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19

TRANSGENDER, GENDERQUEER, AND NON-BINARY IDENTITIES

Social and Structural Inequalities in Public Health

Danielle J. Roe, Jason Schaub, Jessica Lynn, and Panagiotis Pentaris

Introduction

Whilst there have been advances in policy and practice, transgender and genderqueer (TGD) populations continue to experience health inequalities, often deriving from a misunderstanding or generalisation of TGD needs. TGD people, for example, those who are not cisgender, are often grouped with gay, lesbian, and bisexual individuals. This intersection of gender and sexual orientation is problematic as the emphasis often focuses on sexual orientation, leaving challenges faced by TGD people to be poorly understood (Matsuno and Budge, 2017). The dearth of empirical evidence about TGD healthcare (Institute of Medicine, 2011) facilitates such generalisations, meaning the impact for the individual needs a more detailed analysis (Reisner et al., 2016). These knowledge gaps further perpetuate stigma and discrimination. This stigma is central to health outcomes and is a key driver of HIV disparities within TGD populations (Hughto et al., 2015; Poteat et al., 2016a; 2016b), highlighting the need for better knowledge about lived experience to improve services. This chapter recognises that transgender individuals are more likely to have multiple chronic conditions than their cisgender peers (Downing and Przedworski, 2018) and discusses the inequalities that link interventions and outcomes for TGD individuals.

Language and Definitions

It is important to think about the forms and use of language when examining TGD people's lives. Language is central to how societal gendered expectations are formed, reformed, and performed, to uphold structural inequalities in public health (Pearce et al., 2020). Giddens' (1984) theory of 'Structuration' is useful in this context. As was mentioned in Chapter 2, social structures are both the

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medium and outcome of the practices they organise and perform. For instance, to communicate, one mobilises discourses around TGD people through language (structure) to articulate meaning. As a result, employing the rules that govern articulations of discourses through language reproduces it as an outcome/structure of communication which reinforces other social structures such as discrimination and health inequalities more broadly. Through language, we consistently construct broader structures which then feed into the revision and construction of language by individuals, through the use of agency and consciousness, a duality of structure and agency.

In this chapter, we use TGD as an umbrella term, inclusive of gender identities which do not align with the assignment made at birth, or shortly thereafter, any identity outside of, or between, binary categorisations of man/woman, such as non-binary and/or genderqueer (Matsuno and Budge, 2017), and which is independent of any gatekeeping through required diagnosis of dysphoria or medical transition. Although popular in contemporary discourse, Trans-Exclusionary Radical Feminists or TERFs (Smythe, 2018) will be referred to as 'gender critical' as some consider TERF to be a slur (Pearce et al., 2020) despite strong opposition to this claim. We also recognise that terminology and definitions are changing on a regular basis (Matsuno and Budge, 2017). We invite readers to consider this text in line with what language is used at a given time, and drawing on the descriptor above, as well as how language can reflect and reproduce social structures, and provide alternatives for further changes in meaning and discourses.

Whilst there is no one agreed definition of transphobia, as it is not a singular phenomenon with one uniform account (Bettcher, 2014), transphobia can be contextualised as the broad social context in which TGD people, or those perceived to be TGD, are systematically disadvantaged (Hopkins, 1996). The synergistic relationship of transphobia and homophobia dictate nonheterosexual and noncisgender individuals as 'deviant' (Tewksbury, 2015), creating a rationality of 'acceptable prejudice' that supports systemic disadvantages (Schilt and Westbrook, 2009). Health-related stigma is complex and multiple micro, meso, and macro inequalities should be viewed through a lens of intersectionality (Crenshaw, 2017) rather than as independent, separate entities (Rai et al., 2020).

Gender Critical and Trans Affirming: Socio-Political Context

Despite the heterogeneous nature of TGD identities in society (Bettcher, 2014), TGD literature is overbalanced throughout particular areas and topics. The blending of socially constructed Westernised ideals, notions, and understandings of gender, sex, and sexuality suggest a permeation of colonialised legacies, nationhood, and globalisation in gender and health studies, situating 'the West' as a perceived cultural 'centre' to the Majority World's supposed 'periphery' (Bhanji, 2013; Pearce et al., 2020). This over-emphasis complicates any attempt to authoritatively describe the challenges TGD people face globally. However, Giddens and Sutton (2021) highlight how a global outlook of experiences is emerging

from 'cosmopolitanism'. The flow of information via the internet encourages the co-existence of differently positioned knowledge claims (Pearce et al., 2020) providing an understanding of TGD experience in a more globalised context.

Knowledge availability and access through cosmopolitanism, and the resulting cosmopolitan overload (Giddens and Sutton, 2021), are perceived through contemporary proliferations of distrust and misinformation within TGD public discourses (Pearce et al., 2020). This phenomenon enables conceptualisations of differences of opinion regarding TGD to be operationalised in public health contexts. On both occasions, the concept of intersected identities is essential. The 'cosmopolitisation' of sex and gender is by virtue shaped by an intersectional framework (Crenshaw, 2017), which highlights the complex and multiple dimensions of identity and the way it is experienced by individuals. Pearce et al. (2020) identify two core pillars of this debate: the operationalisation of sex and gender and identity self-determination.

As an example, in the United Kingdom (UK), anti-trans sentiment has increased over the last five years (Pearce et al., 2020). Those holding gender critical views often cite Raymond's (1994) position of trans women as male appropriation of the female body to infiltrate women's spaces with the intent to cause harm. Increasing social acceptance of TGD therefore challenges gender critical beliefs about biologically immutable conceptualisations of 'womanhood' and 'femaleness', providing the justification for gender critical actions to reassert essentialist values, reacting in part to cosmopolitan overload (Pearce et al., 2020).

In contrast to gender critical views, trans affirmative views and trans allyship suggest that sex and gender are culturally constituted and performative rather than biologically essentialist (Butler, 1990). From an affirmative view, gender critical approaches are therefore dissonant with how TGD people theorise, identify, and describe their experiences. Pearce et al. (2020) note that the majority of TGD public health (written about' rather than 'by, with or for' TGD people, further compounding health inequality) is characterised by the absence of robust data on TGD populations (Government Equalities Office, 2018). Despite the rapid growth of the TGD health research field (Thorne et al., 2018), gaps remain, such as non-binary identity needs (Clark et al., 2018) and a lack of research on TGD experiences in low- and middle-income countries (Reisner et al., 2016) especially transmasculine experiences (Scheim et al., 2020). This can lead to ineffective care experiences for TGD people, when individuals/organisations tasked with policy-making decisions, have insufficient scientific and/or personal knowledge of TGD needs (Clark et al., 2018). The use of a public inquiry case study will help further explore the differences between trans affirmative and gender critical views and how they relate to TGD public health.

Tavistock Inquiry

England's only gender-identity development service, the Tavistock Centre, was the focus of a public inquiry in 2020 after BBC Newsnight shared preliminary

findings of an investigation into treatment at the Centre (BBC News, 2020; Carmichael et al., 2020), discussing that 98% of patients taking hormone blockers progress on to cross-sex hormones (Carmichael et al., 2020). This case rose to prominence in a suit, filed on behalf of Keira Bell, for the provision of misleading advice about hormone therapy, and the provision of puberty blockers (Bell v. Tavistock, 2020). The suit claimed true informed consent could not be given as the patient, Keira Bell, was 16 years of age at the time (Bell v. Tavistock, 2020). The High Court eventually ruled in favour of Bell, stating those under 16 are unlikely to be able to give informed consent, based upon Gillick competence (Gillick v West Norfolk and Wisbech AHA, 1986), with the Tavistock immediately suspending referrals for under-16s (BBC News, 2020).

Following the ruling, there was swift opposition from trans affirmative care specialists, trans activists, and trans-inclusive Feminists. They stated that TGD youth usually wait to seek help until at a crisis point (McDermott and Roen, 2012), despite evidence of TGD youth being at particular risk for discrimination, violence, rejection, depression, suicidal ideation, and suicide (Taylor et al., 2020). Psychological and social intervention evidence indicates health professionals should not impose binary categories of gender or sex (Clark et al., 2018) and affirmative models of care provide opportunities for resilience and positive mental health for TGD youth (Costa et al., 2015). This stance directly opposes that of gender critical views, which refutes the high risk of suicide among TGD youth, as trans activist 'scare tactics' (Hendley, 2019). The outcome of the original case was overturned by the Court of Appeal in September 2021, suggesting that the High Court should have dismissed the case when it ruled the Tavistock guidance was lawful and that it is the role of clinicians to exercise judgment in relation to puberty-blocking treatment (Thornton, 2021). In March 2021, a separate case involving the Centre also supported trans affirmative care, ruling that parents can consent to their child taking puberty-delaying drugs without a judge's approval, save where the parents and the child are in opposition (AB and CD v. Tavistock, 2021; Greenhalgh, 2021).

Health Inequalities for Transgender, Genderqueer, and Non-Binary Individuals

Like lesbian, gay, and bisexual people, trans people often meet with discrimination and prejudice in their everyday lives. Many, regardless of social position or class, experience isolation and face limited understanding of their lives (Fish 2007). The Stonewall Trans Report in the UK (Bachmann and Gooch, 2018) outlined ongoing discrimination and oppressive behaviours experienced by TGD individuals – 12% of participants were physically attacked in the last year; 25% have experienced homelessness; 41% felt that healthcare professionals lacked understanding; 50% hide their gender identity at work, fearing discrimination; and 7% have been refused healthcare because of their gender identity. Such evidence raises further concerns about the appropriateness of professionals' skills,

primarily on the level of values and ethics, that appear to interfere with their duty of care. These experiences increase the risk for trans people of alcohol abuse, depression, suicide, self-harm, violence, substance abuse, and HIV (Kenagy, 2005).

Further, considerable extant literature prior to the COVID-19 pandemic consistently demonstrates TGD experience multiple health inequalities (Fish and Karban, 2015) leading to an increased prevalence of poor mental and physical health (Wagaman, 2014). The recent pandemic predominantly heightened the need for action (Pentaris, 2021) rather than caused the issues to hand. As a way of conceptualising the healthcare experiences of TGD individuals, some knowledge reviews show a clear link between stigma and healthcare issues. Winter et al. (2016) showed how this stigma complicates the healthcare experiences of TGD patients, calling it the 'stigma to sickness slope' (Winter et al., 2016: 394).

Mental Health Challenges

TGD individuals have higher rates of mental health issues than the general population. Many of these issues are understood to be in response to the widespread discrimination and abuse experienced from both wider society and those closest to them (Reisner et al., 2016). However, there is surprisingly little research looking at the impact of trauma on transgender people's mental health, but those studies that exist suggest widespread and sustained emotional distress, following discrimination both at home, and in social settings (Fish, 2007). For example, a study in Haiti (Joshi et al., 2021) linked an increase in mental health issues for transfeminine individuals to experiences of extreme sexual and non-sexual violence, which was perpetuated against them in hostile environments. Persistent discrimination, and the resulting stress, have been linked to a range of mental health issues including depression, suicidality, anxiety, as well as increased substance misuse as a coping mechanism (Reisner et al., 2014).

These higher rates of mental health issues have specific presentations. A broad study from the UK about TGD people's mental health found that almost 90% of respondents had experienced depression (88%) and three quarters had experienced anxiety (McNeil et al., 2012). Several studies have shown that over one third of respondents had attempted suicide (Fish, 2007; McNeil et al., 2012) and over three quarters had experienced suicidality. This should be compared to suicidality experienced by 1%6% of the general population (Winter, et al., 2016).

In particular, waiting for treatment was shown to have a significant negative impact on mental health outcomes, even for young people (Carlile et al., 2021). Individuals with gender dysphoria may experience several different mental health issues, which can be linked to a long history of seeking treatment, and experiencing discrimination (Murad et al., 2010). It is important to identify the centrality of the role of mental health professionals to accessing and receiving health treatment, a situation that is not found elsewhere in healthcare (Ehrensaft, 2017). There are some calls to challenge this gatekeeping (Ettner and Wylie, 2013), with some suggesting that it unfairly pathologises trans and non-binary

gender identities, and individual's search for support and appropriate healthcare. What is clear is that for people with gender dysphoria, most of them felt their mental health was better after transitioning, reducing both suicidality and suicide attempts (McNeil et al., 2012).

HIV-Related Challenges

Generally, transgender, and gender diverse individuals have a higher proportion of HIV infection than the general population (Poteat et al., 2016b; Reisner et al., 2016). This is often combined with a lack of specific resources and attention, creating a 'perfect storm' for this population. Susan Buchbinder (2016), from the San Francisco Department of Public Health, argued that there is probably no population, which is both more heavily impacted by HIV, and less discussed around the world, than transgender people (Buchbinder, 2016).

It is difficult to identify with any certainty the prevalence and severity of HIV infections for multiple reasons; the challenges of accurately identifying gender identity of research participants, national differences in societal engagement with TGD people, and policy responses, and missing data from large sections of the world. HIV research often subsumes transfeminine people into the category of men who have sex with men (Poteat et al., 2016a), further obfuscating the prevalence and severity of HIV issues for transgender individuals. Transfeminine people have very high HIV rates (up to 40%) (Poteat et al., 2016a), but this is without data available for much of the world (particularly Sub-Saharan Africa and Eastern Europe/Central Asia). Transfeminine individuals often 'engage in sex work for economic survival and gender affirmation' (Poteat et al., 2016a), with associated significantly greater risk of sexually transmitted infections and violence. In addition, services designed for men who have sex with men are inappropriate for transfeminine individuals and may be less welcoming to transmasculine individuals (Poteat et al., 2016a). When considering the experience of transmasculine people, surprisingly, clinicians often do not outline the risks of unprotected sex with men, meaning a lack of knowledge of risk, behaviour, and treatment options. Importantly, this is an area where intersectionality is a key consideration, as there are some studies that suggest that transfeminine people from minority ethnicities have significantly higher rates of HIV (Institute of Medicine, 2011).

A Personal Perspective

My (JL) experience as a transgender activist supports the description that the most painful discrimination experienced by TGD individuals is manifested via healthcare. If TGD individuals are to be validated in their identities, no place is more important than that of a healthcare environment. It is not uncommon to have one's trans identity outlined during unrelated medical visits (and in the most inappropriate ways). A close (trans) friend of mine found that, after having been

released from hospital, following an open-heart surgery, her discharge diagnosis of unstable angina included 'transgender with a history of sex reassignment surgery'. While having x-rays taken of my jaw (because of a car accident), I have been asked whether I had a penis or a vagina – which is wholly unrelated to the issue at hand. Under the guise of curiosity, the subject of a transgender person's body is treated with a levity that, to any cis person, would be reprehensible, if not illegal. Discrimination is, and always will be, an ongoing battle, but it has no place in healthcare. Too often transgender people are asked invasive and irrelevant questions and invalidated by healthcare professionals. When one walks through the healthcare doors, all questions of race, religion, and sex should be discarded if they are not pertinent.

Conclusion

This chapter focused on the health inequalities experienced by transgender, gender-queer, and non-binary individuals. The chapter considered social and structural inequalities which further cause challenges vis-à-vis mental health. The lack of evidence in this area only adds to the challenges in advancing understanding of TDGs' lived experiences, to move forward, and toward a more inclusive and dignified 'for all' system of healthcare. TGD individuals are in the process of navigating the late modern world and complexity of cosmopolitisation, as they stride both 'emancipatory politics' and 'life politics' (Giddens, 1990; 1991; La Placa et al., 2014). Emancipatory politics is the process of liberation from social structures and constraints governing individuals' lives. The process of life politics concerns us more with personal choice and lifestyle, and how individuals construct the authentic self and lifestyle, in response to the flux and instability of the late modern world. The duality of structure and agency can enhance this process on a theoretical level and assist us in understanding the strive for self-determination and equality in healthcare and beyond.

Research Points and Reflective Exercises

TDG individuals face continuous discrimination and experience stigma on the grounds of their gender identity, which deprives them from making effective use of services. By means of reflection, we invite readers to consider:

1. how does poor understanding and lack of knowledge about TGD challenges lead to discriminatory and exclusionary practice?
2. how this can be combated?

Further Resources and Reading

Gender Creative Kids – https://gendercreativekids.com/
Gendered Intelligence – https://genderedintelligence.co.uk/

The Gender Unicorn - https://transstudent.org/gender/
World Professional Association for Transgender Health – www.wpath.org

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