

Guest editorial

Trans and intersex issues in health and care

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Gender and sexuality diversity in the context of health and care has been an important theme in this journal over recent years. A number of excellent papers have been published on lesbian, gay, bisexual and trans (LGBT) health needs and social care provision, as well as issues of access, education and the quality of care received. The heterosexism that is embedded in much health and social care practice is still very apparent (e.g. Standing, 2011). We welcome the contribution of this journal, as crucial benefits will emerge from better education of health and social care providers armed with policy and intervention strategies that are sensitive to the experiences of those who live non-normative gendered and sexual lives.

Nevertheless, a greater focus is required on the specifics of gender non-conformity as it intersects with sexuality, and there is scope for more information about the needs and experiences of *trans-identified* people and those who are classified as *intersexed*. The LGBT coalition, which sometimes expands to LGBTQI, that is, including queer, questioning and intersexed, can serve to highlight shared concerns in relation to experiences of marginalisation, exclusion and stigmatisation. More frequently, recommendations for practice are based on research findings that are informed primarily by LGB participants. A recent example of this from the palliative care field can be found in research on end-of-life care for LGBT people (Cartwright, Hughes and Lienert, 2012), which makes the important recommendation that there should be better education of health and care providers in order to prevent discrimination. Of the 25 participants who contributed to this qualitative research, none identified as transgender. Although we recognise and promote the importance of coalition activism between LGBT people and others who fall outside of normative gender and sexuality identities, as researchers we need to be wary both of tokenistic inclusion and of generalising findings from one population to another. Rather, we should engage with the complexities of trans and intersex people's lives, their relationships with LGB people and communities, the way in which their gender identities

intersect with sexuality identifications, and the distinct relationships that they have with healthcare professions.

In this context we are using '*trans*' as an umbrella term that might incorporate those who identify as transsexual or transgendered, but also those whose gender variation may not simply fit within a narrative of gender transition. For some trans people, the desire is to live as a member of the opposite sex, with full embodied harmony between secondary sexual characteristics and gender identifications. For others, there are challenges to the neat assumption that sexual characteristics map on to gender identifications, and some seek to live between man and woman, feeling as if they are neither or both. When exploring health and care for trans people, the nuances of gender identifications and embodied desires need to be carefully negotiated.

The term *intersex* refers to people who, as a result of sexual differentiation processes involving interactions between chromosomes, hormones and genital development, cannot be simply assigned to the categories of male or female. Intersex can manifest in various ways, and there are a number of diagnostic categories, including hermaphroditism, Klinefelter's disorder and androgen insensitivity disorder (AIS). In line with the feminist biologist Anne Fausto-Sterling (2000), we prefer to see intersexuality as further evidence of the potential for gender variation in humans, rather than as a form of biological abnormality that requires immediate surgical treatment. Nevertheless, intersexed conditions and associated interventions raise particular health concerns, including issues related to sexual sensitivity and reproductive health. These bodily distinctions in trans or intersexed classification reinforce the importance of not simply appending T or I to the end of LGB without a proper understanding of the specific issues that trans and intersexed people face, which may include prejudice from LGB people.

In the literature on the politics of transgender and intersex care we find a more medicalised relationship to healthcare professions than that faced by LGB

people. Although homosexuality as an identity category emerged from the 'medicalisation of the sexually peculiar' (Foucault, 1979, p. 44), and was once classified as a mental disorder, LGB people are not required to interact with health professionals in order to embody their identity. In contrast, trans people are still entrenched in battles over who gets to regulate access to technologies that can help to transform their bodies. Gender identity disorders still feature as a diagnostic category in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* (American Psychiatric Association, 2000), and will remain in the next edition, which is due for publication in 2013. This immediately brings trans-identified people into specific relations with healthcare professionals. In order to access any form of treatment they have to obtain a referral from their GP to specialised gender services. Once transition is identified as the appropriate pathway for them, they begin a lifetime course of hormone replacement therapy, and may opt for surgery to realign their gendered bodies. Little is known about the long-term impact of these interventions on their general health, their experiences of accessing treatment and the quality of care provided, or their need for post-transition care. In an overview of the few studies available from the UK, Johnson (2007, p. 460) claimed that 'if we look at the services available to people in the vulnerable state of transition it is clear that the level of care currently on offer in both [NHS and private] systems is seriously lacking', and argued that the pressing issues for future research and practice related to the medical and social support available to trans people.

Power relationships involved in determining how the transgendered or intersexed body is classified and treated have long been central to the liberationist goals of both groups (e.g. Stryker, 1997; Chase, 1999). Nevertheless, the complexities of trans identifications have been overshadowed by the requirement that trans people enact specific (and at times hyperbolic) gendered positionings in order to access surgery or other healthcare and services. This requirement is further complicated when gender identity is dissonant with embodied health needs, for example, when trans men need smear tests, or when trans women require prostate checks. These embodied needs may run counter to the desired gender and are thus troubling to the trans individual; negative and harmful experiences at the hands of healthcare providers compound the individual's distress and feelings of humiliation. In research undertaken in Brighton, trans respondents spoke extensively of their problematic access to doctors/GPs (Browne and Lim, 2008). Many of them had had experiences of doctors whose treatment for ailments unrelated to gender identities became abusive because of the person's trans status/embodied presentation.

Similarly, intersexed people have battled against the historical practice whereby doctors decide to 'correct' or assign them to a specific gender at birth, pointing to the importance of their agency in decisions about whether they wish to have surgical interventions (Kessler, 2000). Research has focused on the decision making of parents who elect for genital surgery for their children (Zeiler and Wickstrom, 2009) and reasons for undertaking genital surgery in adulthood (e.g. Boyle, Smith and Liao, 2005). The importance of personal testimonies of the intersexed is increasingly recognised (e.g. Harper, 2007; Karkazis, 2008), but further research is required in this field, particularly with regard to the management of everyday health and care needs. We here present an agenda that will give voice to the experiences of these under-represented groups and improve knowledge and practice in the field of gender variance:

- the role of trans and intersexed people in defining health and care pathways, in adolescence as well as in adulthood
- health issues that arise as a result of medical interventions such as long-term hormone treatment, reproductive health and the impact of genital surgery on sexual experiences
- the experience of trans and intersexed people if they become ill, age or require social care (understanding, support, who counts as family, who makes decisions)
- the experience of family services, fostering, IVF, and trans and intersexed parenting
- intersectional issues such as class, race, age, disability and also sexuality
- the experiences of trans and intersexed people as carers and/or professionals working in the health and social care sector.

These issues are not definitive, but rather they give a flavour of the gaps in our knowledge, and are motivated by a desire to promote improvements in health and care practice, and to ensure more appropriate experiences for trans and intersexed people.

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