infants; but, some would argue that the influence was harmful, unethical and negative (Kessler, 1998). His work was in the field of developmental gender theory, founded on the basis of social construction and gender essentialism, and based in the assumption that gender is neutral at infancy and malleable, and that socialization is sufficient to shift one’s gender identity (Butler, 2001; INSA, 2008).

David Reimer, a well-known patient of Money’s, begged to differ. David was born as Bruce, and shortly after his birth his penis was burned off during a treatment accident. He was then strictly socialized as Brenda on the recommendation of Dr. Money; however, Brenda never

identified as female, was hardly happy, and refused to adopt so-called feminine behaviours and activities. Once it was disclosed to Brenda what had happened, he then decided to transition to David and go public with his story, at which point Money's honesty and ethical integrity came under fire. Much had already been published by Money about Bruce/Brenda's smooth transition (under the pseudonyms John/Joan), "extolling the successes of this sex reassignment" (Butler, 2001, p.624). The perceived successes of this case were misleadingly "used by the public media to prove that what is feminine and what is masculine can be altered, and that these cultural terms have no fixed meaning" (Butler, 2001, p.624).

This is an important case to acknowledge because it brings attention to the inborn nature of gender and it helps to eliminate the assumption that gender is a choice. Because parents, "upon hearing their child's DSD diagnosis often struggle to comprehend the medical aspects of the disorder and physicians simultaneously push parent's to make swift decisions about their child's genitals" (Pesc, 2015, p.21), decisions are made that eliminate patient consent and self-determination, which has deep implications for the determination of the infant's future health. Parents of these infants are highly influenced by professionals in making the decision of which sex and gender to ascribe, which has received recent scrutiny since it has been shown that the type of counselling the parents receive, whether it is biomedical or psychosocial, impacts the decisions that are made. As we have previously explored, the information and TIGV-specific care within professional health care services is inadequate, which becomes worrisome when considering the quality and validity within the parental counselling. As Pesc (2015) cautions, "given the irreversible nature of infant genital surgery, society must consider parents' true motivations and re-evaluate the way in which biomedicine communicates with parents" (p.21).

I argue that the best thing to do is to move towards a system adopted by Germany on November of 2013. German parents of intersex infants, previously with only a week to decide, now “are able to choose to avoid choosing” because “alongside the category of ‘M’ and ‘F’, is a new category: ‘X’” (Nandi, 2013). This does not mean that the children live their lives as “Xs” but instead gives them the power to declare at a later time who they are and how they want to present to the world. This is an approach that gives the individuals the right to decide what is best for themselves, a socially just alternative to the decisions parents make in states of stress, worry and panic that often lead to gender-assumed surgery. Germany’s model is a model for which to strive in that it is consistent with a human rights, personalization and care ethics, in that it provides the space for the patient’s voice, a voice that is simply not yet formulated. Self-determination, as expressed by Miller (2015), “is the right to make choices to self-identify in a way that authenticates one’s self-expression and which has the potential for the embodiment of self-acceptance...it presumes choice and rejects an imposition to be externally controlled, defined or regulated” (p.38.). This must become a goal in intersex health in particular, as it reduces “the power of regulation, a power that determines, more or less, what we are and what we can be” (Butler, 2001, p.621), and shifts that power into the hands of the patients.

The SRS Quest

Not everyone who identifies as TIGV desires a surgical transition to a different sex, and not all surgeries are genital (Latham, 2013). But those who do desire the transition often face years of bureaucracy, regulation, expenses, and so on; the logistical quest for a surgical transition is certainly not easy, beyond the already challenging social reality of “out” TIGV peoples. Since

a full presentation of the complexities of seeking and attaining transition via SRS is beyond the scope of this paper, I will focus on a few points of injustice and concern.

Access to SRS is the first point to address. Various social determinants influence who has access to SRS, including having a family doctor, living with a mental health condition, income, insurance coverage, and employment status (Rotondi *et al*, 2013). While many nations have publicly-funded SRSs, made available through health insurance, others do not. But even within publicly-funded systems, it is not always smooth. Rotondi (2013) reports that “barriers to transition-related health care have also been identified within Canada’s ‘universal’ health care system” (p.1830). Privately-funded SRSs are an option at times but can be far beyond the financial means of many TIGV people, depending on the intended procedures, which highlights the classism inherent in the access to SRS. One’s location also influences access; for example, a transman who is a resident of British Columbia (BC), Canada, has less chances of SRS since BC limits their female-to-male (FtM) surgeries to 5 per year (Dedyna, 2013). Systemically, inaccessibility arises in the form of complicated pathways to services and drastically long wait times, upwards of two years once the referral has been made to the one clinic in Montreal that specializes in SRS (CTV News, 2015). Keep in mind, this “two-year” timeframe is not inclusive of preceding requirements like counseling, certain pre-surgery hormone requisites and a Gender Role Experience (GRE) or “real life test”. A GRE, which is sometimes a requirement before SRS is approved, is a one-year commitment; it “is multidimensional and includes documented activity of [one’s] community living in a role congruent with [one’s] gender identity” (Center for Addiction and Mental Health, 2012). Essentially, it is proof of living “as if.”

The systemic inaccessibility of treatment, both hormonal and surgical, is highly problematic in that it invites treatment-seeking TIGV patients to use non-prescribed hormones

and attempt self-performed, “do-it-yourself” surgeries. The use of hormones without the guidance of a trained physician or endocrinologist is a health risk, since the follow-up and bloodwork is left to the wayside. It goes without saying that DIY surgeries are extremely risky, but are not unheard of. Rotondi *et al* (2013) spearheaded an Ontario-based research project that explored DIY treatments, in which it was reported that 5 participants performed surgical procedures on themselves, including orchiectomies (testes removal) and mastectomy. It is noteworthy that 4 of these occurred during the time that Ontario had stopped providing publicly-funded SRSs, to which Rotondi *et al* (2013) respond with the consideration that it “is possible that these participants would not have chosen to self-perform surgeries if SRS had been more accessible” (p.1835).

Being approved for hormone treatment and SRS is contingent on a DSM-5 mental health diagnosis of Gender Dysphoria (GD), previously categorized as Gender Identity Disorder (GID) in the DSM-IV. GD is broadly defined as “discomfort or distress that is caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)” (Coleman *et al*, 2011, p. 166). While the transition from the word “disorder” to “dysphoria” shows a justice-based step forward, it is still argued that the mental health diagnosis is still stigmatizing and problematic (Ferro, 2013).

Having the GD label is a social burden that one must carry, and, furthermore, the diagnosis tends to lead to discrimination regarding who and how one gains access to SRS. In Canada, before people get medical coverage for SRS, they require approval from the Ministry of Health and are compulsory referred to mental health assessments, which to some is deemed inappropriate. Latham (2013) argues that these referrals, “may violate the patient’s ethical right

to self-determination, to direct what happens to his or her body, and may therefore constitute a form of discrimination” (p.648). His argument is founded on the fact that cisgender, non-GD patients receiving the same surgeries (i.e. a woman who receives a breast reduction or a hysterectomy) are not subjected to approval-seeking nor these compulsory and intrusive assessments, which he states is because these surgeries are gender-appropriate and consistent with socially constructed gender norms. Many cisgender people “go under the knife” to appeal to an ideal of beauty and social acceptance, ranging from lip enlargements, pectoral and breast implants, hair transplants, and more, yet these are not interrogated in the ways that TIGV surgeries are, surgeries that are inherently cross-gender. This form of discrimination is getting more attention, and in *Flagg v. British Columbia* (2014), Jackson Rae Flagg filed a successful complaint to the BC Human Rights Tribunal regarding the additional hoops he needed to go through to obtain a mastectomy. He argued, successfully, that “the government unfairly puts itself between transgender patients and their doctors, even though it acknowledges that surgeries are medically necessary,” and highlighted that the application to the Ministry of Health is “invasive [in that] it talks about all these sensitive things that have nothing to do with gender” (Lindsay, 2014). This calls into question the treatment these patients receive in their quest to access essentially life-saving surgeries. Selvaggi & Giordano (2014) report that “data on suicidal behaviour pre- and post-surgery confirm significantly less suicidal ideation and attempts in patients after reassignment” (p.1179). Lucas Wilson, a post-operative FtM, eloquently sums up the SRS application process, speaking to the concept of personalization, when he says:

“By the time a person actually wants to access gender-reassignment surgery, they’ve got a pretty good idea of what they want and what they need for their bodies. A lot of steps, from my perspective, are a lot of the same things said to different people at different places at different times... The effect is to draw out the

process, which is irritating for a transgender person who feels that their bodies aren't being treated like anybody else's body would be" (Lindsay, 2014)

Systemic Barriers to Self-Actualization

Whether or not TIGV individuals decide to pursue SRS, they continue to face barriers to self-actualization, becoming one's actual, inherent, authentic self. This section is meant to briefly shed light upon a few areas within our social systems that impact the lives of TIGV people. The topics here are brief and they could be unpacked and explored to a much larger degree. The points at which TIGV lives interact with and conflict with society are vast, and this list is in no way exhaustive. It is merely a glance at the myriad struggles these communities face on a daily basis.

Prison

Firstly, it is important to bring attention to the penitentiary system, and how TIGV lives in prison are impacted. It is the norm that most prisons, since they rest upon the assumption of a gender binary, segregate inmates on the basis of their biological sex characteristics, regardless of gender identity. This can be highly problematic for pre-operative inmates or inmates who have chosen not to elect for SRS. A female-identified inmate would be placed in an all-male prison, and a male-identified inmate would be placed in an all-female prison. In the case of the prior in particular, the inmate's safety can be called into question. In Jenness (2014) it is reported that inmates continue to assert their femininity in prison, honouring their authentic selves, amidst a "hegemonically-defined, hypermasculine and heteronormative environment with an abundance of alpha males, sexism and violence" (p.13). This leads to a decreased sense of security and an increase in stress owing to the "ongoing management of the threat and reality of violence" (Jenness, 2013, p.15). On a positive note, some jurisdictions are shifting their policies to become

more gender-sensitive. For example, in Ontario, Canada, inmates are now being assessed and housed based on their gender-identity, not on their anatomical characteristics. As part of this ground-breaking shift, further training is being implemented for prison staff (Strapageil, 2015). Similarly, BC Corrections is expected to announce major changes in its policy on transgender prisoners, policies that currently keep transgender inmates at risk (Azpiri, 2015). This marks a transition towards more just treatment of inmates, a transition that meets the individuals where they are on their individual, gender journey.

While these people are housed in prisons, they are still in need of treatment, whether it is hormonal or surgical. Access to treatment is further complicated when imprisoned. For example, in 2010 the Conservative Party of Canada, under Prime Minister Stephen Harper, abruptly halted all funding for inmate SRS (Harris, 2010). This revocation became policy regardless of Correctional Service Canada's mandate to provide "every inmate with essential health care and reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration in the community" (Correctional Service Canada, 2014). Removing such access to treatment is an injustice that must be corrected; the treatment is considered essential for well-being on a national level, and thusly should not be revoked upon imprisonment; these people are still citizens and deserve to be equally treated as such.

Identification

Another systemic challenge that TIGV people face is how they are represented on their identification. Advances have been made in various international locales, such as Germany's addition of the third option on birth certificates mentioned previously. In Canada, honouring that not every gender-variant person elects for SRS, people no longer need to undergo sex-

reassignment in order to change their gender marker on birth certificates (Strapagiel, 2015).

These two changes illustrate a transition towards more socially just, gender-sensitive policies around identity documents

In the United States, Haynes (2013) reports on the National Transgender Discrimination Survey (NTDS) and highlights that only 59% of their American respondents were able to change their gender designation on identification. This is problematic in that it has potential to lead to instances of forced disclosure of one's sex and gender, putting the person's safety at risk, particularly when considering travel to countries with higher rates of transphobic violence. In addition, the NTDS concluded that 40% of respondents who "presented gender-incongruent identification documents reported harassment, 3% reported being assaulted or attacked, and 15% reported being asked to leave the premises" (Haynes, 2013, p.170).

Just this week in Iowa, two transgender women checked into a hotel with "male IDs" but "dressed as females." The hotel staff member who received the patrons called 911 to make sure that they were not "hookers." The police arrived and investigated their hotel room, searching for signs of prostitution to no avail. However, it was discovered that Meagan Taylor, one of these women, was carrying non-prescription, transition-related medication and was therefore arrested (Brydum, 2015). This not only brings attention to the challenges of identity documents, but also to a wider narrative of transgender profiling and the conflation of "transgender" and "prostitution," a topic that deserves a paper of its own. Furthermore, it highlights the need for easier access to transition-related medication.

Washrooms

Recently, there have been relentless legislative attempts to declare explicit rights and protections for people based on gender-identity in both Canada and the United States. Human

Rights clauses commonly include sex and sexual orientation but not gender-identity explicitly, and trans* activists are pushing for their protection. However, these Bills – now colloquially referred to as “Bathroom Bills” – have been amended or derailed based on unfounded fears and concerns that biological men and “pedophiles could be protected when they lurk in public bathrooms” (McGregor, 2015). TIGV people should not have to face oppression and injustice, especially when it comes to something as necessary as the use of a washroom. If these policies do not revoke one’s social citizenship, I am not what does.

Public washrooms can be incredibly uncomfortable places for gender-variant people, “not only do they find them awkward, but also some experience harassment or even violence as a result of not fitting with traditional gender roles” (McGregor, 2015). To expand this point, Herman (2013) surveyed 93 TIGV people and 70% reported being denied access or being harassed and abused, “impacting respondents’ education, employment, health and participation in public life” (p.65) – social determinants.

These three examples – Prison, Identification, and Bathrooms – exemplify systemic barriers to full citizenship and self-actualization. They also underscore various social influences that determine one’s health. Again, these three are only a small segments of life selected to briefly illustrate the manifestation of systemic TIGV injustice.

Conclusion

Without doubt, Trans*, Intersex and Gender-Variant communities endure and, in many cases, overcome unbelievable challenges. Not all of us are born with privilege; many of us are born into lives where oppression and injustice are unavoidable, everyday realities. Through researching this topic, it has become quite evident that TIGV communities endure the lion’s

share of injustice, exacerbated by other intersecting oppressions. This paper brought attention to various aspects of the lives that TIGV people lead, shedding light on areas that need to be overhauled while acknowledging progress that has been made.

I wonder what life would be like if we allowed babies who are born intersex to grow into the human beings that they were meant to become, without the outside intervention imposed upon them based on socially constructed ideals of “normal.” How many lives have been ruined by botched infant surgeries and incorrect gender assignments? How many lives would be saved if we made space for sex and gender variation and adjusted the world around us accordingly? How many suicides would be avoided if we allowed children to use the bathroom that coincides with their core gender? What would happen if treatment was made accessible without stigmatizing and disempowering diagnosis and unethical care? These questions could continue.

It is undeniable that our social constructs play a major role in how we as a society interact with, support, reject, or embrace TIGV communities. Those deemed abnormal are deemed unacceptable, and those deemed unacceptable are left marginalized, oppressed and persecuted. It is time to interrogate what we perceive as normal, and to make the necessary social and political adjustments and abolish the barriers to full citizenship. Our social world determines our health, and positive determination is long past due.

“The point is to imagine a world in which individuals with mixed and indeterminate genital attributes might be accepted and loved without having to undergo transformation into a more socially coherent or normative version of gender” (Butler, 2001, p.627)

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