

The University of Hull

The Interaction of Corporeality, Social Discourses and  
Institutions on the Transition Process and Transsexual  
People's Experiences of Accessing Health and Social Care  
Services Post 2004

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by

Martina Inessa Kirlew, B.A. (Hons), MSc and MA.

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## Glossary of Terms

**Transsexual:** A person who is a transsexual experiences great discomfort with his or her gender. They may feel “trapped in the wrong body” and desire to live full-time in the role and dress of the opposite gender (Whittle, 2000; Department of Health, 2007 and Beaumont Trust, 2010). The person may or may not take hormones and may or may not decide to “have sex reassignment surgery to become as much as possible like someone of the opposite sex” (Davison and Neale, 2001: 382).

**Transgender:** A transgender person can be defined as someone who doesn't identify unproblematically as one or another sex or gender. They may describe themselves for example as 'trans' or 'transgender' (Alleyn and Jones, 2010). Therefore, in this sense terms such as 'trans' and 'transgender' can be applied to those people who have not made a clear move from one fixed gender or sex to the other or may move between or outside traditional categories of sex and gender (Alleyn and Jones, 2010).

**Gender Identity Disorder:** or Gender Dysphoria as it is sometimes known is a condition in which a person feels that there is a mismatch between their biological sex and their gender identity. By altering both the body and the social role, which are intertwined to fit the inner gender identity of a transsexual person, can help to alleviate the distress of severe Gender Dysphoria. Thus, when the inner sense of identity and the body and social role are in harmony the distress caused by Gender Dysphoria may be no longer present or considerably reduced (West, 2004).

**Gender Reassignment Surgery:** is surgery to the genitalia of a man or a woman that creates new genitalia to match that of the sex they have transitioned to. Hines (2007) and Bourke (1994) suggest that Gender Reassignment Surgery for some transsexual people is important

as it enables the coming together of their gender identity and bodily appearance. This can help some transsexual people to gain “physical comfort and well-being and emotional confidence” (Hines, 2007: 70).

**Transition Process:** For the purposes of this thesis the ‘transition process’, refers to the period from which a person contacts their GP or local mental health service requiring a referral to a gender identity service, to the time when they have gained a Gender Recognition Certificate and had gender reassignment surgery if they wish to have it.

**Real Life Experience:** The transition process includes the ‘The Real Life Experience’, which means the transsexual person living full-time in role for at least one year before they can start the process for applying to have gender reassignment surgery if they want to have it (Health Commission Wales, 2009).

**Gender Recognition Certificate:** A transsexual person, who has been in role for at least two years, can apply for a Gender Recognition Certificate if they wish, which means they have the same legal rights as anybody else in their new gender. They can then obtain a new birth certificate to match their new sex and can legally marry someone of the opposite sex (Equality and Human Rights Commission, 2010).

**Screening Services:** a transsexual person may need to use some medical screening services throughout their life that are appropriate for females only as well as some screening services that are appropriate for males only, due to their mixture of biological characteristics (Department of Health, 2008; Feinberg, 2001 and Ashbee and Goldberg, 2006).

**Transphobia:** is “a fear of or a dislike directed towards trans people, or a fear of or dislike directed towards their perceived lifestyle, culture or characteristics, whether or not any specific trans person has that lifestyle or characteristic” (Crown Prosecution Service, 2002).

Being transphobic doesn't have to involve hatred, but includes simply doing something or refusing to do something because the person doesn't like trans people (Crown Prosecution Service, 2002).

**Heterosexual:** This is having sexual desire for someone of the opposite sex to you.

**Homosexual:** This is having sexual desire for someone of the same sex as you.

**Lesbian:** A woman who is sexually attracted to other women.

**Gay:** A homosexual person, but is often used to describe a man who is sexually attracted to other men, although the term can also be used to describe women who are sexually attracted to women.

**Bisexual:** This describes a person who can be sexually attracted to more than one gender.

**Polysexual:** describes a person who is attracted to more than one sex or gender, but do not define themselves as bisexual because that may imply that there is only two binary genders and sexes. A person who is polysexual may be sexually attracted to many different types of people, which includes those who do not clearly define themselves with the binary genders and sexes.

**Sapiosexual:** This term defines someone who finds intelligence the most attractive feature of other people.

**Queer:** This term is an umbrella term that can include lesbian, gay, bisexual, those questioning their sexuality, transgender and transsexual people and those who do not clearly define with heterosexuality.



**Asexual:** This term defines a person who does not experience sexual attraction. Some asexual people prefer to be on their own, others may prefer close friendships and some may have a desire for more intimate romantic relationships and may seek long term partners.

**Health:** refers to the body being free from diseases. Health is a goal one can aim to achieve.

**Wellbeing:** is the overall balance of your physical, social, spiritual, emotional, intellectual, environmental and occupational wellbeing. Wellness is a lifestyle and the need for balance throughout one's life.

**Insider researcher:** Griffith (1998: 361) defines an insider researcher as “someone whose biography (gender, race, class, sexual orientation and so on) gives them a lived familiarity with the group being researched- that tacit knowledge informs their research providing a different knowledge than that available to the outsider researcher.”

**Outsider researcher:** Griffith (1998: 361) defines an outsider researcher as “a researcher who does not have an intimate knowledge of the group being researched prior to their entry into the group.”

## List of Abbreviations

**GID** - Gender Identity Disorder

**GRS** - Gender Reassignment Surgery

**MtF** - Male to Female Transsexual

**FtM** - Female to Male Transsexual

**GRC** - Gender Recognition Certificate

**RLE** - Real Life Experience

**IVF** - In Vitro Fertilisation

**ICP** - Integrated Care Pathways

**CCG** – Clinical Commissioning Groups

**LATs** - Local Area Teams

## Introduction

This thesis addresses the following central questions that were the focus of the research study. Firstly, what are the experiences of transsexual people accessing health and social care services since the introduction of the Gender Recognition Act 2004? Secondly, to what extent have health and social care services implemented and enforced this legislation in their policies and practices? Thirdly, what is there that people in practice can do to improve things?

Prior to 2004, transsexual people were not recognised in their acquired gender under the law of the United Kingdom. The purpose of the Gender Recognition Act 2004 is to provide transsexual people with legal recognition in their acquired gender. Therefore, for example, a MtF transsexual person can be legally recognised as a woman in English law and a FtM transsexual person can be legally recognised as a man in English Law. On the issue of a full gender recognition certificate, the person is entitled to a new birth certificate reflecting their acquired gender and is able to marry someone of the opposite sex (Office of Public Sector Information, 2004).

The Services Directive 2004 was introduced in December 2007, which means public authorities are under a duty to have due regard to the need to eliminate unlawful discrimination and harassment on grounds of gender reassignment in the provision of goods, facilities and services, which includes health and social care services (Office of Public Sector Information, 2007). The introduction of the Equality Act 2010 strengthens the law for transsexual people in a number of areas. Whereas previously the Sex Discrimination Act 1975 required a transsexual person to be under medical supervision in order to be protected by it, the Equality Act 2010 stipulates that this is no longer a requirement (Office of Public Information, 2010). The Equality Act 2010 “defines the protected characteristic of gender

reassignment for the purpose of the Act as where a person has proposed, started or completed a process to change his or her sex. A transsexual person has the protected characteristic of gender reassignment” (Office of Public Information, 2010: 14). The introduction of the Equality Act 2010 means that public bodies have to consider how their policies and practices affect people with protected characteristics and “take positive action so as to enable existing or potential employees or customers to overcome or minimise a disadvantage arising from a protected characteristic” (Office of Public Information, 2010: 15). Therefore, knowledge of the experiences of transsexual people accessing health and social care services since the introduction of the Gender Recognition Act 2004 and other legislation are vital in order to assess whether transsexual people are still facing discrimination and a lack of understanding when accessing services. These experiences are also important to assess the extent to which services are implementing and enforcing this legislation in their policies and practices.

The focus of this thesis is on those transsexual people who wish to be legally recognised in their newly acquired gender and therefore at present needed to access specialist medical services, even if they do not have hormone therapy and/or sex reassignment surgery in order to achieve legal recognition. This thesis also acknowledges that there may be some transsexual people who are living their lives without feeling the need for any medical intervention to help with their transition. In order to apply for a Gender Recognition Certificate, it is presently a requirement that transsexual people firstly need to provide two medical reports, one from a medical practitioner or registered psychologist practicing in the field of Gender Dysphoria stating that the person has been diagnosed with that condition and one report from a registered medical practitioner who may, but need not, practice in that field (Office of Public Information, 2004). Secondly, the reports have to state that they have attended a gender clinic and can prove that they have lived full-time in role for at least two years by providing documents, such as change of name deed poll, driving licence, passport

with their new name and gender and a letter from an employer, university or employment agency, for example, that they have been living full time in role (Office of Public Information, 2004).

This means that although a person may not have hormone therapy and/or GRS when they attend the gender clinic during the transition process it still needs to be documented in a psychiatrist's report that they have been attending a gender clinic on a regular basis in relation to their transition process in order to meet the requirements to gain a Gender Recognition Certificate. Whilst I acknowledge that some transsexual people may still benefit from the support the gender clinics can offer, even though they choose not to have hormone therapy and/or GRS, others who do not need that support are still obligated to attend the service. Therefore, this suggests that there are still constraints on gaining approval for a Gender Recognition Certificate, and that these contribute to the normative regulation of what it is to be a transsexual, or not. The medical position within the transition process is an important one for many transsexual people, as it can help them to relieve their distress and live their lives in their chosen gender and sex. However, at present in relation to gaining legal recognition, there is still a requirement and reliance on a medical opinion for gaining legal recognition.

Although research is important for assessing the experiences of trans people in general, it is important to acknowledge that there may be differences in needs and experiences of those people with different identities when accessing health and social care services. At present transsexual people have legal recognition as male or female in the UK, thus it is important to ascertain to what extent those rights are being implemented in the policies and practices of health and social care services, and if implemented, to what extent this is of value to transsexual service users. Secondly, the term 'transgender' is often used as an umbrella term in health and social care services, as it is in wider society. Therefore, it is important that this

thesis ascertains whether research participants feel they are recognised and respected within their acquired gender, or whether they feel that they are regarded as ‘other’, as in ‘transgender’, and what affect this has on their sense of identity. This is important because having both legal and social recognition as a man or a woman is an important factor that can contribute in a positive way to a transsexual person’s overall health and wellbeing, and lead to a successful transition process.

Definitions of ‘transsexual’ and ‘transgender’ are relative rather than absolute, as these identities vary according to their historical and geographical context. Although the term ‘transsexual’ was conceived in the 1940s, ‘transgender’ is a recently conceived term and identity category. A person who is a transsexual experiences great discomfort with his or her gender. They may feel “trapped in the wrong body” and desire to live full-time in the role and dress of the opposite sex (Whittle, 2000; Department of Health, 2007 and Beaumont Trust, 2010). The person may or may not take hormones, and may or may not decide to “have sex reassignment surgery to become as much as possible like someone of the opposite sex” (Davison and Neale, 2001: 382). A transgender person can be defined as someone who doesn’t identify un-problematically as one or another sex or gender. They may describe themselves for example as ‘trans’ or ‘transgender’ (Alleyn and Jones, 2010). Therefore in this sense terms such as ‘trans’ and ‘transgender’ can be applied to those people who have not made a clear move from one fixed gender or sex to the other. or may move between or outside traditional categories of sex and gender (Alleyn and Jones, 2010). However, the term ‘transgender’ has also been used as an umbrella term incorporating practices and identities such as intersex, cross-dressing, transvestism and transsexuality (Hines, 2007). Others may use the term ‘trans’ as an inclusive term for transsexual, transgender and transvestite people (Alleyn and Jones, 2010). Recent writers such as Alleyn and Jones (2010) have discussed issues such as exclusion and inclusion within the category of ‘transgender’, and the concerns

that the transsexual identity poses to transgender and vice versa. For example, transsexual people can be seen by some transgender people as defenders of binary sex and gender categories, whereas some transsexual people may see transgender people as a risk to the traditional transition process and existing surgical procedures for gender reassignment surgery (Alleyn and Jones, 2010). Moreover, Vidal-Ortiz (2008: 433) suggests that the term 'transsexual' was "pathologised" in the twentieth century; however it is at present being reconsidered as a less stigmatised term to refer to current transitioning experiences and narratives".

Chapter one explores how transsexualism has been approached within different theoretical fields in order to set the context, within which, discussions of the three central questions of this thesis have been approached in this research study. The main perspectives concerned with transsexualism that are discussed in this thesis are the medical perspective, the feminist perspective and the trans perspective. This will be followed by a discussion of the theoretical perspective, which has been adapted for the purpose of analysing the research findings of this thesis, which is Frank's (1991) theory of the body. I suggest that Frank's (1991) theory of the body is a useful tool that can be adapted and applied to analyse the findings of this research study. The reason for this is that corporeality of the body, social discourses and institutions cannot be examined in isolation of each other, as Frank (1991) argues. This is because each of these areas has an important role to play within the transition process and can influence, in a positive or negative way, each other area at the same time. For example, if legislation is implemented into policy, but not enforced within practice, then this may still lead to negative experiences for a transsexual person accessing health and social care services. Frank's (1991) theory of the body is a useful tool for the analysis of the complex interaction of corporeality, social discourses and institutions in the context of the experiences of transsexual participants when accessing health and social care services. This also serves to highlight some of the key

issues that impact on and restrict health and social care staff from improving their practice when working with transsexual people. Therefore, one of the main aims of this study is to identify ways to improve practice at an individual level, and at an institutional level.

In Chapter Two, the literature review will firstly examine the literature around the issues some transsexual people have faced during the transition process whilst accessing health and social care services, prior to the introduction of the Gender Recognition Act 2004. Two approaches dominate this literature, a medical approach and a political and economic approach to service provision. This will be followed by a discussion of the literature in relation to how some services have tried to tackle those issues, and tried to improve access for transsexual people in an attempt to make services more inclusive of transsexual people's needs when accessing particular health and social care services. Then there is a discussion of how changes in services have been influenced by identity politics, local political movements and legislation. However, these changes have not always gone smoothly. The literature review will then lead on to consider issues of contesting those legal rights gained by transsexual people since the introduction of the Gender Recognition Act 2004. For example the prison service refusing to move a transsexual woman from a male only prison to a female only prison, even though she has a Gender Recognition Certificate, and the impact this may have in future on other services deciding to contest the legal recognition of transsexual service users, and thus the negative consequences this may have on a transsexual person's health and well-being due to them being refused access to a particular service. There will finally be a discussion of the different stages of transition a person usually goes through, from questioning one's gender and initial contact with health services, through to choosing to have sex reassignment surgery, although it should be noted that a person may go through with some of the stages of transition, but not others. The different stages of the transition process are important to the main two questions of the research study, because without medical



support a transsexual person within the UK cannot gain at present legal recognition, nor can they access specialist services like the gender clinics.

Chapter Three focuses on the design and methodology of this study. It is split into two sections. Section one of this chapter will discuss the research paradigms that have influenced how the research study was undertaken. These included feminist research principles, emancipatory research principles and emic and etic perspectives. I share many values as a researcher with the paradigms discussed in this chapter and emphasise some of these values through the way I have approached the research process, and by the use of some of my personal reflective diary entries that are included throughout this chapter. There then follows an account of the issues I needed to be aware of as an insider researcher, and the steps I could take to reduce the likelihood of any potential problems negatively affecting my own research study. These issues included previous experience of associating with the trans community, disclosing one's insider identity, and gaining a representative sample of transsexual participants. I would argue that my position as an insider researcher played a significant role in helping me to gain a significant variety of transsexual participants at the different stages of the transition process, and from different socio-economic backgrounds in England, Wales and Scotland. There is then a discussion of the ethical research principles of the study, which follow guidance from the Economic and Social Research Council, British Association of Social Workers and the University of Hull ethics committee.

The selection of entries from my reflective diary during the research process highlight some of the issues I faced as an insider researcher, and explain the development of the research methods and questions, and my personal thoughts on how successful the research process was progressing.

Section two provides a descriptive account of the three phases of the research, which includes both quantitative and qualitative research methods. The first phase of the research study explores the design of the survey, which ran concurrently alongside the sequential phases of the research design. The latter involved semi-structured interviews followed by an online focus group. The survey was used to obtain data from research participants from across the UK. This included research participants from those geographic areas not covered in the focus group and semi-structured interviews. Categories such as age, country, county, identity and which year participants started the transition process are discussed with the help of bar, column and pie charts.

The second phase of the study involved semi-structured interviews. These were chosen because it was considered that the flexibility of this method would allow participants to explore the topics in detail without too much constraint. How successful the interview process was, and the advantages of using this research method, are then discussed. This includes examples of how the study was influenced by the research paradigms discussed in this chapter, and how some of those values, such as reducing the hierarchical relationship between the researcher and the research participants, influenced my decision to give participants some control over where they were interviewed. Following on from this there is an evaluation of the successfulness of using a digital voice recorder to record the interviews. This was an important research tool that enabled me to concentrate fully on what the participants were saying, without been distracted by writing notes. Telephone interviews are then discussed. This was a flexible research method that allowed the interviews to be set up at a convenient time for the research participants in the comfort of their own homes, and especially for those from remote rural areas of Wales, where it could have been extremely difficult to have otherwise gained their views and experiences.

The third phase of the study which involved an online focus group using Skype is then discussed. This includes describing the design of the focus group and the advantages of using this research method. Finally the colour coding system that was used to analysis the interview transcripts is explained.

Chapter Four examines the corporeality of the transsexual body, and its impact on health and social care services. This chapter starts by discussing how for Frank (1991) the body is a corporeal phenomenon which itself affects how people experience their bodies (Shilling, 2003). Therefore the body can be seen as a vehicle that enables a person to express themselves, but at the same time places constraints on that action. This chapter explains how there are three dimensions to the constitution of the body in Frank's analysis, two of which will be discussed later in this thesis; social discourses in chapter five and institutions in chapter six. The first dimension of the constitution of the body is the corporeality of bodies.

As will be discussed in chapters four and five, there is an exclusion of the transsexual body in transition in the remit of institutional culture and social discourses, and a lack of its classification in health care ICT systems. The inadequacies of these binary ICT systems are the source of many of the difficulties in transsexual people's experiences in care settings, as well as being the root of much of the misunderstanding. In many significant ways these ICT systems contribute to rendering transsexual needs invisible, as this study will demonstrate. I will argue that there is a need to integrate these transsexual bodies, and variations of bodies, into the organisational culture, policy, practices and social discourses within institutions at a macro and micro level and within social discourses in general.

Then the transsexual body is explored as a place of desire and resistance, and also a site for violence, abuse, self harm and loss of who the person use to be in their previous gender. Some research suggests that there can be higher than normal rates of suicide, abuse, drug

abuse, violence and self harm amongst transsexual people, compared to non transsexual people (Kenergy, 2005; Bockting, Knudson and Goldberg, 2006).

This is followed by a discussion of the corporeality of the body before transition. In the pre-transitioning body, there is often a need to start making visual changes to the body, and accommodate them in the previous gender identity without raising too much suspicion from others, such as friends, family and work colleagues. Changes in grooming that are usually appropriate for the opposite gender are an important step for both MtF and FtM transsexuals.

The corporeality of the body during transition is then examined. As mentioned in the literature review, hormone therapy can be an important part of the transition process for some transsexual people, as it can help them to be more at ease with themselves both physically and psychologically (Department of Health, 2007; West, 2004 and Namaste, 2000). This is a common and frustrating experience for some participants when they have started hormone therapy as their body slowly starts to show development of characteristics associated with their new gender identity, whilst still having many characteristics of their previous gender identity. It's a time when their body needs to change to align its self with their new sense of self, and also at the same time, be a body that portrays their new gender identity in a social context. These difficulties are examined in this chapter.

The issue of having surgery to promote intimacy is then discussed. Deciding to have a full Vaginoplasty or a Cosmetic Vaginoplasty in the case of a MtF transsexual or a Phalloplasty in the case of a FtM transsexual, or no surgery at all, is a decision the person has to take during the transition process. The reasons for these choices may be to alleviate the psychological distress, align their body to their new gender and promote physical well being. But it also may be undertaken to promote their sexuality, reach fulfilment sexually and increase intimacy with a partner, or help to establish a sexual relationship with a new partner

if they wish. The issue of transsexual women being unable to give birth is then explored. Transsexual women are unable to bear children as they do not have internal female reproductive organs. They therefore miss out on the chance to experience pregnancy, childbirth, the postnatal body and motherhood, and the relationship this has to the self. The gendered identity of woman can be seen as a tragic loss for some transsexual women, just as it can be for other infertile biological women who wish to have children. The corporeality of the body after transition is then discussed, focusing on the issue of having to deal with, and learning to adapt to, a different physicality, for example loss of muscle development and strength for some MtFs after GRS.

Chapter Five examines the impact that social discourses have on the transition process, identity and transsexual people's experiences of accessing health and social care services. This chapter firstly discusses how Frank (1991) defined and used the model of the communicative body for the purpose of his theory of the body. There will then be a discussion of how it has been adapted for the purpose of this thesis. The complexities participants had with defining themselves at different stages of the transition process will then be examined. This leads to an exploration of the types of interactions participants had with other people and the impact that had on their identity, the transition process and their experiences of accessing health and social care services. This chapter will highlight the importance people put on labelling themselves and others in everyday interactions, and how people may question those they interact with who don't match what they perceive to be appropriate for that person's presumed identity.

Chapter Six examines the impact that institutions can have on the transition process and transsexual people's experiences of accessing health and social care services. This chapter starts with a discussion of the importance Frank (1991) placed on institutions for the expression and promotion of the communicative body in his theory of the body. As

mentioned earlier, the introduction of the Gender Recognition Act 2004 has meant that transsexual people can now gain legal recognition in their acquired gender under the law of the United Kingdom (Office of Public Information, 2004). Institutions have therefore played an important role in enabling the expression of transsexual research participants' new identities, through the interactions they have had with those institutions, such as health and social care services, local government departments and banks and building societies. However, it is also the interactions that transsexual people have with members of those institutions that help to illustrate the issues raised by the transsexual identities and bodies for an institution's systems, policies and practices that render the transsexual identity, body and health needs as invisible. This chapter discusses the issues that were raised by two health care professionals who have experience of working with transsexual patients. This was an important part of the research process as there was little evidence of research into the experiences of health or social care professionals working with transsexual patients within the existing literature. It was important that this study was able to show the issues health care professionals face when working with transsexual patients, and their views on some of the problems treating a transsexual patient generates for their policies, practices and computer systems. The chapter goes on to discuss the structuring of the NHS. There are four different healthcare systems in the UK as follows: - NHS (England), NHS (Scotland), NHS (Wales) and Health and Social Care in Northern Ireland (HSENI). Therefore, where possible if there has been a significant issue discussed in this study that has been raised by participants in a particular country, then the appropriate NHS term will be used for that country. At the time the fieldwork was undertaken for this thesis, Primary Care Trusts (PCTs) were still in place within England, and were responsible for commissioning health and social care services to meet the needs of local populations.

There is then a discussion on how the collaboration between different professionals, and different health and social care services, can help to provide better services to meet the needs of patients and service users. For patients and service users, collaborative working between services can help them to feel less frustrated as they do not have to repeat the same information through duplicate assessments. The issue of a lack of effective communication between GP surgeries and hospital outpatients is then explored, through the experiences of participant B. Participant B mentioned that the amount of information provided by the referral process may be sufficient for health care staff, in most cases, to efficiently carry out scans on biological males and females, but transsexual people are likely to have a mixture of biological characteristics of both sexes, and may have the opposite genitalia to the gender they currently present in. This can sometimes lead to confusion for health care professionals and administration staff in relation to whether the scan the transsexual person has come for is appropriate to them, or whether there has been a mix up with the paperwork. Health care professional's experiences of treating transsexual patients, and wanting to act in a sensitive way that does not offend are then discussed, as are the problems transsexual participants can encounter in gaining appropriate screening services. This is followed with the confusion blood test samples of transsexual people can cause to blood testing computer systems. Then the importance for some transsexual people to merge their faith with their new gender identity is discussed as well as the Transphobic verbal abuse and threats of violence or actual violence in social situations that transsexual participants have experienced.

Transgender and transsexual support groups, the gay village at Manchester, and a transgender safe house in Wales are then examined, and there is a discussion on the important roles these institutions play for both promoting one's transsexual identity, and gaining support to express that identity. Finally, there is a discussion of the experiences of transsexual participants accessing social care institutions.

Chapter seven, the final chapter, draws on the findings of this thesis and makes recommendations for future research in relation to the transition process and transsexual people's health and social care needs. It emphasises the importance of examining transsexual people's experiences of accessing health and social care services within corporeal, social discourse and institutional contexts simultaneously. This chapter also makes recommendations for practice as to how the issues identified in this study can be addressed.



## **Chapter One: Perspectives on transsexualism and the need for a more holistic approach**

The aim of this chapter is to explore how transsexualism has been approached within different theoretical fields. This will set the context within which discussions of the three central questions of this thesis have been approached in this research study. The theoretical fields that are discussed are transsexualism within a medical context, feminist theory and trans theory. This will be followed by a discussion of a theoretical perspective that has been adapted for the purpose of analysing the research findings of this thesis, which is Frank's (1991) theory of the body. The reason for using and adapting Frank's (1991) 'theory of the body', I would argue, is that whereas a medical context, feminist theory and trans theory have looked at individual elements of transsexualism, such as medical interventions, gender categorisation and activism, Frank's 'theory of the body' can help anyone to take a more holistic approach to analysing the transition process, and the impact that corporeality of the body, social discourses and institutions in their wider context, have on a transsexual person's experiences of accessing health and social care services and the transition process. This is because each of these areas has an important role to play within the transition process and can influence in a positive or negative way each other area at the same time. For example, if legislation is implemented into policy, but not enforced within practice, then this may still lead to negative experiences for a transsexual person accessing health and social care services. Therefore, using Frank's (1991) theory of the body to analyse the complex interaction of corporeality, social discourses and institutions, in the context of the experiences of accessing health and social care services that those transsexual participants in this thesis had, has helped, it will be argued, to provide a greater understanding of the complexities of

transition, and supports the argument that each of these areas cannot be analysed effectively in isolation from each other.

### *Transsexualism within a medical perspective*

Schacht and Ewing (2004) suggest that transsexual people “have perhaps always existed, but during this past century, through technology and surgery, we have witnessed the creation of the transsexual individual who can biologically and often legally become a member of the opposite sex” (Schacht and Ewing, 2004: 13). Prosser (1998); Whittle (2002) and Sullivan (2003) point out that it was through the activities of sexologists in the 19<sup>th</sup> and 20<sup>th</sup> Centuries, that the categorisation and diagnosis of cross-dressing or cross living were developed. From this division came the development of the categories of first transvestism, and then transsexualism in the 1930s and 1940s. The construction of a mental disorder by sexologists enabled the treatment of transsexuals to become the professional domain of psychiatrists, surgeons and endocrinologists (Whittle, 2002). Therefore, transsexualism was seen as something that needed treating and the gender clinics became gate keepers to those who needed access to hormone therapy and sex reassignment surgery (Mallon, 2009). Billings and Urban (1996) highlight the role the medical profession has had on constructing the term ‘transsexualism’. The creation of gender reassignment surgery has “produced an identity category- transsexual- for a diverse group of sexual deviants and victims of severe gender-role distress” (Billings and Urban, 1996: 100). The obvious weakness of this argument is that some transsexual people today do not go through with sex reassignment surgery, and some do not regard themselves as a man or a woman. From this perspective the medical profession can be seen as helping to label a group of people who do not fit the norms of what is regarded as appropriate behaviour. Thus, in the transsexual’s case someone who acts and dresses like the opposite sex, but doesn’t have the genitalia of that sex is placed in this category to define what the medical profession regards as an illness. Halberstam (1998) suggests that the

medical description of transsexualism has focused on individuals in ‘the wrong body’ whereby a person’s gender identity and biological sex are at odds with one another (Halberstam, 1998). The advances in surgery to reassign a person’s gender have “made the option of gender transition available to those who understand themselves to be tragically and severely at odds with their bodies” (Halberstam, 1998: 143).

Transsexualism within a medical perspective could be seen as helping transsexuals to relieve their distress and live the lives they want to in their chosen gender and sex. Many transsexuals do go on to lead successful and happy lives after transition (Stryker and Whittle et al., 2006). If the only way a person feels they can reach their potential is through belonging to one of the two sexes, then medical intervention could be seen as successful. However prior to Trans activism, Shapiro (1991), Stone (1991) and More and Whittle et al., (1999) suggest that transsexualism within a medical perspective was also a mode of control. Transsexualism within a medical context emphasised passing as male or female and disappearing into society (More and Whittle et al., 1999). Shapiro (1991) suggests that although it is still not known what causes transsexualism, seeing transsexualism within a medical context helps to keep the two-category system of gender intact by re-categorising the transsexual into their new gender (Shapiro, 1991). I would agree that in the past transsexuals have been under enormous pressure from medical professionals to have sex reassignment surgery. This is because genitalia was and still is the most important signifier of sex. Without their genitalia matching their gender the transsexual was likely to never be truly accepted as the sex they wanted to be. The transsexual’s behaviour and body did not fit naturally into the two categories of gender.

Within a medical perspective issues of rights and citizenship in its wider context can be seen to be avoided, since the main aim within a medical perspective is to help alleviate the distress a person has about their gender and corporeality, and thus helps to make the person a more

functional member of society. Whilst medical intervention can go some way to alleviate physical and psychological distress, it cannot alleviate the psychological distress faced by some transsexual people in relation to housing, cultural background, employment, religious beliefs, discrimination by wider society and physical abuse or the threat of physical abuse (Mallon, 2009). This is precisely why this thesis is important as it will look at the transition process in a more holistic way, rather than focusing on one element such as medical interventions. Even when one focuses on just medical interventions for transsexual people, I would argue that it is important not to ignore the impact corporeality, social discourses and institutions within their wider context have on the experience that a transsexual person will have accessing a particular medical intervention, be it in a positive or negative way.

### *Feminist theory*

From a medical perspective, transsexualism is defined in terms of a biological cause and anatomical parts, which can be cured through medical intervention. Whereas, feminist theory is concerned with the social construction of gender categories, and the limitations and boundaries the categories themselves produce (Alsop, Fitzsimons and Lennon, 2002). A feminist perspective suggests looking at gender as a continuum rather than two distinct ends, and that people can vary in femininity and masculinity (Halberstam, 1998). It is interesting to add that Halberstam (1998) makes the point that a transsexual person can spend a long period of transition living between genders. This long period of transition living between genders is rarely discussed in any great detail in the literature reviewed in the next chapter. However, the issue of living between genders is explored in more detail in chapters 4, 5 and 6 of this thesis.

Looking at the three different aspects of gender that Alsop et al., (2002) suggest which are, firstly seeing gender as a part of subjectivity. “Secondly, gender refers to the cultural

understandings and representations of what it is to be a man or a woman. Thirdly, gender operates as a social variable, structuring the pathways of those so classified within society.” (Alsop et al., 2002: 3). Within this research study this may help to assess the ways in which gendered inequalities are constructed within society, and how they impact on a transsexual person’s sense of self. It is also useful to explore how social norms and shared experiences contribute to that sense of identity, and how social and economic status contributes to the successfulness of the transition process and a transsexual person’s overall health and well-being.

However, some writers from a feminist perspective have been less than understanding about transsexual people and the issues they may face on a daily basis. Radical feminist writers such as Janice Raymond have shown their hatred and fear of transsexuals, and more specifically, male to female transsexuals who call themselves lesbian feminists in their writings (Nicholson, 1998). For example the work of Raymond (1979) suggested that transsexual women were medical constructs created “to invade women’s spaces and appropriate women’s power” (Stone, 1991: 283). Considering the fact that only a small minority of transsexuals were involved in the women’s movement did not stop Raymond (1979) saying that the transsexual lesbian feminist, “is able to gain entrance and a dominant position in women’s spaces because the women involved did not know he was a transsexual” (Raymond, 2006: 134). Although Raymond acknowledges in her (1979) work that there are only a small number of transsexual lesbian feminists, she suggests that they are able to be very visible and thus are able to take centre stage (Raymond, 2006). What is interesting to add is that Raymond refuses to use ‘she’ when referring to a male to female transsexual and refers to her as ‘he’ (Raymond, 2006). Clearly Raymond feels strongly about her position as a radical feminist. As Butler (1994: 75) suggests Raymond (1979) over generalises beyond what would usually “be acceptable practice in any academic work; that’s a mark of her

fanaticism.” However, being fanatical about something is no excuse for the hatred Raymond expresses in her work for transsexuals, and her misguided views could no doubt today be interpreted as inciting transphobic hatred. As Stryker and Whittle (2006: 131) argue, Raymond’s book “did not invent anti-transsexual prejudice, but it did more to justify and perpetuate it than perhaps any other book ever written.”

I would suggest that Raymond’s hatred of transsexuals goes beyond what is acceptable in an academic writing, and thus she loses a lot of credibility in her argument. Although, when Raymond’s (1979) work was published, one could take the view that perhaps her transphobic views were due to the increasing public awareness of transsexual medical practices in the media and published autobiographies by transsexual women at that time, which she saw as a threat to the feminist cause, nor had transsexual activism gained momentum. However, as Stryker and Whittle et al., (2006) suggest even with the republication of her (1979) work ‘Transsexual Empire’ in (1994) with a new introduction, Raymond’s views had not changed even in light of many years of critique (Stryker and Whittle et al., 2006).

Whittle (2002); Sullivan (2003) and Whittle and Stryker et al., (2006) all suggest that Raymond’s position as a radical feminist, is one that is not shared by all feminists, although her work and views still continue to give rise to misunderstandings and prejudices, as well as informing the debates about whether or not male to female transsexuals should be allowed access to women only groups and communities (Whittle, 2002; Sullivan, 2003 and Stryker and Whittle et al., 2006). The views which radical feminists, such as Janice Raymond have regarding transsexuals are far from representative of feminism as a whole. In contrast to Raymond’s (1979) work, Kessler and McKenna (1978) were not interested in transsexualism in itself, but rather in what it might highlight about the social construction of gender in

everyday life. For Kessler and McKenna (1978), transsexualism can shed light on the behaviours and rules by which non transsexuals socially construct gender in a Western context. Kessler and McKenna (2000) state that transsexualism was considered radical back in 1978 when their work was first published, though they did envisage a time when transsexualism would become more widely accepted in society.

Hausman (2006) takes a similar view to that of Raymond in her work, but rather than seeing transsexuals themselves as dangerous to women, she sees them as helping to reproduce gender stereotypes that could damage personal freedom and feminist progress (Hausman, 2006). Hausman (1995) provides a feminist analysis of transsexualism within her theoretical framework which sees the subjective position of transsexuals as reliant on medical intervention, such as hormone therapy and gender reassignment surgery. Hausman (1995) sees transsexual patients and doctors working together to concoct an account of transsexuality that serves to justify access to those medical services in the gender clinics.

Stone (1991) was opposed to the medical model and the position offered by Raymond. For Stone (1991: 295) transsexual people are an oppressed minority who “currently occupy a position which is nowhere, which is outside the binary oppositions of gendered discourses.” Stone criticised transsexual people for taking a position within a medical context that didn’t give a true account of their subjective experiences as transsexual people. Stone (1991) suggested that transsexual people were using a well rehearsed account of what to say to medical staff, and how to act coerced by others within the transsexual community, in order to gain hormone therapy and GRS.

Marshall (2000) suggests that the inclusion of transsexual people within anti-discrimination laws created debate within the feminist movement and women’s organisations on the

implication of it on women only spaces (Marshall, 2000). Some feminists saw the inclusion of transsexuals into women only spaces as “a backlash against the women’s movement and feminism” (Woo et al., 1998 cited in Marshall, 2000: 61). Koyama (2006) argues that objections by some radical feminists, such as Raymond (1979) and Jefferys (2003) to transsexual women within women only spaces have been based on the notion that transsexual women are different from all other women, because they were raised with male privilege (Koyama, 2006). This is problematic on two counts. Firstly to suggest that transsexual women’s experiences are different from other women you would need to assume that all other women’s experiences are the same, which is clearly not the case as women come from different classes and cultures (Koyama, 2006). Secondly, to argue that transsexual women have experienced “some degree of male privilege should not bar them from women’s communities, because not all women are equally privileged or oppressed” (Koyama, 2006: 702). I would suggest that even if born male and having a degree of male privilege, many transsexual women would have not enjoyed that, as they would have been uncomfortable with their gender anyway. The introduction of legislation that provides legal rights for transsexual people in the UK should mean that women only, and men only groups and services, are now open to transsexual women and men to access. It is certainly an issue that this thesis has examined with research participants to see if they had been refused access to male only or female only groups and services. This is because transsexual people have now been given the right for legal recognition in their acquired gender, but, is this enforced within services, or even legally challenged by those services, that refuse transsexual women and men access?

Fighting for representation within the category ‘woman’ has become as much a part of transsexualism as has fighting for social equality and asserting the value of womanhood (Stryker, 2006). “The fight over transsexual inclusion within feminism is not significantly



different, in many respects from other fights involving working class women, women of colour, lesbian women and disabled women” (Stryker, 2006: 7). As Haraway (2006) suggests the “painful fragmentation among feminists along every possible fault line has made the concept of woman elusive, an excuse for the matrix of women’s dominations of each other” (Haraway, 2006: 108). In contrast to radical feminists, such as Raymond (1979) and Jefferys (2003), the works of Scheman (1997) and Heyes (2003) contribute to an effort at promoting trans and non-trans feminist coalition.

It is from a personal position as a woman with a transsexual background, and that of a researcher, that I wish to briefly make a comment about the importance of the autobiographies, theoretical writings and empirical studies that have been produced by transgendered and transsexual people within the wider society, and in academic institutions. As the theoretical perspectives on transsexualism from a medical model and feminist perspective discussed in this section show, until relatively recently, transsexual and transgender people had no vehicle for responding to the comments and discussions about transsexualism that were published within a medical context or radical feminist context. It is only after the publication of autobiographies such as Jorgensen (1967) Morris (1974) that the personal accounts of transsexual people were heard. Incidentally this only fuelled the flames for such radical feminists as Raymond to lead an attack on transsexual people especially MtF. This led to academic writings from transsexual women, such as Stone (1991), being able to discuss their own theoretical perspectives on transsexualism, and have a right to reply to those within the medical profession and the feminist movement. I would suggest that these writers and academics gave up their privacy in their new gender to raise trans consciousness and activism within the community, and to give trans voices a public platform.

### *Trans theory*

Trans theory as a perspective like feminist theory also challenges the rigid categories of sex and gender (Whittle, 2002). For example, some transgender people don't wish to be a woman or a man and want to live in between, as they are without medication and surgery (Halberstam, 1998). From this perspective transsexualism is defined by what's in the mind, not just determined by biological factors and gender categorisation. Trans theory has also helped to raise activism within the transgender community as a whole (Stryker and Whittle et al., 2006). From this perspective, genitals and other bodily characteristics do not have to be an important signifier of a person's gender for some transsexual people to regard themselves as male or female.

In contrast to seeing transsexualism and transgender identities within a medical context, trans theory moves away from an individual focus on transsexualism, and particularly medical intervention, and focuses more on society and the oppressive ways it affects transgender people. Trans theory is concerned with collective action to gain legal rights for transgender people, and raise awareness of the issues facing transgender people; it aims to reduce discrimination and the negative attitudes that are found in the wider society. For trans activists, the oppression transgender people face is a matter of civil rights and social issues, rather than simply a medical issue for individuals.

Prosser (1998) and Lewins (1995) suggest that rather than seeing the transition process as moving from one sex and gender to the other and wanting to become completely the opposite sex, which prior to 1980s was usually the case, now some transgender people want to make the transition into the identity. Instead of becoming one sex and gender and passing, some transgender people want to be publicly known as trans, queer, gender queer, bi-gender or intersex or by some other term and be somewhere in between the two sexes as an identity

(Alleyn and Jones, 2010). This perspective sees transgender people not wanting to conform to the transsexual identity imposed by the medical services. This can be seen as a form of activism, in which transgender people live their lives how they want, as any sex or gender, or any identity in between, with or without the help of the medical services (MacKenzie, 1994). One criticism of this perspective is that the medical services, rather than imposing an identity of transsexualism, are more likely to be working in partnership with transsexual people and transgender people (Stryker and Whittle et al., 2006). After all, in most cases, it is the transsexual person and/or transgender person who seeks out medical help and support. However, in order to gain medical help and support, the transsexual person will still need to meet certain criteria defined by the medical profession for transsexualism. Therefore, whilst meeting the criteria imposed by the medical profession may be in part related to ensuring the transsexual person is appropriate for certain treatments, and is making an informed choice, I would suggest that this criteria may also serve the purpose of putting constraints on gender identity services, and constraints on transsexual people gaining approval for funding from local primary care trusts.

There has also been a significant development in the use of the internet by trans people. Hence, Whittle (2002) and Mallon (2009) examined the development of online communities for transsexuals and transgender people, and appropriate websites that have been used as important resources of information about transsexual and transgender people. Whittle (2002) suggests that whereas gender had been previously “theoretically tied to the body through social construction, performativity or biologic essentialism it has now been successfully re-codified within cyberspace to successfully detach gender from such limiting paradigms” (Whittle, 2002: 84). The internet has allowed individuals to form communities that would have not been possible in real life. People are being able to express and be the self they want to be, without their body or gender constructs totally determining who they are (Whittle,

2002). Mallon (2009) suggests that the internet has “permitted those persons at early stages of disclosure of a trans identity to explore their gender identity in a private and anonymous manner within the confines of their own homes” (Mallon, 2009: 26). Whittle (1998) suggests that the experience of a virtual self in cyberspace has helped people to acknowledge an experimental or an actual self, and become more aware of the inadequacies of the self they experience in the real world, through the rigid dichotomies of sex and gender (Whittle, 1998). Mallon (2009) suggests that, although it still requires access to a computer, the internet has enabled those in rural areas to now have the same access to transsexual and transgender information and resources as those in more urban areas, which previously would not have been the case (Mallon, 2009).

In keeping with this, Nataf (2006) suggests that transgender politics is raising the consciousness of transsexuals and other transgendered people, and is helping them to find solidarity. She suggests that this is helping this community to support one another with the trauma of growing up and living as a transgendered person in “a culture that stigmatises that experience” (Nataf, 2006: 444). This is helping to challenge the stereotypes and notion of two genders, because some people do not want to pass as one gender and create lies about one’s past. However, Nataf (2006) also makes the point that in order to achieve these goals of not passing, and not lying about one’s past, then this requires transsexual people to educate and challenge the non-transgendered people around themselves (Nataf, 2006). I agree to some extent with Nataf (2006) about the need for transsexuals who don’t want to pass or hide their past having to educate and challenge those around them. However, I would argue that those transsexuals who do want to pass as the opposite gender, and may need to lie about their past in order to become invisible within society, should have their wishes respected as well.

Although medical and psychiatric services do not have such a strong hold on defining transsexual and transgender identities, they still have an important role to play in the

transition process for many transsexual people, and for that matter transgender people who do not identify as clearly with the gender binary identities. Certainly within the UK at present, the medical and psychiatric services have an important role to play in a transsexual male or female being able to obtain legal recognition in their acquired gender.

Connell (2010) suggests that some within the transsexual community may want to blend in to society and may not have the energy left over for activism or may see their transition from an individualistic perspective (Connell, 2010). However, I would argue that any transsexual person who wants to be legally and socially recognised as male or female is actively challenging notions of identity in their everyday experiences of interactions with others on personal and social levels. Due to the legal rights that transsexual people have acquired within the UK recently, these people, it seems to me, are frontline activists for the transgender community as a whole. This is because their interactions within society have to include an element of legal recognition, so this may impact on the assumptions and practices of those they interact with. This also means that male and female categories within the UK can no longer be based solely upon supposed genitalia. The assumptions of staff and the thinking of a health service as a whole, on what it means to be a man or a woman, may be reflected in its practices and policies on corporeal, social and institutional levels. Therefore to some extent these assumptions are challenged when a transsexual person accesses health and social care services.

Trans theory has brought about trans activism, which in turn has helped to gain more legal and civil rights for transsexual people in the UK, and raised more awareness of collective experiences of oppression. It can be suggested that individual identities, issues and experiences can be lost, as the focus remains on collective experiences, rather than looking at the issues facing a particular group. The term transgender for some transsexual people is therefore regarded as an inclusive umbrella term which is disempowering, and therefore

rejected (Davidson, 2007). Davidson (2007) suggests that another reason for “rejecting inclusion in the category ‘transgender’ includes the critiques of binary sex and gender offered by trans theorists, and the belief that these critiques deny transsexual experiences of transformation and movement from one side of the sex and gender binary to the other” (Davidson, 2007: 65). For example the works of Bornstein (1994) and Feinberg (1998) have been rejecting the sex and gender binary, and challenging the apparent coherence of sex, gender and genitals. This has been seen “by some within the transsexual community as disabling access to medical treatment and legal status” (Davidson, 2007: 64). This is because the works of Bornstein (1994) and Feinberg (1998) contradicted the previous structuring of the transsexual identity within medical institutions that insisted on gender reassignment surgery as a requirement, rather than one option amongst others, as it is today. This was seen by some within the transsexual community as threatening their access to gender reassignment surgery, in that it may lead to the conclusion by medical services that sex reassignment surgery was no longer required (Davidson, 2007). It has therefore been important that this thesis has asked questions in relation to whether research participants considered themselves to be legally and socially recognised and respected within their acquired gender or whether they feel that they are regarded as ‘other’?

Discussions within feminist theory and trans theory help to raise awareness of the variations in normative and non normative identities, categories, and groups of people. What appears to be missing from these perspectives, and the literature discussed in this chapter is a discussion of the fact that a person can now be legally recognised as male or female in the UK, without having any hormone therapy or sex reassignment surgery. Therefore this may challenge previous assumptions within society of the importance of genitalia as the main signifier of being male or female, and have important implications for the provision of services. Thus, in order to gain a better understanding of how assumptions within wider society on sex and

gender can be challenged by those transsexual people who do not have sex reassignment surgery, I propose to use and adapt Frank's (1991) 'theory of the body'. This theory can help to analyse the complex relationship between corporeality, social discourses and institutions that contribute to the assumptions wider society has of what it is to be male and female.

### **Frank's (1991) theory of the body**

Frank's (1991) theory of the body suggests that the body is formed in the intersection of an equilateral triangle of institutions, discourses and physical matter (Frank, 1991). Bodies are the foundation of both institutions and discourses, as well as the product of them. Discourses are reproduced only through bodies and their techniques (Frank, 1991). Institutions are formed through the labour of bodies, and are reproduced through this labour. However, it also needs to be recognised that institutions are constituted in and through discourses, and discourses are instantiated and modified within institutions (Frank, 1991). These discourses are the social interactions people have with each other. Frank (1991) suggests that "bodies are real, lived experiences, and institutions cannot be understood apart from those experiences" (Frank, 1991: 91). This is precisely why I have wanted to research the personal experiences of transsexual people accessing health and social care services, because it is only by gaining knowledge of these experiences that the extent to which legislation is being implemented into policy and practice within services can be determined, and how this contributes to the health and wellbeing of research participants during the transition process, and their sense of identity, can be understood.

Frank (1991) suggests that the object of his theory of the body is to insist upon the body's consciousness of itself being the starting point of theory. "Only on this grounding can theory put selves into bodies and bodies into society." (Frank, 1991: 91).

Frank's (1991) theory of the body focuses on the ways in which embodied consciousness of the self is created and expressed through the body. Frank (1991) suggests that the body becomes most conscious of itself when it experiences resistance when it is in use and acting. This creates four dimensions which are desire, control, self-relatedness and other-relatedness. These four dimensions then generate four types which represent styles of body usage, which are the disciplined body, dominating body, mirroring body and communicative body (Frank, 1991). Whilst the disciplined body, mirroring body and dominating body can be seen as controlled by discourses and institutions, the communicative body can be seen as the site of expression. This is not to say that the communicative body is not formed amongst discourses and institutions, but instead of being constrained by them, the communicative body uses them as a media for its expression, and therefore they enable more than they constrain (Frank, 1991). Although Frank's notion of the communicative body is developed in relation to the ill body and losing one level of expression and creating a new one, I would argue that transsexual embodiment can also be seen in a similar way. This is because, whether or not a transsexual person has hormone therapy and/or sex reassignment surgery (which is one form of embodied expression), they will be losing one form of expression which has been their previous gender, and in a process of creating a new form of expression in their new gender. It is by using discourses and institutions that social recognition for the new self can be created. Zola (1982), Murphy (1987) and Frank (1991) suggest that it is about achieving interpersonal recognition, through a combination of one's own efforts and the narratives we share with others, which are essential for forming relations with others. For Frank (1991) social recognition is the medium of the communicative body. Therefore I would suggest that the introduction of the Gender Recognition Act 2004 can be seen as a crucial element at the disposal of a transsexual person that can help them to express their newly acquired gender identity. This is because with the introduction of this legislation, a transsexual person can



now have legal recognition and change public documents to express their newly acquired gender in the UK. For example when a transsexual person changes their bank details and has a new credit card and cheque book, these are important items that signify the person's name change and gender, which are used in many different interactions for purposes of proving identification. Therefore this is a powerful tool for the transsexual person for expressing their self and in obtaining legal recognition, and to some extent social recognition. This form of empowerment, I would suggest, would help a transsexual person's health and wellbeing to some extent. However, it should be remembered that gaining legal recognition can be achieved after only two years of living full time in role, whereas the transition process can be considerably longer than this and is a journey of becoming the opposite gender and gaining social recognition for some transsexual people, which is just as important as legal recognition (Connell, 2010).

Frank's (1991) notion of the communicative body is in relation to the ill body and losing one level of expression and creating a new one. However, I would argue that transsexual corporeality can also be seen in a similar way. This is because the transsexual body can be seen in a similar way to the communicative body in Frank's (1991) theory, as when a transsexual person starts the transition process, they are starting to lose one level of expression, their previous gender identity, and accommodating and experiencing a new level of expression in their new gender identity. This adaptation of Frank's (1991) theory of the body will also emphasise the importance and the presence of corporeality within those social discourses that transsexual people have with medical staff in institutions.

Frank's (1991) theory of the body, I would argue, is a useful tool that will be adapted and applied in the analysis of the research findings of this research. The reason for this is that corporeality, social discourses and institutions cannot be examined in isolation of each other. This is because each of these areas has an important role to play within the transition process,

and can influence in a positive or negative way each other area at the same time. For example, if legislation is implemented into policy, but not enforced within practice, then this may still lead to negative experiences for a transsexual person accessing health and social care services. Therefore using Frank's (1991) theory of the body to analyse the complex interaction that corporeality, social discourses and institutions have on each other, and on the experiences of transsexual people accessing health and social care services, may help to provide a greater understanding of the complexities of transition and emphasise that each of these areas cannot be analysed effectively in isolation of each other.

Another area in which Frank's theory of the body (1991) could be adapted and applied is in relation to the complex interaction that key determinants may have on a person's health and wellbeing. This is because research that focuses on transsexual people's health will often give primacy to gender over other key determinants, such as age, cultural background, religion, sexuality, and socio-economic status (Hines, 2007; Schorfield, 2008 and Weyers et al., 2009). There is also a tendency, even when other key determinants are mentioned, to fail to adequately address the interaction among these determinants on a person's health and wellbeing. For example, even though this research study may highlight differences to a person's health and wellbeing when comparing participants from urban areas to those from rural areas during the transition process, this is too simplistic an analysis, as other key determinant need to be considered such as economic background. Thus, I would suggest that Frank's (1991) 'theory of the body' is important for the analysis of my research findings in relation to transsexual people's experiences of accessing health and social care services, as it provides a framework for looking at the complex interaction that corporeality, social discourses and institutions have on a person's health and wellbeing.

A recent study by Davy (2011) explores embodiment and bodily aesthetics of trans people at different stages during the transition process. Davy (2011) states that "bodily aesthetics

inform social relations and how judgements made about trans bodies, in sum, how trans bodies are recognised personally, politically and medicolegally.” (Davy, 2011: 5). In contrast to this, my thesis devotes much of the discussion to exploring the experiences of transsexual people in terms of accessing health and social care services, offering specific examples of good practice from health and social care professionals. Davy’s work also fails to investigate the relationship between geographical area and the transition process, whereas this thesis examines the impact that geographical location can have on the transition process. This thesis also focuses on people’s perceptions of the GRA 2004 and the practicalities of the process for gaining legal recognition.

Whittle (2006: XIV) suggests the “labels “man” and “woman” are inadequate to describe the trans experience, as the trans person’s history and knowledge of the world is so different from that of “men born men” or “women born women”.” It is the experiences of self those transsexual participants had, and I, as a researcher, want to recognise and articulate that position in this thesis. Therefore, this thesis aims to authenticate the experiences of self in transsexual participants’ lives within the spheres of corporeality, social discourses and institutions, whilst at the same time critiquing previous literature, to enable the voices of participants to be heard throughout the empirical chapters of this thesis.

## **Chapter Two: A review of the literature on transsexualism within social discourse, medical and political and economic contexts**

Exploring the literature on transsexualism I have identified that there are three primary areas, these are social discourses, medical intervention and political and economic constraints. To set the context for this thesis, in this chapter I will review the key debates of each body of literature, considering their impact in the way health and social care practitioners have approached trans issues to date. Looking at the literature, the review starts by examining a number of themes that dominate in the social discourses. These are transphobia, family, sexual orientation and employment. This will be followed by a discussion of the way that some general practitioners may still confuse transsexualism with a form of disguised homosexuality (Shapiro, 1991; Ross, 1994 and More and Whittle, 1999). This illustrates how there is a lack of awareness generally amongst health care staff about transsexualism; the issues transsexual people may face accessing health care services and a lack of knowledge about where to refer a patient who has issues about their gender identity.

The second section examines the literature within a medical context. Literature on transsexualism within a medical context focuses on two main areas, doctors assisting in changing the corporeal body, and the role of medical and social care institutions within the transition process. Significant themes identified in this context include the discrepancies in the provision of specialist transsexual services, and a lack of awareness of the needs of those transitioning when accessing sheltered accommodation, and health promotion campaigns rarely targeting the transsexual population. The different stages of the transition process are then examined within this literature review, as they help to show the systems and medical assessments a person has to go through in order to gain a Gender Recognition Certificate.

This also shows the power that medical institutions have in the process for obtaining legal recognition, even if a transsexual person does not wish to have hormone therapy or gender reassignment surgery. This will help to show the complexities of the transition process and the time line for achieving different stages of it, and for gaining legal recognition. The different stages of the transition process a person usually goes through start from questioning one's gender and initial contact with health services, through to choosing whether or not to have gender reassignment surgery, although it must be noted that a person may go through with some of the stages of transition, but not others.

The third and final section examines the literature within a political and economic context. The aspects examined in this section include policy makers' understandings of transsexualism, clinical governance, and health economic data. Just as with people in wider society, policy makers can have a broad range of attitudes and understandings of what transsexualism is. Their culture, values, and beliefs can all impact on how they judge others in a positive or negative way. The use of Clinical Governance to achieve consistency in the quality of healthcare provided to patients across the UK within medical institutions is then examined. Health economic data is increasingly used within health and social care services to inform allocation of resources that meet the needs of different populations. However, there is little data on the health care needs of minority groups, so general data is used to assess the needs of the local population, which may not meet their requirements.

The changes within some medical and social care institutions that have been influenced by political activism, and the implementation of legislation are then explored. Finally this section will examine the literature in relation to institutions contesting those legal rights gained by transsexual people. This is explored through the illustration of the prison service contesting the legal rights of a transsexual prisoner who had a Gender Recognition Certificate. This example illustrates the problems some institutions may face in implementing

those legal rights gained by transsexual people, and the possibility of those legal rights being contested in the future by health and social care institutions.

Before considering these three bodies of literature, it is necessary to discuss the terms transsexual and transgender. Terminology within the transgender community varies and can change over time (Centre for Transgender Equality, 2009). Many people can have considerable confusion over what is appropriate language to use when engaging with transsexual people, and can fear offending them (Equality and Human Rights Commission, 2010).

### **Definitions of transsexual and transgender**

Definitions of 'transsexual' and 'transgender' are relative rather than absolute, as these definitions vary according to their historical and geographical context (Whittle, 2002 and Bullough and Bullough, 1993). Whilst the term 'transsexual' was conceived in the 1940s, 'transgender' is a recently conceived term and identity category. A person who is a transsexual experiences great discomfort with his or her gender. They may feel "trapped in the wrong body" and desire to live full time in the role and dress of the opposite gender (Whittle, 2000; Department of Health, 2007 and Beaumont Trust, 2010). The person may or may not take hormones and may or may not decide to "have sex reassignment surgery to become as much as possible like someone of the opposite sex" (Davison and Neale, 2001: 382). In contrast, the term 'transgender' is used by some as an umbrella term to describe a wide variety of people who have a non traditional view of their gender identity. This may include transsexuals, transvestites, cross-dressers, and intersex people (Hunter 2005; Whittle, 2002 and Stryker and Whittle et al., 2006). However, the term 'transgender' may be used to describe someone who does not identify un-problematically as one or another sex or gender. They may describe themselves or be described as 'trans' or 'transgender' (Alleyn and Jones,

2010). Therefore in this sense terms such as ‘trans’ and ‘transgender’ are applied to those people who have not made a clear move from one fixed gender or sex to the other or may move between or outside traditional categories of sex and gender (Alleyn and Jones, 2010). As Whittle (2006: XI) suggests “Cultural spaces and historiographies are constantly reframing the community, the identities, the cultures, and the language.” Therefore, terminology within the transgender community, and outside it, varies and can change over time, so there is a need to be sensitive to usage within different communities, places and spaces (National Centre for Transgender Equality, 2009).

As Whittle (2006) and the National Centre for Transgender Equality (2009) suggest terminology can vary geographically within the trans community, and that how one person defines a certain term may be considerably different to the meaning another person attaches to that term. However I would question here if people within the trans community cannot agree on the usage of a term such as ‘transgender’, then how can it realistically be expected that the general public will have a clear understanding of what transsexual and transgender mean? This can add to the confusion that staff in health and social care services may have about what is appropriate language to use when addressing people from the different communities. This issue also needs to be considered from an institutional perspective to examine who has the power in contributing to how these definitions are defined and who is implementing them into policy and practice. For example many advisory groups consisting of people from the LGBT community, and other health and social care professionals, have worked in collaboration on documents that aim to improve understandings of what transsexualism and transgenderism are, and the health and wellbeing needs of transsexual and transgender people accessing health and social care services (Williams, et al., 2013; Department Of Health, 2007, 2007a, 2007b, 2007c, 2007d and 2008). However, this requires that firstly, healthcare commissioners, policy makers and professionals are aware of the

material and the fact that transsexual people may be using or may need to use their service in the future. Secondly, this relies on policy makers' to interpret the material correctly and implement it appropriately into a service's policies, and for individual staff to implement it correctly into their working practices. This highlights the complexities of trying to achieve understandings of what transsexualism and transgenderism are within, and between, different institutions.

Language is one element which affects social discourse, and in the next section, the literature is looked at with in a social discourse context.

### **Section one: The impact discourses of trans in the wider society have on transsexual people**

Some people have considerable confusion over what is appropriate language to use when engaging with trans people, and the fear of offending them (Equality and Human Rights Commission, 2010). This confusion is partly due to a lack of knowledge that they have of the identities that come under the umbrella term transgender, and the issues trans people may face in everyday life. The difficulties with appropriate terminology are also partly due to the lack of consensus about terminology definitions within and between different transgender groups, as discussed above (Equality and Human Rights Commission, 2010). This would suggest that more work needs to be done with different groups within the transgender community to gain clarity and consensus on appropriate trans terminology in order to help educate the general public, and those within health and social care services, about trans identities (Equality and Human Rights Commission, 2010). Having a more universal language in relation to trans identities would help wider society, and those within health and social care institutions, to have a more effective engagement with trans people. However, realistically, a universal language may not be totally achievable because of the factors that



have already been mentioned in this chapter, such as, historical and geographical contexts which are constantly reframing trans identities, communities and language.

The next section identifies the issues that have affected transsexual people living in the UK during the transition process. When a transsexual person starts the transition process there can be many issues they may have to face within many contexts, for example, at home, work and out in public places. The transition process may also affect a transsexual person's established relationship with a partner or impact on them forming a relationship.

### ***Transphobia within social discourse situations***

A transsexual person may also have to deal with some transphobic reactions by others due to their gender change. Transphobia is “a fear of or a dislike directed towards trans people, or a fear of or dislike directed towards their perceived lifestyle, culture or characteristics, whether or not any specific trans person has that lifestyle or characteristic” (Crown Prosecution Service, 2002). Being transphobic doesn't have to involve hatred, but includes simply doing something, or refusing to do something, because the person doesn't like trans people (Crown Prosecution Service, 2002). The term transphobia has been created to raise awareness of the ways that prejudice against trans people can differ from prejudice faced by other groups. During transition other people may question the gender identity of the transsexual person and show prejudice. A transsexual person can suffer transphobia for wanting to use a bathroom designated for the sex that person self identifies as belonging to by other users, who are biological males or females, who don't perceive the transsexual person to be that sex (Juang, 2006).

### *Family Support*

It was found that there was limited literature available that dealt with couple and family relationships during the transition process, and how this might be negotiated. Female partners of MtF transsexuals were more commonly mentioned within the literature, although Brown's (2009) study focused on female sexual minority partners of FtM transsexuals. Family support can be very important for a transsexual person during the transition process, but for some it may mean that they may split up from their partner, lose their home or job, or both, and may lose a lot of old friends (Bockting, Knudson and Goldberg, 2006; Leichtentritt and Arad, 2004). The transition process can be a very hard time for families as well as for the transsexual themselves. Some relatives may disown a loved one who starts the transition process. Some family members may have trouble coping with the transition and may suffer a wealth of emotional feelings such as confusion, shame, guilt, anger and mourning for the loss of who that person who is transitioning once was, whilst coming to terms with it all. (Bockting, Knudson and Goldberg, 2006).

Health literature in relation to family support has often focused on the negative impact the transition process can have on a transsexual person and their family. However, a few writers such as Israel (2004, 2005) and Bischof (2011), have discussed the positive outcomes of support from relatives and partners of loved ones who are transsexual and going through the transition process. Israel (2005) highlights that having at least one supportive relative can significantly improve the chances of having a successful transition process.

Israel (2004) also suggests that there is a need to highlight within transsexual and transgender literature the positive aspects of couples that stay together during and after the transition process. These include having positive experience of renegotiating the gender roles within the

relationship, being open and honest to each other about how they feel about each other, and a sense of the relationship becoming stronger than before.

(2011) suggests that health and social care staff need to gain more knowledge about this type of couple relationship. An emphasis on shared decision making should be encouraged by staff to help the partners of transsexual people to feel they have some control over the process, and to ensure their views are gained and respected. There were certainly similarities in the findings of my own study and the findings of Israel (2004) and Bischof (2011) in relation to some families becoming stronger and closer, sharing decision making and having each family member's views respected. This will be discussed in chapter five.

### ***Sexual orientation***

As well as family roles, a person's sexual orientation is also an important part of their identity (Hines, 2007; Brown, 2009 and Morgan, 2013). However, some transsexual people may have confusion about how they should define their sexual orientation after they start the transition process. Roch et al., (2010: 11) suggest that "it can be very difficult for transgender people to work out which term to use if they live in more than one gender at the present time or have remained with the same partner throughout their transition." Continuing a relationship or starting a new one during the transition process can sometimes be extremely difficult for a transsexual person and their partner (Brown, 2009). Roch et al., (2010) suggest that there are many factors that make relationships difficult for transsexual people. These may include the isolation of some transsexual people and their partners in society, the renegotiating of gender roles within existing relationships that were established prior to one partner starting the transition process, and transphobic attitudes to transsexual people in relationships from some of the general public (Roch et al., 2010). It is also important to acknowledge that the partners of transsexual people who start the transition process are also likely to have been exposed to

transphobia, may be questioning their own sexual orientation, and may face rejection from family and friends for staying with their transsexual partner (Bischof (2011) and Roch et al., (2010). Again there were certainly similarities in the findings of my own study, and the findings of Roch et al., (2010) in relation to renegotiating the gender roles in relationships and setting boundaries that will be discussed in chapter five.

### ***Employment***

Employment is an important element of the transition process, not only in terms of making a living, but it is also a requirement of the gender identity clinics that the transsexual person needs to provide proof of their occupational activity during the transition process, be that paid or voluntary work, in order to successfully pass through the care pathway and gain gender reassignment surgery if wanted (Leeds Gender Identity Service, 2010). Providing evidence of occupational activity for the first six months of transition, such as a letter from the transsexual person's employer, is common practice. This is used by occupational therapists within the clinics to help them assess how well a transsexual person is interacting with others and integrating in to social life in their new gender. Previous studies such as Whittle et al., (2007) and Dietert and Dentice (2009) have suggested that transsexual people have often had a poor experience of acceptance within the work place. This has sometimes resulted in a transsexual person having to use an inappropriate toilet, suffer verbal abuse or physical harm, and even having to change their job (Whittle et al., (2007). While studies such as Dietert and Dentice (2009) and Whittle et al., (2007) have focused on the impact social discourses have had on the transition process within the workplace, they have failed to consider and discuss the complexities that the transsexual corporeal body, an organisation's culture, and individual attitudes of staff can all contribute to the experience a transsexual person has within the workplace. This is precisely why this thesis will argue that a more holistic approach is

required when studying the experiences of transsexual people during the transition process, that enables a more thorough examination of the complexities of the situation.

The review of the literature would suggest that understandings of transsexualism and the issues transsexual people can face is poor within wider society generally. A transsexual person may have to deal with transphobic reactions from others due to their gender change. This can include members of the public, work colleagues, and even relatives. Families can have an important role to play in supporting a loved one who is transitioning, yet they may find it difficult to adjust or accept the loved one's new gender identity. An area of confusion for some transsexual people and their partners is in relation to their sexual orientation. This can be in terms of renegotiating the roles within their relationships, and the identity labels that they now use to define their sexual orientation. Finally employment is important for making a living, yet the literature would suggest that transsexual people have often had a poor experience of acceptance within the work place, which includes health and social care work spaces.

### **Confusion over what transsexualism is within health and social care institutions**

Just as within the wider society, health and social care staff can also have a broad range of attitudes and misunderstandings of transsexualism.

Beyond Barriers (2003), Drabble et al., (2003) and Whittle et al., (2007) suggest that there has been a need to educate health and social care professionals in relation to transsexualism as it has tended to be misunderstood. For example, some doctors and psychiatrists have tended to confuse transsexualism with issues of sexual orientation, including confusing it for a form of disguised homosexuality (Shapiro, 1991; Ross, 1994; More and Whittle, 1999; Drabble et al., 2003; Beyond Barriers, 2003; Fee, 2006 and Whittle et al., 2007). However, if

a health or social care professional misunderstands the distress a service user has about their gender for underlying issues of homosexuality, then this can not only add to the distress the service user has, but also the service user may interpret that their need to come and seek help from this professional has been misdirected (More and Whittle, 1999). There can also be a lack of knowledge about where to refer the person on to with regards to their gender issues, and the procedure to gain a referral to a gender clinic (Fee, 2006). It may be that some general practitioners may never come into contact with a person who is questioning their gender, yet they need to be aware of specialist services or referral procedures.

Transsexualism is about a person's sense of gender and is separate from issues a person may have about their sexual orientation. Transsexual people can be heterosexual, homosexual, bisexual or asexual or may not wish to categorise their sexuality at all (Hines, 2007). Health and social care professionals and some members in wider society have tended to have difficulty in understanding how the transsexual person defines their sexual orientation (More and Whittle, 1999; Beyond Barriers, 2003 and Hines, 2007). This is an issue that is explored in this thesis with research participants, in order to determine if health and social care professionals are still sometimes misunderstanding transsexualism and confusing it with issues of sexual orientation.

Confusing transsexuality with homosexuality has not been the only issue transsexual people have faced when accessing medical institutions, for example, healthcare professionals have held a broad range of views of transsexualism, from empathy to strong moral disapproval (Scottish Needs Assessment Programme, 2001). This has led sometimes to inappropriate attitudes and/or practices towards transsexual patients. For example, breaches of confidentiality and the practice of placing transsexual women on male hospital wards, and transsexual men on female hospital wards (Eyler and Whittle, 2001). This again suggests that there has been a lack of knowledge by medical staff on transsexualism, which has then

impacted on the levels of respect, privacy and quality of care provided to transsexual patients. Whittle et al., (2007) suggest that some transsexual people have had problems with the attitude of their GP when they have wanted to start the referral process to a gender identity service, with their GP refusing to help (Whittle et al., 2007). Some transsexual people have had to leave their GP to find either another GP, or pay for a private referral to a gender identity clinic, as their GP would not take any action to support a referral due to them not seeing it as a medical issue, or because of their moral disapproval (Scottish Needs Assessment Programme, 2001 and Department of Health, 2008a).

A lack of training within health and social care services on transsexualism may lead to insensitivity to simple issues of respect. For example some health and social care staff may struggle around pronoun usage when addressing a transsexual person (Sperber, Landers and Lawrence, 2005, Mallon, 2009 and Alleyn and Jones, 2010). Hunter (2005) suggests that it is important that health and social care professionals can communicate effectively with transsexual service users, that they value diversity, and that whatever they present about themselves is totally acceptable (Hunter, 2005). While I agree with Hunter (2005) that it is important that health and social care staff can communicate effectively with transsexual people, she fails to recognise that staff may have a wide range of attitudes to transsexualism. The levels of effective communication that staff may have with transsexual people will be influenced by their personal attitude, knowledge of transsexualism, the organisation's culture, and whether legislation in relation to transsexualism is implemented into policy and reflected in practice. Their words must be backed with genuine actions and understanding for this to be effective. Health and social care professionals need to show respect to the transsexual person they are working with by using the name and pronoun the person prefers to be addressed by, just as they would any other service user.

### ***Concluding remarks***

This section has discussed the impact social discourses have on the transition process, identity, and transsexual people's experiences of accessing health care services. Transsexual people starting the transition process will be losing one form of expression which has been their previous gender, and in a process of creating a new form of expression in their new gender. The use of social discourses can help an individual to promote their new identity and gain, to some extent, grades of social recognition. Having social recognition in one's new gender identity, family support, an understanding of what transsexualism is, and an awareness of the needs of transsexual people accessing health care institutions, may help a person to have a more positive transition process. Moreover, there is a lack of knowledge and understanding of what transsexualism is in wider society, and within health and social care institutions (Eyler and Whittle, 2001; Fee, 2006; Hines, 2007 and Mallon, 2007). There is a failing within medical institutions to recognise the positive or negative impact that the interactions transsexual people and their staff have on the experiences of that transsexual person accessing their services. The literature discussed in this section emphasises the importance put on labelling ourselves and others in everyday interactions, and how people may question those they interact with who don't match up to what they perceive to be appropriate for that person's presumed identity, or how they define themselves.

### **Section two: The medical context**

In the past health and social care services have offered few practices specifically for transsexual people, and have often lacked an understanding of transsexual people's needs when accessing their services. It was not until 1966 that the first gender identity clinic in the UK was set up at Charing Cross Hospital, London (Whittle, 2000). The first support group in the UK for transsexual people was called The Beaumont Society which was set up in 1966



(The Beaumont Society, 2010). Therefore, it is only relatively recently that some health care services, such as local mental health teams and local health authorities, have acknowledged the existence of transsexuals and have started to provide specific services for these people, although there remains much inconsistency in provision.

### ***Medical and social care institutions roles within the transition process***

Research by Murjan et al., (2002) highlighted the discrepancies in prioritisation and provision of clinical services for transsexual people amongst one hundred and twenty health authorities in Great Britain. For example, some health authorities regarded transsexualism to be a ‘low priority.’ These authorities would not normally fund NHS surgery. This could be seen as a breach of the Human Rights Act 1998 (Murjan et al., 2002). Alarming, some health authorities would fund initial assessments and hormone use, but not GRS. The implication from such a policy is that “transsexual people could receive irreversible hormonal masculinisation or feminisation without recourse to surgical reassignment, thereby creating a permanent pseudo- hermaphrodite state” (Murjan, Shepherd and Ferguson, 2002: 211). Although some transsexual people may not have wanted GRS, those who did would be likely to be left in distress due to a refusal by these institutions to fund it.

Failure by local authorities and social care services to provide appropriate sheltered accommodation has also been an issue for some homeless transsexual people. Thaler, Bermudez and Sommer (2009) and Buchan (1995 cited in Roche, 2005) suggest that some transsexual people can experience transphobic attitudes from family members as mentioned in the previous section, which can lead to verbal and physical abuse, and even homelessness. This can be especially so in the case of those young transsexual people who have been living at home with parents and may become transients, moving from house to house, or end up sofa surfing (Thaler, Bermudez and Sommer 2009). According to Namaste (2000), Mottet and

Ohle (2003) and Thaler, Bermudez and Sommer (2009) those youths and adults that identify as transsexual, can experience extreme difficulties in obtaining adequate and safe sheltered accommodation. Homeless transsexual people, and especially those who are in the process of transitioning, have often endured suffering and distress by being classified by homeless shelter staff as the gender they do not identify with. This has led, for example, to some transsexual women being required to sleep in men only dormitories, or rooms with male residents, which has increased the risk of verbal, physical and sexual harassment, and assault (Mottet and Ohle, 2003 and Thaler, Bermudez and Sommer 2009). Some shelters, that have properly classified transsexual people as the gender they identify with, have not always provided adequate privacy and safety for transsexual residents. For example transsexual men in men's facilities have often only been allowed to shower in open showers with other men, a situation that increases the likelihood that they will be harassed or attacked (Mottet and Ohle, 2003). According to Mottet and Ohle (2003) some shelters had rooms set aside for people who needed more privacy. These rooms had been given to transsexual people on occasions. This may have helped a transsexual resident to feel safer in one of these rooms. However requiring a transsexual resident to sleep separately from others can make them feel more isolated, and it could also draw more attention to them, which could make them more unsafe (Mottet and Ohle, 2003). This highlights the problems that shelters can have in accommodating the transsexual corporeal body within their shelter, policies and practices, even when some shelters have been aware of the needs of homeless transsexual people. There is a need for health and social care institutions to see the whole picture when accommodating the needs of transsexual people within corporeal, social discourse and institutional contexts together, as this thesis addresses.

There has also been an issue around transsexual women meeting the specific criteria for accessing individual sheltered accommodation services. Namaste (2000) suggests that some

women only shelters have only allowed post operative transsexual women to use their service. This position not only discriminates against non-operative and pre-operative transsexual women using their services, but also presumes that all transsexual women want gender reassignment surgery (Namaste, 2000). Those shelters that have allowed pre-operative and non-operative transsexual women to use their service have stipulated that a letter from a gender identity clinic or doctor is required to prove their commitment to gender change, and have sometimes made judgements as to how feminine looking the transsexual person is, and whether their presence will disrupt other residents (Namaste, 2000). This again highlights the power medical institutions have during the transition process and how they combine with social discourses to impact on a transsexual person accessing health and social care institutions. Not only does requiring a transsexual woman to provide documentation of her acquired gender put extra stress and burden on her at a time when she is homeless and most in need of support from social services, but this also suggests that she is subjected to judgements by others as to whether she is a 'woman', and whether her presence will be disruptive to other residents. As Namaste (2000) suggests "we might ask whether staff members judge all their clients on this basis, or just those who are known to be transsexual" (Namaste, 2000: 180). Certainly a non-transsexual woman, I would argue, is unlikely to be put in a position when accessing health and social care services whereby she has to prove that she is a woman. This can impact in a negative way on a transsexual woman's self-esteem. It may also be extensive if she has been refused entry to a women only shelter as she is likely to have low self esteem issues about her physical appearance anyway. This would suggest that homeless services have sometimes taken this position of focusing attention on the individual transsexual person to meet their criteria for accessing their service, rather than educating their staff and residents to the diversity of women's lives, and the real issue of providing services to those in need. The transsexual corporeal body within these situations is problematic as it

does not reflect for many transsexuals their felt gender identity as women. There is a contradiction within these health and social care services, demanding evidence that transsexual people are living as their desired gender successfully, but not supporting them to do it. This raises the issue of the difficulties for service provision for transsexuals in transition.

Cull, Platzer and Balloch (2006) focused on the experiences and needs of homeless lesbian, gay, bisexual and transgender youth in the Brighton area. It is interesting to add that this study also highlighted that the lesbian, gay, bisexual and transgender community was over represented in the homeless population.

According to their research, transphobic attitudes from other residents in sheltered housing had often contributed to further episodes of homelessness for young transsexual people. This study also highlighted that the young people's vulnerability and their priority for housing was not always recognised (Cull, Platzer and Balloch, 2006). Some transsexual participants in the study had suffered transphobic harassment from other residents in sheltered accommodation, and there had been a lack of appropriate intervention by staff (Cull, Platzer and Balloch, 2006).

Studies by Namaste (2000), Mottet and Ohle (2003); Cull, Platzer and Balloch (2006) and Thaler, Bermudez and Sommer (2009) have also highlighted the lack of understanding within homeless accommodation services of transsexualism, and the needs of transsexual people when accessing homeless accommodation. It is clear that homeless services have failed to meet the needs of transsexual people, and have shown them very little understanding or respect. Due to a lack of understanding of transsexualism within services, this has sometimes led transsexual people to be placed in a position where they were likely to suffer harassment, and even assault by fellow residents. Research shows that there is a strong need for homeless

accommodation services to include transsexualism within their equality and diversity training, in order that staff are more aware of the needs of transsexual people and can support them more effectively (Cull, Platzer and Balloch (2006) Namaste, 2000 and Mottet and Ohle, 2003).

While privacy can be an issue for everyone accessing women only or men only homeless services, this raises particular issues for homeless transsexual people. Their gender identity can be challenged by staff and other service users, and the practicalities of accommodating the transsexual corporeal body, within such areas as shower areas and dormitories, may put a homeless transsexual person at further risk of verbal abuse or violence. There is clearly a need for more interagency communication between housing associations, social services, and homeless shelters to find ways to accommodate homeless transsexual people, and ensure more privacy and safety for all service users. For example, homeless shelters could avoid providing only communal showers.

### ***Health Promotion Campaigns***

Another area that has been slow to accommodate the needs of transsexuals is health promotion campaigns. Research by Drabble, Keatley and Marcell (2003) suggests that health promotion campaigns have rarely targeted the transsexual population. This is surprising considering the transsexual and transgender population as a whole appears to have disproportionately high rates of depression, self harm and suicide (Whittle, Turner and Al-Alami, 2007; Nemoto et al., 2005; Bockting et al., 2005 and Mathy, 2002). However, I would argue that this is further evidence that the transsexual identity, body and health care needs are often invisible within health care services and practices. In a study by Bockting et al., (2005) among 181 transsexual participants 52% reported depression and 47% reported that they had

considered, or had attempted, suicide. A comparison study by Mathy (2002) of psychosocially matched transsexual and non-transsexual people, found that transsexual participants reported significantly higher levels of suicidal thoughts and suicide attempts than their fellow non-transsexual participants. Drabble, Keatley and Marcell (2003) recommended that the transgendered community should be involved in the development of appropriate health communication campaigns. I would agree with the points Drabble, Keatley and Marcell (2003) make that health and social care services should involve transsexual service users more. By working in partnership with transsexual service users, services are not only ensuring that policies, practices and services are more appropriate to meet the needs of transsexual service users, but are also showing transsexual people respect by involving them in the development of campaigns, policies and new services. This should be in relation to health campaigns in general such issues as screening services. Certainly within my own research study this was an issue that the study wanted to address to assess the extent to which research participants had themselves been involved in participating in health communication campaigns, and/or involved in local health and social care services patient and service user advisory panels. It was also important to assess whether research participants felt the transgender community was acknowledged in health and social care information leaflets and posters in services' waiting areas, as this was likely to be the first impression of a service a service user had. As Mallon (2009) suggests the creation of a physical environment that welcomes transsexual people, be that as service users, or as prospective employees, can help to reassure some transsexual people that this may be a more safe and accepting place to access (Mallon, 2009). Whilst I would agree with Mallon (2009) that a few posters and leaflets signifying acceptance of transsexual people in services' waiting rooms may create a more welcoming environment for some transsexual people and reassure them, it may still be the case that practice does not reflect policy in all cases. After all, the attitudes professionals

have with regards to transsexualism are likely to be influenced by their culture, personal beliefs and past experiences in general like anyone else. Therefore, as will be discussed in the methodology chapter of this thesis, the research study asked questions in relation to whether participants felt they were being respected by services that had a more welcoming waiting area compared to those that didn't, or did they feel it was the same. Secondly, whether research participants had accessed a service that had transgender material on display in their waiting room had still felt disrespected by staff members of that service. This type of questioning helped to establish if there was still a difference between policy and practice in relation to transsexual people's experiences of accessing those services. Finally this section of the literature review discusses the different stages of the transition process.

### **The different stages of the transition process**

This final part of section two will discuss the different stages of the transition process a person usually goes through. Although as previously stated, it should be noted that a person may decide to stop at any stage of transition process, and therefore may decide to not have hormone therapy or gender reassignment surgery, yet may still want to have legal recognition and apply for a Gender Recognition Certificate. Discussing the different stages of the transition process a transsexual person may choose to go through will help to show the complexities of the transition process and the time line for achieving different stages of it, and for gaining legal recognition. While the different stages of the transition process are set within an institutional framework, it is important to include them in this section, as medical assessment and medical intervention are central to a transsexual person gaining legal recognition in the UK in their new gender.

### *Early stage of initiating the transition process*

As stated the current procedure for initiating the transition process requires a person having a supporting letter from their general practitioner sent to the gender identity clinic, and a supporting letter and report from the person's local psychiatry team, stating that an initial diagnosis of Gender Dysphoria has been made (Leeds Gender Identity Service, 2010). This highlights the importance of health care professionals as gate keepers to specialist medical institutions, and the systems transsexual people have to go through in order to gain that medical treatment. The term 'Gender Dysphoria' refers to the distress caused "by discrepancy between sense of self (gender identity) and the aspects of the body associated with sex/gender, other people's misidentification of one's gender, and the social roles associated with gender" (Fisk, 1973 cited in Bockting and Goldberg, 2006: 83). Whilst a person is waiting for their initial appointment at the gender clinic, they will still be required to have follow-up appointments with the local psychiatry team with regards to their gender issues.

The internet can be a useful tool for transsexual people during the early stages of the transition process to find out about transsexual support groups that they may be able to attend in their local area. Connell (2010) suggests that during the early stages of the transition process the transsexual person may have support from other transsexual people, or a support group. This can be beneficial for the transsexual person to have an outlet for their frustration, to ask questions, and to provide reassurance from those people who may have, or are going through, a similar experience with the transition process. People may also find out about these groups through the internet. Knowing that someone else has gone through a similar traumatic change and made a success of their life can be enough reassurance that the individual can make it (Connell, 2010). I would agree with Connell (2010) to some extent that support groups can play an important role with providing information and support to someone who is going through the transition process. However, I would argue that within the



UK, transsexual support groups are either providing services due to a shortfall in health or social care services within their local area, or they are struggling to survive due to a lack of support from local authorities to help them find suitable venues. Whittle (1998) suggests that the internet has been crucial in the development of new geographically spread, but no longer isolated, trans communities (Whittle, 1998). The internet has helped to create a community with an understanding and awareness of common experiences (Whittle, 1998). Many members of the trans community now participate in policy development at local council level and/or government level (Whittle, Turner and Al-Alami, 2007). Therefore this may suggest that accessing support groups is an important part in the early stages of transition, as this can be a time when a person may be at their most vulnerable during the transition process and lacking confidence in their new gender identity. Thus I wanted to ask research participants if they had accessed transsexual support groups in the early stages of transition or at any time in transition as this may be regarded as an important part of support and care for transsexual people throughout the transition process or at certain stages of the transition process. It was also interesting to find out the extent to which research participants felt they needed to retain links, or cut links, with support groups and other transsexual people in the later stages of the transition process in order to move on with their lives, and whether this contributed to their health and wellbeing in a positive way. I asked participants these questions and found similarities with previous research studies such as, (Connell, 2010). These findings will be discussed in chapter six of this thesis.

During the early stages of the transition process it is a requirement that a transsexual person can provide evidence to show that they have changed their name by deed poll so that they can now be regarded as the opposite sex (Leeds Gender Identity Service, 2010). Under section 22 of the Gender Recognition Act 2004, transsexual people have new privacy rights. This means that anyone who acquires knowledge, in their professional capacity, of a transsexual person's

history and knows that the person has a Gender Recognition Certificate and/or new birth certificate, “may be prosecuted and fined up to £5,000 pounds and/or be jailed for up to 6 months if they pass that information onto a third party without the transsexual person’s consent” (Department of Health, 2007d: 12). How implementable these privacy rights are into practice within health and social care services, I would suggest, is questionable, as it may be difficult to prove where and by whom information was leaked to a third party. I would also argue that, in a fluid, highly staffed medical centre, it is impractical to get permission from a transsexual patient for each nurse/agency nurse at short notice that works with them, who needs to share information about them with a third party. It is now considered to be good practice, when a transsexual person changes their name by deed poll, to regard them as a member of their new sex for all purposes (Department of Health, 2007d). This study asked research participants questions about how their change of name and gender has been dealt with within health and social care services when changing patient records, and in relation to correspondence. Analysis of these findings is examined in chapters four, five and six of this thesis.

### ***The Real Life Experience***

The transition process includes the ‘The Real Life Experience’, which means the transsexual person has to live full time in role for at least one year before they can start the process for applying to have GRS, if they want to have it (Health Commission Wales, 2009). The transsexual person has to be in role for at least two years before they can apply for a Gender Recognition Certificate if they wish, which means they have the same legal rights as anybody else in their new gender, including a new birth certificate to match their new sex (Equality and Human Rights Commission, 2010). This could be seen as institutional control of the transsexual corporeal body, as the transsexual person has to successfully pass through

different stages of the transition process by medical and institutional assessment. Living in role for at least two years can help the transsexual person to achieve an understanding of the socioeconomic, interpersonal and legal consequences of gender transition (Bockting and Goldberg, 2006). It is also a time of adjustment, experimentation and learning how to relate to oneself and to others in their new gender identity (Bockting and Goldberg, 2006). It is interesting to add that Bockting and Goldberg (2006) is one of the few studies that stress the importance of a two year period of adjustment for a person to negotiate one's new gender identity during the transition process.

### ***Doctors assisting in changing the corporeal body***

The stages of hormone therapy and GRS during the transition process can be seen as a period when doctors are assisting in changing the corporeal bodies of those transsexual people who wish to have hormone therapy and/or GRS. The process for alleviating the distress of severe Gender Dysphoria may lie in altering both the body and the social role, which are intertwined to fit the inner gender identity. However body modification is not compulsory in order to successfully progress through the transition process and obtain a Gender Recognition Certificate. When the inner sense of identity and the body and social role are in harmony, the distress caused by Gender Dysphoria may be no longer present or considerably reduced (West, 2004). Hormone therapy can be an important part of the transition process for some transsexual people, as it can help them to be more at ease with themselves both physically and psychologically (Department of Health, 2007; West, 2004 and Namaste, 2000). Some of the physical effects of taking testosterone for a female to male transsexual may include muscle development, deeper voice, beard and body hair growth, increased libido and menstruation ceases (Department of Health, 2007 and Namaste, 2000). For a male to female transsexual some of the physical effects of taking oestrogen may include the redistribution of fat, muscle reduction, breast development, softer skin and facial and body hair may become

weaker (Department of Health, 2007 and West, 2004). However, hormone therapy does not bring immediate physical changes. As Hines (2007) suggests, starting hormone therapy can be a frightening time for some transsexual people. As the body slowly changes, they can feel frustration and low self esteem due to the slow development of their body, and the mixture of both male and female body characteristics they will have during the transition period. There can also be confusion over their emotional state of mind at certain times, in the sense of what is down to their natural feelings and what is down to the effects of the hormone therapy (Hines, 2007). Hormone therapy and GRS can bring a sense of security to a transsexual person, but more importantly, it is done to alleviate the distress of living in a body and social identity that didn't match the self identity of the transsexual person. It is important to add that body modification should be seen as a continuum, as some transsexual people may not wish to have hormone therapy and surgery, and will use strapping and special clothing to modify their bodies. Other transsexual people will want to start hormone therapy only, and yet other transsexual people will want to have hormone therapy and gender reassignment surgery. These differences underline the importance of corporeality for transsexual people, and the difference it makes to their experiences within the transition process. The next section discusses GRS and the postoperative factors that can lead to regret for a small minority of transsexual people, and the preoperative factors that can influence a positive postoperative outcome for the majority of transsexual people who have GRS.

### ***Gender Reassignment Surgery***

Hines (2007) and Bourke (1994) suggest that GRS for some transsexual people is important as it enables the coming together of their gender identity and bodily appearance. This can help some transsexual people to gain “physical comfort and wellbeing and emotional confidence” (Hines, 2007: 70). Lewins (1995); Pfafflin and Junge (1998); Landen et al., (1999); Schorfield (2008) and Weyers et al., (2009) suggest that the majority of transsexual

people who undergo GRS are satisfied with the outcome. However, a small minority may have regrets, which can often be associated with loss of social support, or disappointment with the surgical results. As Olsson and Moller (2006) mention, persistent regrets after GRS is a possibility for a small minority of transsexual people and is influenced by many factors, including psychosocial adjustment, cosmetic and functional results, the ability to experience pleasure from sexual relations, and the existence of partners (Olsson and Moller, 2006). The preoperative factors that seemed to predict a favourable post surgery outcome were emotional stability, successful adjustment in the new role, and an understanding of the limitations and consequences of the surgery (Green and Fleming, 1990 cited in Davison and Neale, 2001). Therefore this suggests that being aware of the risks of surgery and having emotional stability are important factors to the success rates of GRS. This raises questions of the extent to which gender clinics assess a patient's emotional stability, awareness of the risks of surgery, and their successful adjustment in their new role as part of the assessment process at gender clinics? This is an important question to consider in order to ascertain the contribution that the intersection of corporeality, social discourses, and institutions play in the successful adjustment of transsexual people during the transition process. This is an issue that is discussed in the empirical chapters of this thesis.

The literature on transsexualism within a medical context discussed in this chapter has focused on two main areas, medical and social care institutions roles within the transition process, and doctors assisting in changing the corporeal body. Existing research on changing the corporeal body of a transsexual person has included studies around the use of hormones and the successfulness of gender reassignment surgery. Literature on the role medical institutions have played in the transition process has included the systems and assessments a transsexual person has to go through in order to pass through the different stages of the transition process, the support of written evidence by medical staff in order to gain a Gender

Recognition Certificate, and the lack of both an understanding of transsexualism and provision of appropriate services within medical institutions to meet the needs of transsexual people. The literature within a medical context discussed in this chapter has failed to recognise the transsexual corporeal body within a social discourse context. It is my contention that applying and adapting Frank's (1991) theory of the body will enable this study to look at the transsexual corporeal body within social discourses and the impact this can have on those interactions within chapter four.

The following section looks at the literature within a political and economic context. This will be defined for the purposes of this thesis as those factors that can influence health and social care institutions, including the social and economic conditions, assessing and meeting the needs of specific groups or local communities, politics, legislation and policies (World Health Organization, 2010). Firstly there will be a discussion of the impact policy makers' understandings of transsexualism may have on the decisions that policy makers make, of what to include within institutional policies. This will be followed by examining the impact and success of the use of Clinical Governance to achieve consistency in the quality of healthcare provided to patients across the UK within medical institutions. Thirdly there will be a discussion of the ways service provision has been influenced by the civil rights movement, LGBT political movement, and legislation. The developments within some health and social care institutions to meet the needs of transsexuals are then examined. Finally there will be a discussion of the possibility of institutions contesting those legal rights gained by transsexual people since the introduction of the Gender Recognition Act 2004.

### **Section three: Political and economic context**

There is still some confusion over the needs of transsexual people accessing services. This is partly due to the fact that policies and practices within services may not even recognise that transsexual people may access their services, or the confusion the transsexual corporeal body may create to health services in particular. This thesis aims to shed more light on these issues, which are discussed in some detail in the empirical chapters in relation to the experiences of some transsexual participants, and the health care professionals. This highlights the complexities of health care provision and the impact a lack of representative data of minority groups' healthcare needs, institutional culture, and the assumptions it has about the body and the values of individual staff within it, can all impact on the quality of health care given to transsexual people.

Policy makers need to be aware of legislation and have researched the issues affecting different groups of people who need to access their service. None of the literature analysed in this review mentions the impact personal values, beliefs, levels of knowledge and understandings of what transsexualism involves, can have on the decisions that policy makers make of what to include within institutional policies. If policy makers of medical and social care institutions are unaware of the issues transsexual people can face when accessing their services, this can impact on both the staff and transsexual users of that institution. Staff may hold various levels of attitudes and understanding of what transsexualism is, as previously stated, and may need further education and training. Failing to include the needs of transsexual people in an informed way within policies that can inform practice and educate staff, may result in a lack of respect, privacy, and quality of appropriate care that meets transsexual people's health care needs. For example a lack of awareness of the needs of the transsexual corporeal body within some screening services' individual policies. This is examined in chapter five.

*The use of Clinical Governance to achieve consistency in the quality of healthcare provided to patients across the UK within medical institutions*

Donaldson (1998) defined clinical governance as “The government’s approach to matching consistency in quality across the NHS with sensitivity to the needs of the individual patient and local community” (Donaldson, 1998: 1.12).

The key principles of Clinical Governance include clear lines of responsibility and open accountability; continuous improvement in systems and processes; clinical audit; commitment to implementing and monitoring standards; ongoing training and education of all staff and quality assurance processes and risk management procedures (Churchill, 2010).

Brown (2008) suggests that Clinical Governance was introduced with the aim of rebuilding patient trust. This was particularly in relation to responding to, and addressing, poor quality patient care that was highlighted in high profile health care cases in the media. These included Dr Harold Shipman, the Alder Hay organ scandal and the Bristol Royal Infirmary Hospital (Donaldson, 1998; Brown, 2008; Churchill, 2010 and Menrryn, 2010). Dr Shipman unlawfully killed 215 patients by administering lethal overdoses of diamorphine. System failures included falsifying medical records indicating that patients had been in poor health, and the reliance on information from one doctor on death certificates (Baker, 2004). Hundreds of organs and tissue samples were removed from dead babies without their families’ consent between 1985 and 1998 at the Alder Hay Children’s Hospital in Liverpool (Hall, 2001). At the Bristol Royal Infirmary Hospital, there was growing concern over the high mortality rates of babies undergoing heart surgery. An inquiry found secrecy about surgeons’ performance, staff shortages, a lax approach to safety and a lack of monitoring by hospital management (Smith, 1998).



This thesis highlights that the delivery of the NHS's clinical governance guidelines to achieve consistency in the quality of healthcare services across the UK with sensitivity to the individual needs of the patient and local community, remain problematic. This will be discussed further in chapters four and six

Clinical governance has, I would suggest, been used to assess the risks of negative consequences in healthcare outcomes to make sure they are reduced. The ongoing monitoring of clinical performance within healthcare and the introduction of explicit guidelines and standards has created a culture of openness in the reporting of near misses. However I would argue that the issues raised by research participants in this study in relation to Clinical Governance supports the work of Churchill (2010) who suggested that the bureaucracy and tick box exercises surrounding Clinical Governance had diverted attention away from the real aim of it, that being the continuous improvement of providing quality health care.

Health and social care provision is influenced by many factors including the social and economic conditions, politics, legislation, policies, and meeting the needs of the defined population (World Health Organization, 2010). Ong (2012) suggests that health economic data is increasingly used within health and social care services to inform allocation of resources that meet the needs of different populations. "However there is comparatively little evidence relevant to minority groups. In part this is due to a lack of cost and effectiveness data specific to these groups upon which economic evaluations can be based" (Ong, 2012: 1). Therefore many services rely on mainstream data that may not be representative of the local population as a whole to make informed decisions on allocation of resources, which may fail in meeting their needs. Ong (2012) suggests that if service provision decision makers have access to economic data "that more accurately represents the needs and context of disadvantaged groups, which is particularly important if addressing health inequalities is a stated goal" (Ong, 2012: 1).

The issues raised within this section with regard to quality of care and service provision suggest that resources for meeting transsexual people's needs within health and social care services in the past have been clearly lacking. As Williams (2005) suggests, NHS resources are limited and "if more favourable treatment is provided to some inevitably less favourable treatment is accorded to others" (Williams, 2005: 397). I would argue that the criteria a transsexual person has to meet to start the transition process and progress through it, even to the present day, means to some extent constraints are in place on gaining approval for getting funding for GRS, and on accessing gender identity clinics.

### *Service provision influenced by civil rights movement, LGBT political movement and legislation*

The literature discussed in this chapter so far has shown that health and social care institutions have often lacked an understanding of transsexualism and the needs of transsexual people when accessing services. However, recent attempts to address this have been influenced to some extent in three ways by civil rights movements, LGBT, local political movements and legislation.

Groups such as the 'women's rights movement', 'black civil rights movement' and 'disability rights movement', have all been created in the past to enable people with a shared identity to come together and politically challenge the structural inequalities they have faced (Finkelstein, 1993). The women's civil rights movement for example, "centred on improving the rights of women in relation to equal pay, domestic violence, sexual discrimination and self-determination over reproductive matters" (Alsop, Fitzsimons and Lennon, 2002: 222). These groups have helped not only to put pressure on the UK government to introduce legislation such as the 'Race Relations Act 1976', but have also helped to raise awareness in wider society of the ways in which these groups were disadvantaged. Therefore, these groups,

and the issues they have faced, have been part of the political and social background that has helped to challenge social attitudes and promote diversity and equality rights within the UK.

Political activism by LGBT communities has helped to raise awareness within the public domain of the social and institutional discrimination faced by them, not least in health and social care services (Alleyn and Jones, 2010). The development of Trans theory had also helped to raise awareness of shared identities and issues of transsexual and transgender people and helped to create Trans activism. For example groups such as Press for Change and Transsexual Menace have been pressing for civil and human rights for transgendered people (Namaste, 2000; Stryker and Whittle et al., 2006 and Hines, 2007). Transsexual writers such as Stone (1991), Bornstein (1994) and Whittle (2000) have helped to raise awareness of transsexuals and transgendered people in society, and have encouraged others within the transgendered community to write their autobiographies and academic articles (Whittle, 2002).

LGBT communities have also been led to create their own services in response to the lack of understanding and discrimination they can face within health and social care services. For example, The Project for Advocacy, Counselling and Employment (PACE), is an organisation that was created to respond to the emotional, mental, and physical health needs of lesbians, gay men and bisexual people, and has developed services that are now inclusive of transgender and transsexual people (PACE, 2010). PACE services are open to transgender people who identify as lesbian, gay or bisexual, although the goal of the service is to be inclusive of all transgender people shortly (PACE, 2010). PACE staff and volunteers have been trained on transgender issues, and the organisation aims to have a diverse and welcoming team that reflects the diversity of its service users (PACE, 2010). However at present PACE is only available to people who live in and around the Greater London area. This is clearly a good example of practice that could be implemented by other health and

social care services within the UK to ensure that their services are inclusive of transsexual people and their needs; have a diversity of staff that reflects the diversity of their service users, and that staff and volunteers are trained on transsexual issues.

The introduction of legislation including the Gender Recognition Act 2004, the Services Directive 2004 and the Equality Act 2010 has placed a duty on health and social care services to ensure that they take positive action within their policies and practices to include the needs of transsexual people within their services, and minimise any disadvantages transsexual people can face when using them (Office of Public Information, 2010).

### ***The developments within some services to meet the needs of transsexuals***

There have been developments within some services to meet the needs of transsexuals. For example, Brighton and Hove City Council reviewed its homeless and housing strategies in 2007. This now includes a new lesbian, gay, bisexual and transgender housing strategy (Brighton and Hove City Council, 2007a). This has led to developing a support service specifically for young people from the lesbian, gay, bisexual, and transgender communities in relation to ensuring accommodation services are more accessible and welcoming to these groups (Brighton and Hove City Council, 2007b).

The Department Of Health has also published guidance pamphlets for health and social care professionals on the care of transgender service users (Department Of Health, 2008). The aim of this literature is to improve the knowledge and preparedness of professionals coming into contact with transgender people as patients, and to make services more accommodating to transsexual people's needs (Department Of Health, 2008). An example of this is guidance for transgendered people and their primary care team, covering the importance of health screening over the course of the transgendered person's lifetime. For example, that transsexual women are screened for breast cancer and prostate cancer, but not called for

smear tests, and that transsexual men are appropriately called for smears (Department Of Health, 2008). Feinberg (2001) suggests that some cancer screening protocols are sex/gender specific based on assumptions about what body parts men and women have, for example, screening of cancer of the breast, cervix, ovaries, prostate, penis, testicles and uterus. It can be difficult to know what to recommend for transsexual people as hormone therapy and gender reassignment surgery can change these body parts, and can also increase or decrease the risk of cancer (Ashbee and Goldberg, 2006). There is further confusion within health screening services as to what screening is appropriate for a transsexual person at different stages of the transition process. For example, is the individual non-operative, pre-operative or post-operative? These different stages of transition, the different techniques used in gender reassignment surgery, and the biological characteristics at birth will all be important factors that determine what cancer screening programmes the individual transsexual person should be included in (Ashbee and Goldberg, 2006). What is interesting to add is that the Department of Health publications on trans health (2008) briefly mention the need to screen trans patients in relation to their anatomical needs rather than their pre or post gender identity alone. Yet the Department of Health publications that provide specific information for staff and patients in the individual screening programmes fail to include trans information, for example in relation to prostate cancer, breast cancer and cervical cancer (Department of Health, 2009; Department of Health 2009a; Department of Health 2009b and Department of Health, 2009c). This highlights another limitation within medical institutions to recognise the transsexual corporeal body in its policies and practices, which can lead to issues of a lack of respect, privacy, and quality of care by health staff.

In addition to advice about integrating transsexual people into population wide screening programs, good advice should also be given to enable the transsexual person and their doctor

to agree a healthcare monitoring program specifically addressing the person's individual needs as a result of long term hormone therapy, and/or gender reassignment surgery. For example, the need to adapt hormone regimes as the transsexual person ages, and advise about screening for Osteoporosis (Department of Health, 2007c).

As the literature in this chapter so far suggests there has been a lack of awareness of the issues transsexual people can face when accessing health and social care services. The introduction of civil rights movements, political activism, and legislation have influenced recent changes in health and social care services to some extent, so that policies and practices are likely to be more aware of the needs of transsexual people when accessing their services. However, implementing these changes in legislation since 2004 has not been effective, and in some cases, these new rights have been contested.

#### ***The issues and difficulties facing transsexual identities and needs in institutional contexts***

This section of the literature review considers issues and difficulties facing transsexual people in institutional contexts. There is now a brief discussion about the prison service, contesting the legal rights of a transsexual prisoner who had a Gender Recognition Certificate. This is given as an example to illustrate the problems some institutions may face in implementing those legal rights gained by transsexual people, and the possibility of those legal rights being contested in the future by health and social care institutions. There may be other reasons underlying the prison service contesting the legal rights of the transsexual prisoner, such as logistics, time, and costs. However, if an institution contests the legal rights of a transsexual person and denies them their legal right to be to be recognised in their new gender, then this could have serious consequences to a transsexual person's health and wellbeing. This example also further supports a key issue of this study, that transsexuals as a minority group

with particular needs are still largely invisible, and their needs are largely not being considered by institutions, despite the introduction of recent legislation to protect their rights.

Whittle, Turner and Al-almi (2007) suggest that in 1997 the prison service was in the process of drawing up guidelines for issue to prisons on the care, management, and treatment of prisoners with Gender Dysphoria. However, ten years on there are still no guidelines on the care of transsexual prisoners even though a study by Goodchild (2000) was commissioned, and Press for Change were asked to advise on five separate versions of prison guidelines for the care of transsexual prisoners (Whittle, Turner and Al-Alami (2007)).

Jones (2009), Allen (2009) and Hewitt (2010) discuss the case of a transsexual woman serving a prison sentence. The prison authority had refused to move her to a women's prison so the transsexual prisoner had taken them to the high court. The transsexual prisoner is now to be moved to a women's jail after the high court ruled that holding her in a male prison was a violation of her human rights. Three years ago the transsexual woman was granted a Gender Recognition Certificate under the 2004 Gender Recognition Act, which requires her to be recognised as a woman "for all purposes". Although on hormones the transsexual prisoner had been unable to undergo GRS because the prison authorities had refused to move her to a female prison. The prison authority's reason for not moving her was that it would be too expensive because she would have to spend considerable time in segregation, as she would be equally unaccepted by the female prisoners. The gender identity clinic treating the transsexual prisoner would not approve surgery until she had spent time living as a woman in a female prison (Jones, 2009; Allen, 2009 and Hewitt, 2010). Whittle, Turner, Al-Alami (2007); Jones (2009); Allen (2009) and Hewitt (2010) suggests that the prison authority's failure to recognise the transsexual prisoner in their new gender is impacting in a negative way upon the transsexual prisoners' progression through the transition process as well as their health and wellbeing. This suggests that there is clearly a failing within some services to

acknowledge the legal rights of transsexual people and a lack of policy and practice in situations where a transsexual person has acquired a Gender Recognition Certificate. This could be interpreted as institutionalised transphobia being present in some services. What is worrying about the approach by the prison service to legally contest the legal recognition of a transsexual person is the impact this may have in future on other services deciding to contest the legal recognition of transsexual service users. The prison service is a government body, therefore it is reasonable to suggest that a transsexual person's legal recognition may also be challenged in the future when accessing some health and social care services, and/or by individual service users, and employees of health and social care services. Therefore it has been important for this thesis to assess the extent to which research participants feel their identity is being respected by health and social care services, and the ways in which they feel their identity has been challenged by services users and/or individual employees of these institutions. It would also be useful to ascertain if there are any differences in the experiences of transsexual men and transsexual women accessing women or men only health and social care services. Firstly, this research study is essential for discovering the extent to which health and social care institutions are implementing this legislation into policies and practices. Secondly, it is important to assess both the extent to which these institutions respect transsexual people, and the relevance of the practices and services they provide to them.

In terms of legal rights gained by transsexual people with the introduction of the Gender Recognition Act 2004 and other legislation such as the Services Directive 2004, there are barriers to achieving those rights, such as the process for gaining a Gender Recognition Certificate, which relies heavily on a medical diagnosis of Gender Dysphoria being made in the first instance; identity documents such as a passport and driving licence, and change of name by deed poll are required to prove the individual has been living in their acquired gender for at least two years before an application for a Gender Recognition Certificate can



be issued; a medical report from the gender clinic on any treatment, such as hormone therapy and/or sex reassignment surgery the individual has had, or is wanting to have in the future, is also advantageous; the assurance that the individual wishes to live the rest of their life in their acquired gender. This is not to discredit the importance of medical intervention for some transsexual people during the transition process, but it does question the need of a medical diagnosis, not for access to specialist services, treatment and surgery, but for obtaining a Gender Recognition Certificate.

As was discussed earlier in this chapter in the past health and social care services have provided few services specifically for transsexual people. However, I would suggest that there is still a real lack of service provision in relation to meeting the specific needs of transsexual people when accessing health and social care services, especially specialist services such as gender clinics and surgeons specialising in GRS. I would argue that eight years on since the introduction of the Gender Recognition Act 2004, health and social care services are still regarding the needs of transsexual people as low priority, if they recognise them at all. This will be discussed in further detail in chapters four, five and six, and in recommendations in chapter seven of this thesis.

The introduction of the Gender Recognition Act 2004 has meant that transsexual people can now gain legal recognition in their acquired gender under the law of the United Kingdom (Office of Public Information, 2004). Therefore institutions have played an important role for enabling the expression of transsexual research participants' new identities through the interactions they have had with different institutions, such as health and social care services, local government departments, and banks and building societies. However it is also the interactions that transsexual people have with members of those institutions that helps us to see the issues transsexual identities and bodies can present for an institution's systems, policies and practices.

The literature review has shown that there is strong evidence that gaining access to good health and social care services as a transsexual person in the UK varies enormously from area to area. Furthermore, when accessing health and social care services, transsexual people have experienced a range of difficulties stemming from ignorance of their needs, through to prejudice from individual staff within services, or from the service itself, especially when it comes to women only, or men only, services.

The review has shown that transsexual people and their needs have often been excluded in terms of policy and practice. Although some services have tried to address this, what appears to be missing from the literature is research findings of transsexual people's experiences of accessing health and social care services since the introduction of the Gender Recognition Act 2004. Whittle et al., (2007) highlight the inequalities and discrimination that some transgender people (transvestite, transgender and transsexual) in the UK have faced within social and legal contexts over a ten year period. There is a lack of literature on the experiences of people accessing services during the transition process since the introduction of the Gender Recognition Act 2004 who want legal recognition in their acquired gender as male or female. Although research on individual services that transsexual people access may help to show if that service is meeting the needs of those transsexual service users and the extent to which the Gender Recognition Act 2004 and other legislation is being implemented into policies and practice, it is unlikely to inform us about the complex interaction that corporeality, social discourses, and institutions have on each other to affect the health and wellbeing of the transsexual person during different stages of the transition process. Therefore, this thesis examines the issues mentioned in the literature that transsexual people can face when accessing health and social care services, such as lack of respect, understanding, and social and legal recognition. Rather than looking at individual services, as previous research has done through the single lenses of either social discourses, medical or

political and economic contexts, Firstly, this thesis examines the combination of health and social care services at different stages of the transition process in order to assess whether services are meeting the needs of transsexual people. Secondly, it examines the extent to which services are implementing the Gender Recognition Act 2004 and other legislation in their policies and practices. Thirdly, it examines how the complex interaction of corporeality, social discourses, and institutions have impacted on transsexual people's health and wellbeing during the transition process, and on the experiences they have had of accessing health and social care services. In order to achieve this Franks (1991) theory of the body will be adapted and applied in order to explore the varied experiences of transsexual people in their full complexity. The research methods and methodology that will enable this thesis to achieve this will be discussed in chapter three.

Although there was much discussion within the literature concerning issues facing transsexual people accessing health and social care services, none of the literature has looked at corporeality, social discourses and institutions together, or their combined affect on the health and wellbeing of transsexual people during the transition process. As will be discussed in chapters four, five, and six of this thesis, there is an exclusion of the transsexual corporeal body in transition in the remit of institutional culture and social discourses, and I would argue, much of this is rooted in a lack of its classification in binary health care computer systems. There is a need to integrate recognition of the corporeality of transsexual bodies and their diversity into the organisational culture, policy, practices, computer systems, and social discourses within institutions at a macro and micro level.

What is clearly lacking is any analysis of the impact corporeality, social discourses, and institutions have on each other and to the detriment of a transsexual person's health and wellbeing during the transition process. It is for this reason that Franks (1991) theory of the body presents a useful starting point for the analysis of the complexities of the transition

process, and the impact corporeality, social discourses, and institutions have on the experiences of transsexual people accessing health and social care institutions.

There is a need for care providers to have more awareness of the general issues transsexual people can have accessing health and social care services. Previously, the three main contexts have been looked at in isolation of each other. They need to be brought together and that has been the focus of this chapter.

It is to chapter three that I now turn to discuss the methods and methodology that will be used to examine the interaction corporeality, social discourse, and institutional contexts together have on the transition process and the experiences of transsexual people accessing health and social care services.

## Chapter Three: Design and methodology of the research study

I would argue that the literature reviewed in the preceding two chapters has failed to recognise the significance of the transsexual corporeal body within the transition process, and the experiences of transsexual people accessing health and social care services along with its significance within everyday social discourses within and outside institutions.

This study attempts to explore the significance of the above three contexts and their interaction, in order to examine the complexities of the transition process and transsexual people's experiences of accessing health and social care services. Therefore, Frank's (1991) theory of the body as outlined in chapter one is a useful tool that was adapted and applied in the analysis of the research findings of this research study. The reason for this is that health and social care needs, corporeality, social discourses, support, and institutions, which factor in trans individuals' health and social care experiences, cannot be examined in isolation of each other. This is because each of these areas has an important role to play within the transition process and can simultaneously influence each other area in a positive or negative way. For example, if legislation is implemented into policy, but not enforced within practice, then this may still lead to negative experiences for a transsexual person accessing health and social care services. Therefore, using Frank's (1991) theory of the body to analyse the complex interaction that corporeality, social discourses, and institutions have on each other, and on the experiences of transsexual people accessing health and social care services, will help to provide a greater understanding of the complexities of transition, and emphasise that each of these areas cannot be analysed effectively in isolation of each other.

Furthermore research that focuses on transsexual people's health often gives primacy to gender over other key determinants, such as age, cultural background, religion, sexuality, and socio-economic status (Hines, 2007; Schorfield, 2008 and Weyers et al., 2009). There is also

a tendency even when other key determinants are mentioned, to not adequately address the interaction among these determinants on a person's health and wellbeing. For example even though the research may have highlighted differences to a person's health and wellbeing when comparing participants from urban areas to those from rural areas during the transition process, this is too simplistic an analysis, as other key determinants need to be considered, such as economic background. Therefore I would suggest that Frank's (1991) 'theory of the body' was also important for the analysis of my research findings in relation to the complex interaction that key determinants may have on a person's health and wellbeing. This is because the model provided a framework for looking at the key determinants through the three contexts simultaneously, and therefore, enabled equal attention and a thorough investigation of each key determinant to be achieved.

Section one of this chapter will firstly discuss the research paradigms that have influenced how the research study was undertaken. These included feminist research principles, emancipatory research principles, and emic and etic perspectives. I share many values as a researcher with the paradigms discussed in this chapter and emphasise some of these values through the way I have approached the research process, and by the use of some of my personal reflective diary entries that are included throughout this chapter. There then follows an account of the issues I needed to be aware of as an insider researcher, and the steps I could take to reduce the likelihood of any problems that might arise within my own research study. These issues included previous experience of associating with the trans community, disclosing one's insider identity, and gaining a representative sample of transsexual participants. My position as an insider researcher played a significant role in helping me to gain a significant variety of transsexual participants at the different stages of the transition process, and from different socio-economic backgrounds in England, Wales, and Scotland. There is then a discussion of the ethical research principles of the study, which follow

guidance from the Economic and Social Research Council, British Association of Social Workers, and the University of Hull ethics committee.

A selection of entries from my reflective diary during the research process are also discussed. These highlight some of the issues I faced as an insider researcher, and explain the development of the research methods and questions, and my personal thoughts on how successful the research process was progressing.

Section two gives a descriptive account of the three phases of the research, which involved both quantitative and qualitative research methods. Firstly the design of the survey is explored, which ran concurrently alongside the sequential phases of the research design, which involved semi-structured interviews followed by an online focus group. The survey was used to obtain data from 59 research participants from across the UK. This included research participants from those geographic areas not covered in the focus group and semi-structured interviews. Categories such as age, country, county, identity and which year participants started the transition process are discussed, with the help of bar, column and pie charts.

The second phase of the study involved 9 semi-structured interviews consisting of 2 health care professionals and 7 transsexuals. This method was chosen because it was considered that the flexibility would help participants to explore the topics in detail in a relatively unrestricted way. There is then a discussion of how successful the interview process was and the advantages of using this research method. This includes examples of how the study was influenced by the research paradigms discussed in this chapter, and how some of those values, such as reducing the hierarchical relationship between the researcher and the research participants influenced my decision to give participants some control over where they were interviewed. Following on from this there is an evaluation of the successfulness of using a

digital voice recorder to record the interviews. This was an important research tool that enabled me to concentrate fully on what the participants were saying, without being distracted by writing notes. Telephone interviews are then discussed. This was a flexible research method that allowed the interviews to be set up at a convenient time for the research participants in the comfort of their own homes, and especially for those from remote rural areas of Wales, where it could have been extremely difficult to have otherwise gained their views and experiences.

The third phase of the study was an online focus group using Skype which consisted of 8 transsexual participants. This includes describing the design of the focus group and the advantages of using this research method. Finally a colour coding system is discussed that I used in the analysis of the interview transcripts.

### **Section One: Guiding principles that have influenced the research process**

The methodological frameworks or research paradigms that influenced how the research study was undertaken included feminist research principles, emancipatory research principles, and emic and etic perspectives. Many of the research principles that shape feminist and emancipatory approaches are important to my own research as an insider researcher. For example, empowerment, reducing the hierarchical relationship between researcher and research participants, and reducing the oppression of minority groups (Letherby, 2003; Barnes, Mercer and Shakespeare, 1999). Emic and etic perspectives are important to me as an insider researcher as they help me to be aware of the various ways I am both an insider and an outsider as a researcher researching my own minority group. Therefore what follows is a discussion of some of the ways that the different research principles and values were implemented into my own study.



### *Feminist guiding principles*

Some of the main principles of feminist research include a commitment to reducing the hierarchical relationship between researcher and research participants, a commitment to reducing the oppression of women and minority groups, reflexivity, and exploring the relations between knowledge and power, and the interaction of gender relations with other power relations (Ramazanoglu and Holland, 2002; Letherby, 2003; Naples, 2003 and Maynard, 1994). Often some feminist research has a political commitment to produce knowledge that will help bring change to women's lives, and those groups that are marginalised and oppressed (Letherby, 2003).

What I have taken from the principles of feminist research is a commitment to reduce the hierarchical relationship between myself and the research participants of my research study, ensuring that participants could speak freely in interview; using anonymised direct quotes; and exploring the interaction of gender relations and other power relations, such as those inherent in legislation and medical approval during the transition process, and for gaining a Gender Recognition Certificate, that transsexual people as a minority group face.

Acknowledging the researcher's subjective position within the research process is an important part of some feminist research (Naples, 2003 and Maynard, 1994). Giving a personal biography this can help to show that the knowledge produced by the research is influenced by the researcher's class, race, culture and gender, thus this will influence why the researcher has chosen a certain topic, their relationship with participants, and how they analyse the research data (Harding et al., 1987; Letherby, 2003). Therefore feminist researchers find it important to give a reflexive account of their position in the research process in the final write up of their research, as this can help to give the reader an insight into the personal thoughts the researcher had during the research process, how their

characteristics influenced the research relationship, and any ethical or methodological issues they faced (Olesen, 1994 cited in Mauthner and Doucet, 1998; Roberts, 1981 cited in Letherby, 2003). Therefore, I have included a reflexive account of my position in the research process, as I consider it important to show how my identity as a woman with a transsexual background may have influenced the research process.

Campbell and Wasco (2000) suggest that feminist research emphasises the importance of feelings on shaping the research process. This means not only acknowledging the participants emotions throughout the research process, but also analysing the researcher's emotional experiences to hearing the research participant's emotional account (Campbell and Wasco, 2000). As Campbell and Wasco (2000) suggest "a non hierarchical, caring research environment is a defining feature of feminist scholarship" (Campbell and Wasco, 2000: 787). Naples (2003) suggests that a feminist way of doing research is to have a more equal relationship with those being researched. As Harding et al., (1987) terms it "locating the researcher in the same critical plane as the overt subject matter" (Harding et al., 1987: 8). Thus, for Naples (2003) where one positions themselves in the research process will affect how they gather information and analyse that information. Taylor (1998) suggests that feminist research should emphasise the need to eradicate the hierarchy relationship between researcher and the researched. "This includes not only participating in the activist community being studied, but empowering the community by encouraging their involvement in the research process" (Cancian, 1996; Naples and Clarke, 1996 cited in Taylor, 1998: 370). However being able to totally eradicate a hierarchical relationship in the research process is unlikely as it is impossible to have an equal relationship. As Letherby (2003) suggests the researcher often has the balance of power throughout the research process, because they will usually ask the questions in a certain order, do the analysis of the data and the final write up (Letherby, 2003).

Although some feminist researchers in the past have favoured qualitative methods as “they have been seen as more useful in capturing women’s stories and legitimising those experiences as sources of knowledge” (Jayaratne and Stewart, 1991 cited in Campbell and Wasco, 2000: 784). Some contemporary feminist research often uses both quantitative and qualitative methods now, even multiple methods (also known as triangulation) in a complementary rather than a competitive way (Brannen, 1992 cited in Maynard, 1994). Indeed Letherby (2003) suggests that “there is nothing distinctive about feminist methods and, contrary to popular non-feminist academic opinion, there is in fact no such thing as a feminist method as any method can be used in a pro-feminist or non-feminist way” (Letherby, 2003: 5). Feminist research as Letherby (2003) suggests “acknowledges the ‘messiness’ of the research process and considers the detail of doing research and the relationship between this and the knowledge produced” (Letherby, 2003: 6).

The choice to include reflective diary entries in this thesis is also influenced by feminist research principles that I value strongly, such as reflexivity, and reducing the hierarchical relationship between researcher and research participants. For example, Ramazanoglu (1992) suggests that there is often a rejection of the hierarchies between the researcher and the research participants, and a conscious attempt to create equality, which may influence the research methods chosen by the researcher, and what happens to the data afterwards.

Ramazanoglu (1992) suggests that “Feminist methodologies expose unreasonable assumptions about the superiority and neutrality of reason. Feminism has no general solution to problems of validation, but it cannot be dismissed as unconvincing on the grounds of assumed superiority of a rational scientific community. All researchers should be explicit about the politics of their research, as it is more logical to accept our subjectivity, our

emotions and our socially grounded positions than to assume that some of us can rise above them” (Ramazanoglu, 1992: 207).

### ***Emancipatory guiding principles***

Just as power relations and a commitment to reducing the oppression of minority groups are important within feminist research principles, so they are also important to emancipatory research principles. Barnes, Mercer and Shakespeare (1999: 215) define emancipatory research as “an approach which emphasises the role of research in promoting the interests of ‘oppressed’ groups”. The key features of emancipatory research are accountability, a strong leaning towards qualitative data collection methods, and empowerment (Swain, French, Barnes and Thomas, 2004). The qualitative methods used for collecting the data on the experiences of transsexual research participants are effective methods for collecting narrative data, and have been essential to answer the research questions of this study. Qualitative research can be empowering for members of oppressed groups and communities, as it can give a “voice to those whose views and experiences are not typically captured in traditional research studies” (Lincoln, 1995 cited in Hash and Cramer, 2003: 50). For some participants who lived in rural areas of Wales, they felt that because of the remoteness of the areas they lived in, they had few opportunities to participate in transsexual research studies on issues that mattered to them. They were of the opinion that research studies would often use transgender support groups in the major cities to conduct focus groups and interviews, consisting of participants from those groups. As one research participant put it:

*“It’s usually a case of the usual suspects getting in on the research studies. It’s as if their opinions are the only ones that matter.”* (Woman with a transsexual background aged 50-59).

Therefore the three research methods used in this study aimed to draw participants from a wide geographical area across the UK and at the same time enable some flexibility in the way

that potential participants could participate in the research study in three important ways. Firstly, the survey enabled participants from all of the different stages of the transition process, and those from both urban and rural areas, to equally participate, so long as they had internet access. Secondly, having the option of a telephone interview was empowering for those participants who lived in remote rural areas of Wales, enabling them to have their say in more detail on issues that were discussed in the online survey. Thirdly, the use of an online focus group using Skype enabled 8 participants from across England to come together "virtually" to discuss the topics of the focus group.

### ***Emic and etic guiding principles***

“The terms ‘emic’ and ‘etic’ describe the different perspectives used to understand groups or communities that are the focus of social science research” (Pike, 1967, 1990 cited in Lasala, 2003: 16). Kanuha (2003) suggests that the insider researcher often arrives at their research study from an emic perspective. “Emic suggests a subjective, informed, and influential standpoint, contrasted with an etic perspective that is more objective, distant, logical, and removed from one’s project” (Headland, Pike and Harris, 1990 cited in Kanuha, 2003: 441). Therefore the emic perspective can be seen as describing behaviour in the terms of what it means to the participants and the insider researcher (Lasala, 2003). Whereas, an etic or outsider perspective, will explain behaviour or events “using theories that are thought to be applicable to all groups and cultures” (Lasala, 2003: 16). If one of the perspectives is favoured over the other one, the research may be seen short-sighted and biased (Sands and McClland, 1994 cited in Lasala, 2003). Therefore it was essential that I was aware that I may have had many things in common with the research participants, however, my experiences of those things may have been slightly different, and there will have been other issues I or the research participant hadn’t experienced, or we may have experienced them

differently. Lasala (2003: 16) suggests that although researchers have been interested in the emic perspectives of their research participants the “etic perspectives have been historically overemphasised”. Lett (1990 cited in Lasala, 2003: 23) suggests that “developing and maintaining an awareness of the various ways they are both insiders and outsiders, can help the researcher achieve a balance between emic and etic perspectives believed necessary for knowledge building”. Thus certain aspects of the researcher’s identity will be the same as those studied, and other aspects will emphasise difference (Narayan, 1993 cited in Simmons, 2007). Certainly within the research process there were similar issues that I and the research participants had experienced, yet our experiences would be slightly different. This was reflected in my diary entry:

*‘It was a really good interview today, which has generated a considerable amount of rich data on the issues transsexual people can face when accessing health and social care services. This included an in-depth discussion on the differences in support before surgery and follow up support after surgery that the participant had experienced when accessing both NHS and private health care services. It is interesting to add that the participant mentioned that she had lost a lot of family members and friends when she decided to start the transition process. She said ‘in general you find that the ones you suspect will have a problem with you transitioning are actually the ones that support you and the ones you think will be fine with you transitioning are the ones who can’t accept what you are doing.’ This statement resonated strongly with me, as I had expected younger members of my own family to be accepting of me wanting to transition and that the older members of my family would not be able to accept me in my new gender. Yet in reality when I started the transition process it was the opposite way round. Thursday June 2011.*

### *Social work guiding principles from holistic and inductive approaches*

An holistic approach is important in social work practice and social work research for seeing factors such as mind, culture, society and environment together in order to fully view the person in environment. An inductive approach is also important for social work practice and social work research, as this means starting from where the service user is and observing or asking about their personal experiences (Floersch, Longhofer and Nordquest Schwallie, 2009). Floersch, Longhofer and Nordquest Schwallie (2009) suggest that “both traditions assume that theory needs to be near the experience. Social work assumes that this method will help keep practitioners ethical because it is committed to empowering clients rather than using deductive theory to exert power over clients” (Floersch, Longhofer and Nordquest Schwallie, 2009: 160). Both holistic and inductive approaches are important to my own research as I am interested in not only the individual experiences of research participants, but also the social environment and social structures which can influence their experiences, and/or contribute to their oppression, or help them to achieve equality and be respected. I also hope that by using both an holistic approach and an inductive approach in my own research, that my research findings will help to contribute to new ways of working and thinking with regards to transsexualism. This would not just be in relation to transsexual people accessing health and social care services, but also the way transsexual identity is shaped by social structures and how it may be perceived in the future.

Critical social research “regards social structures as oppressive and maintained through political and economic power... Seeks to make visible oppressive practices and... seeks ways to resist and change them” (Humphries, 2005: 283). This is an important influence on my own research, as I feel my research is focused more on making visible oppressive practices of agencies, and challenging and changing them.

### *My role as an Insider researcher*

As a woman with a transsexual background, I have completed this research study for my thesis within my own minority community. However, there has been some debate within the social sciences as to the strengths and limitations of insider research and whether an ‘insider’ or an ‘outsider’ is best positioned to undertake research on minority communities (Buckner, 2005 and Griffith, 1998). Therefore, what follows is a discussion of some of the issues that I, as an insider researcher, needed to be aware of, and which I may have faced when researching my own minority community. I also needed to consider how I, as an insider researcher, would take steps to reduce the likelihood of those issues in my own research study.

In qualitative research, researcher influence on data generated and interpretation has been a much debated issue (Buckner, 2005). Koch and Harrington (1998 cited in Buckner, 2005: 60) suggest that qualitative research is still viewed by some with suspicion and labelled “‘unreliable’ and ‘not scientifically sound.’” This is mainly due to the intense debate between those that favour qualitative research methods and those that favour quantitative research methods. It is still believed by some that the social sciences should follow the research methods of the natural sciences in order to justify the validity of their findings (Buckner, 2005). Those that favour quantitative research methods insist that the researcher needs to be objective and distanced from that or those that they study (Buckner, 2005). The writing style of most research reports has also helped to hide the researcher’s subjective position from the reader in many research reports. Traditionally research studies in the social sciences have been written in the third person. “In this way the voice of the researcher has, by design, become distant in the research that an article reports” (Butler, 2001).



In contrast Griffith (1998: 361) suggests that social research “is of the world it seeks to describe. We as researchers cannot be outside society and thus activities such as ‘science’ or ‘objectivity’ are striated with procedures for minimising or celebrating the presence of the researcher in the research product”.

Griffith (1998) suggests that questions such as, does the biography of the researcher, privilege or disqualify their knowledge claims? And if an insider researcher has tacit knowledge of a minority community, does that mean they construct research findings that are more authentic and trustworthy than those of an outsider researcher? Are the main focuses of the insider/outsider debate in the social sciences? (Griffith, 1998).

Koch and Harrington (1998 cited in Buckner, 2005: 60-61) suggest that “perceptions of qualitative research as lacking that rigour and thus validity have led to attempts to establish and increase the plausibility of qualitative findings.” This has included debates about the presence of researcher subjectivity and the use of reflexivity in research findings. The purpose of reflexivity is to enhance the credibility of the research findings. Mauthner and Doucet (2003 cited in Buckner, 2005: 61) suggest reflexivity can help the researcher to “analyse how their emotional responses to respondents can shape how they have interpreted respondents’ accounts.” Buckner (2005) suggests that it is important to keep a reflexive diary during the research process as it can increase creative thinking and intellectual rigor, which can lead to more robust research. Moffatt, George, Lee and McGarh (2005: 89) suggest that “subjective engagement is essential to fully understanding prejudice and exclusion as it is experienced by minority communities.” This is certainly something that I considered extremely important to do before, during, and after the research process of my own study. Reflective accounts of the research process of my own study, where appropriate, are included

later in this chapter, and other chapters, that examine the empirical data. These diary entries highlight my personal thoughts during the research process, including adding new questions to the interviews, and how reflecting on my position within the research enabled me to consider how some of the experiences of transsexual participants were like my own experiences during the transition process.

Van Heugten (2004) suggests that human research requires the researcher to become an instrument of the research with their identity, emotions and experiences now widely recognised as valid sources of academic knowledge (Van Heugten, 2004). Qualitative research methods can give those involved in the research study a more direct voice than they would have had through quantitative research methods, such as surveys and experiments (Shah, 2006).

Butler (2001: 267) discusses some of the different ways “researchers have tried to make the subjective views of research subjects and researchers visible in texts in order to clarify whose views are being put forward in a report and from what position.” For example the use of sections of transcripts that have both the researcher’s and the participants’ comments (Butler, 2001). The use of reflexivity should not be something that the researcher does and keeps personal to themselves. It should be an important part of the published findings that state the position of the researcher, which enables the reader to make a judgement on the issues the researcher has discussed and their position to them. As Butler (2001: 274) states “positionality is rather... an issue for public debate. Recognition of motivation, differences of position and an awareness of personal reasons for the promotion of particular issues can all be put to valuable use to piece together a more complete picture of society.”

A researcher contemplating research within their own community needs to be aware of the issues they may face and how they can strengthen their position to reduce biases and increase the validity of the research. Some minority communities such as transsexual, gay, lesbian, disabled, and ethnic communities have had some bad experiences when participating in research by outside researchers, which has led to some communities being suspicious of the researcher's motives, and sometimes reluctant to participate in research studies (Barnes, Mercer and Shakespeare, 1999; Meyerowitz, 2006; Gibson and Abrams, 2003). However, I would argue that studies by Golding (1997) and Mottet and Ohle (2003) have helped to reveal the inequalities experienced by minority communities and the social attitudes that can underpin those inequalities. Vernon (1997:160) suggests that research "can either be a significant aid in the maintenance of oppression or it can be a critical tool for eradicating oppression depending on how research is carried out, for whose aims, who it is carried out by and on whom".

There can be a risk that an insider researcher's previous experiences, interactions and opinions of associating with different groups and identities within their own minority community may colour the insider researcher's judgement on who to include in a sample (Paxton, Guentzel and Trombacco, 2006). Therefore to lessen the risk of this happening in my own research study, participants were chosen from many different groups within the transsexual community. For example 'male to female', 'female to male', 'those just starting the transition process', 'pre operative' and 'post operative', different ages, those from cities and rural areas, and different economic groups. This helped to provide a more representative sample of the community in relation to transsexual people's experiences of accessing health and social care services (Berg, Mimiaga and Safren 2008). It should be noted that this study was unable to attract participants from the following ethnic minority groups, Asian, Black,

Chinese, or Mixed Background. This study would support the findings of a previous study by Hines (2007) which discussed the difficulties of gaining transgender participants from ethnic minority groups. However I was fortunate to have an informal discussion with an Asian man, a Sikh, who attended a support group for transgender people that I visited during the research process, who was considering starting the transition process as a MtF transsexual. It was apparent that the Sikh articles of faith, including having unshorn hair and a full beard for men, were a tremendous obstacle to overcome when this person was presenting as female in their preferred gender. For many transsexual people before they transition full time, there is a period of experimentation. This may involve dressing in the clothes associated with the opposite gender, wearing make-up if MtF, and going out in public in their preferred gender identity at times. This may mean body modification such as shaving legs in the case of MtF's, and FtM's transsexuals using strapping over the chest. Many MtF's before they transition, may be able to hide the fact that they shave their legs, or make an excuse that it is for sporting reasons such as swimming or cycling, whilst still living in their previous gender assigned at birth. However in the case of this Sikh man who had not started the transition process full time as a MtF transsexual, he was unable to shave his beard, as this would go against his faith and draw unwanted attention as to the reasons for doing it. This meant that when he became she in her preferred gender identity, she could only dress in private or get changed at the support group and present herself in female clothing with make-up and a full beard, which was still distressing for her. There were comparisons to be made with this issue in this study and the work of Roen (2001) which highlighted the need for more critical thinking on the impact of traditional cultural values and beliefs on the transsexual corporeal body. This highlighted the difficulties of negotiating and merging a trans identity with one's ethnicity and faith. There will be further discussion of this issue in chapters five and six.

### *Advantages of being an insider researcher*

Conducting research from the position of insider has in recent times become commonplace within some areas of social research, for example in youth cultures (Hodkinson, 2005). The term ‘insider researcher’, which will be the term used in this thesis to define my position within the research process, has also been referred to as “‘ethnography of the self’ (Walcott, 1999), ‘native ethnography’ (Walcott, 1999), and ‘pure observant participation’ (Brewer, 2000)” (Hodkinson, 2005: 131). Merton (1972: 21) defines insiders as “the members of specified groups and collectivities or occupants of specific social status.” Griffith (1998: 361) defines an insider researcher as “someone whose biography (gender, race, class, sexual orientation and so on) gives them a lived familiarity with the group being researched- that tacit knowledge informs their research providing a different knowledge than that available to the outsider researcher.”

Those who have epistemological privilege, because of them belonging to the community they are researching, may be more capable of seeing and understanding things more as the researched see them, compared to an outsider researcher. Stanley and Wise (1993) question whether “oppressed people, by virtue of their knowledge of both oppressors’ views of reality and that of their own subjugated group, have access to a priori better or truer knowledge of reality? Feminists such as Hartsock (1987) assume they do, and take the position that a feminist epistemology is a privileged one” (Stanley and Wise, 1993: 227). Merton (1972: 11) suggests that the insider can be seen to have “privileged access to certain kinds of knowledge.” Merton (1972) criticises the insider approach as it limits the work of a researcher to only those groups they belong to. However, I would suggest that Merton’s (1972) criticisms have to be taken into context as at the time of his criticisms the insider research position was still in its infancy as a social research approach. Zinn (1979 cited in

Griffith, 1998) suggests that the insider researcher has epistemological privilege and biography should be seen as sufficient grounds for knowledge. Merton (1972) sees both insider and outsider perspectives as having advantages and disadvantages. For example he suggests that an outsider researcher may see what the community take for granted, and an insider brings a tacit knowledge to their research. Interestingly, Merton (1972: 36) suggests that “we no longer ask whether it is the insider or the outsider who has monopolistic or privileged access to social truth; instead we begin to consider their distinctive and interactive roles in the process of truth seeking.” This suggests that there is a lot to be gained from having insider and outsider teams, when researching difficult to access minority communities, as they can use their positions to gain a rich source of data. However this is not to say that it is only focusing on the knowledge gained from the researcher’s position in the study, as Zinn (1979) suggests that participants will also shape the knowledge available to the researcher depending on how they perceive the researcher’s position within the research study. Zinn (1979) criticises Merton (1972) as situated in a social science that has, at times, ignored or exploited the knowledge held by minority communities.

Desai (2002) suggests that some researchers and research participants believe that it is important that the researcher is from the same or similar background to participants. The advantages of this include “a better understanding of the cultural background, community norms and a greater sensitivity to issues such as body language or tone of voice” (Desai, 2002: 1). Al-Makhamreh and Lewando-Hundt (2008) suggest that because Al-Makhamreh was a Jordanian woman, she used her insider knowledge of Jordanian social perceptions and understandings of gender to construct her behaviour and interactions appropriate to Jordanian culture. For example when gaining access to potential research participants, Al-Makhamreh would use informal, but respectful strategies, such as with elderly people she would “ use

fictive kinship terms addressing them as ‘father’, ‘mother’, ‘grandfather’ or ‘grandmother’ to indicate respect” (Al-Makhamreh and Lewando-Hundt, 2008: 18). Weston (2004) suggests that many of her respondents (lesbian women), would not have talked to her had she not been a lesbian herself. Some respondents mentioned that they had suffered “bad experiences of having had their words misinterpreted by heterosexual researchers” (Weston, 2004: 202). This was certainly something I experienced from some participants, who felt it was nice to see for a change somebody that they perceived to be from their own community undertaking research on issues that were of great importance to them.

The insider researcher will often find it easier to engage with the community and be less reliant on gate keepers than an outsider would be (Dunne, 1997; Kanuha, 2000; Al-Makhamreh and Lewando-Hundt, 2008; Dwyer and Buckle, 2009). Although this is not to say that gatekeepers wouldn’t still be used. Craig, Tucker and Wagner (2008) suggest that research participants may sometimes feel more comfortable answering questions from an insider researcher, as they may have experienced, or could potentially experience, the same discrimination, for example, that the participants have experienced (Craig, Tucker and Wagner, 2008). Baca Zinn (1979 cited in Sprague, 2005) suggests that potential research participants might see insider researchers who are members of their own community as more trustworthy than outsider researchers. This may be due to the belief that the insider researcher’s study “will not harm and might somehow benefit their common community” (Baca Zinn, 1979 cited in Sprague, 2005: 63). Dunne (1997) suggests that because of her insider status, her research participants revealed private aspects of their lives to her because they perceived her to be a more sympathetic listener (Dunne, 1997). Shah (2006) an insider researcher states that “it may be argued that the acquisition of rich quality data, during this study, was facilitated by the fact that the interviewer and the participants came from the same

minority community” (Shah, 2006: 210 Meezan and Martin (2003) mention that an insider researcher may create questions that might not occur to an outsider researcher (Meezan and Martin, 2003).

An insider researcher may be better equipped to create an environment in which research participants feel more comfortable and willing to talk freely (Shah, 2004 cited in Sands, Bourjolly and Roer-strier, 2007). Lasala (2003) a gay man who researched his own community, suggests that his participants were keen to be involved in his research study, “because they believed that, as a gay man he could be trusted to accurately portray their lives” (Lasala, 2003: 18). Kanuha (2000) suggests that the motives for an insider researcher wanting to do research on their own community can be more self evident than they would have been if the researcher was an outsider. Thus members of the community are more likely to want to participate in the research and publicise the research study within the community (Dunne, 1997; Kanuha, 2000). This suggests that minority communities can be keen to be included in insider research studies, as they believe that the researcher will portray them accurately, and hopefully change some of the misconceptions wider society has about their minority community. Because an insider researcher and their respondents share similar experiences, this can create a greater empathy on the part of the researcher for their participants, and thus can help to create a deeper trust and honesty in the research participants (Dunne, 1997; Lasala, 2003). However, this suggests to me that the researcher needs to reflect on the relationship between themselves and the participants to ensure that they do not let their keenness for successful research manipulate the relationship they have with the researched.



Gibson and Abrams (2003) suggest that diversity exists within minority communities, therefore, it is important that the researcher does not make generalisations about the research participants' lives, and needs to probe to ensure they uncover the participants' life experiences (Gibson and Abrams, 2003). This was also an important issue for me when gaining the trust of research participants. For example disclosing one's insider identity to the research participants may cause problems within the interview process. Hash and Cramer (2003) mention that because the researcher was from the same community as themselves respondents assumed that the researcher would understand particular terms they used or situations they described. Therefore, some participants were surprised when they were probed by the insider researcher for further explanations (Hash and Cramer, 2003). This suggests that being open about one's identity may still create problems within the research process, and lead some participants to question whether the insider researcher can be regarded as a true insider, or can be fully trusted. This in turn could lead to some respondents withholding information, which could distort the researcher's analysis and research findings. Thus on occasions I would use a technique used by Kanuha (2000), Meezan and Martin, (2003) and Simmons (2007) to overcome making generalisations during the interview process and reassure research participants that I was a true insider from the same minority community as them. Simmons (2007) suggests that in order to maintain credibility as an insider whilst interviewing participants and asking probing questions, she would state "I know you might think I know this but..., then I would explain that I needed to explore the issues with them as a researcher in order to be able to use their responses as data" (Simmons, 2007: 14). It was important that a diverse range of research participants were used for this research, as this enabled me to highlight not only that everyone's experiences of accessing health and social care services are different, but also helped to highlight specific issues that are associated with

participants accessing health and social care services from different social and economic groups.

Lasala (2003) suggests that because the insider researcher and their participants share similar characteristics and experiences, the researcher “might be tempted to develop social or even sexual or romantic relationships with certain respondents” (Lasala, 2003: 23). Zinn (1979) suggests that it is quite common for participants to invite the researcher to overstep the boundaries of their researcher- researched relationship (Zinn, 1979). However this was not an issue I faced during the research process.

The knowledge I have of the community I have been studying means I have produced a different type of knowledge to that of an outsider researcher, because my personal biography gives me a partially shared lived experience that has been familiar to those I have studied, and has therefore influenced how I have shaped the research questions. The outsider researcher is likely to not have had any intimate knowledge of the community prior to entering the community, whereas I have intimate knowledge of some of the community areas, transgender support groups, and forums, which I have used to attract potential research participants. For example, support groups around the areas of Manchester, Leeds, Hull, and London, and online support groups and forums for transgender people. Sending emails to groups and forums to see if I could advertise my research flyer often entailed giving a little information about my transsexual background and stage of transition, as it would be for any transsexual or transgender person who wanted to become a member. This helped to establish some authenticity about my identity, as did having my photo on the research flyer. It is interesting to add that during two interviews with transsexual participants I was asked if I used to attend the weekly social evenings run by a transsexual support group in ‘The Village’,

a term used for an area around Canal Street in Manchester known as the ‘Gay Village’. One participant asked at the beginning of the interview *“your face looks awfully familiar. I have seen you somewhere. Did you used to go to the support group in Manchester?”* (Women with a transsexual background aged 60-69). Another participant half way through the interview suddenly said *“I have been sat here the last few minutes thinking I am sure I have met you before, but I can’t think where?”* (Transsexual woman aged 40-49). It transpired that they had both attended the same support group in Manchester, a couple of years earlier when I had attended on the same occasion. Having a perceived shared identity with me as an insider researcher put participants at ease, and so they felt more able to be open in their responses.

The subjectivity and position of the researcher can be addressed through the process of reflexivity (Goodley, 1999). Paechter (1996 cited in Goodley, 1999) suggests that reflexive accounts in research studies seem to be mainly written by three main groups. These are “established researchers looking back on mistakes they are assumed to have learned from, PhD candidates writing methodological appendices, and action researchers” (Paechter, 1996: 92 cited in Goodley, 1999: 26). Paechter (ibid) criticises the use of reflexive accounts in research studies as predominately written by the least powerful people in the research community. I feel Paechter’s criticisms of reflexivity, have to be taken into context, as they are seventeen years old and clearly, as this literature review has identified, there are many social researchers that are now using reflexivity within their research studies, for example Kanuha (2000) and Paxton, Guentzel and Trombacco (2006). Goodley (1999) suggests that “reflexive accounts expose some relationships between the position of the researcher and the research culture that is under investigation” (Goodley, 1999: 26). The use of reflexivity for Al-Makhamreh and Lewando-Hundt (2008) helped to give them additional meanings to the data. An insider researcher does not have to influence the research study in a negative way.

The researcher needs to ensure they use detailed reflection on their subjective position, and personal biases to reduce the disadvantages, or potential disadvantages, associated with insider research (Dwyer and Buckle, 2009). Fetterman (1989 cited in Hewitt-Taylor, 2002) suggests that “research of any kind is subject to bias, and that making the potential biases of a study explicit can, to some extent, mitigate against their effects on the findings” (Fetterman, 1989 cited in Hewitt-Taylor, 2002: 34).

The reflexive nature of the research process can be both therapeutic and empowering for the research participants. As I was asking questions on transsexual participants’ lives before they started the transition process, during and after the transition, this was a natural process for the participants to be reflecting on their experiences. This was certainly the case for some transsexual participants, who saw the interview process as an opportunity to reflect on how far they had come with the transition process, and to some extent reevaluating their identity, experiences, and recognition of some of the oppression they may have faced in the past.

*“Actually, looking back now I can see how far I have come with all the changes in my life during the transition process. I guess you could say I am now in a place where I am settled with who I am.”* (Trans woman aged 50-59).

*“I think I have a lot of confidence now when I’m in public. When I started this journey I suffered quite a bit of verbal abuse, but now I have very little. I don’t know if this is due to me having more confidence in my appearance in public or whether it is due to greater levels of acceptance of transsexual people by the general public.”* (Woman with a transsexual background aged 30-39).

### *Empowering research participants from minority communities*

Participating in socially responsible research may help participants from minority communities to become more empowered. For example through the research process they may become more aware that some of their emotional distress is not due to them having some personal weakness, but rather related to oppression from wider society (Moane, 2008). As Moane (2008:140) suggests “Participants can realise that they can shift the dynamics of oppression in their own lives through a variety of actions. This could be in reading and education and getting involved in political activism.” If a researcher works in partnership with research participants from a minority community, then they may help to assist in uncovering the narratives that will help to release the internalised power within the minority community (Tully, 2000 cited in Craig, Tucker and Wagner, 2008). Socially responsible research undertaken with minority communities, “can help to build knowledge about these marginalised or ignored groups as well as using research for programme improvement and organisational learning about the best way to deliver services” (Meezan and Martin, 2003: 12). Hash and Cramer (2003) suggest that minority community participants can show a great deal of interest in how the research findings are presented, and who will have access to them. For example in Hash and Cramer’s (2003) research study, some respondents wanted the findings to be available to health and social care professionals to affect changes in service provision and greater awareness and empathy of their community. Other community members hoped the research findings would be available to others within their own community who were going through similar experiences (Hash and Cramer, 2003). Wheeler (2003) suggests that researchers working with minority communities should consider trying to publish their research findings in a local community newspaper, as well as in academic journals, as this can help to raise awareness of issues within the community (Wheeler, 2003).

However, I was slightly surprised at this suggestion by Wheeler (2003). Even though confidentiality will have been assured, depending on the sensitivity of the issues being researched, a small close knit community may be able to make assumptions about who has said what in the research study. This could lead to disruption and arguments in the local community.

As a social worker I work in partnership with service users and have empathy for their feelings and situation, whilst having some control over my own feelings. Also, within my working capacity as a social worker, I am required to use reflective practice to reflect on my own professional practice to ensure I learn from my experiences and am open to new ideas and ways of thinking (Thompson, 2005). Reflexive thinking “requires us to consider how power is exercised in the knowledge-making process in which we engage. Furthermore, locating ourselves within these operations of power is seen as an intensely moral action.” (D’Cruz and Jones, 2007: 11). These social work values and practices that inform my practice when working with service users have also been used in the interactions I have had with the research participants in this study. I would agree that this is a particular advantage when researching one’s own community. It has enabled me to have empathy with my research participants, especially in relation to sensitive issues, whilst ensuring I was able to distance my own personal feelings. Furthermore, any research participants’ experiences that evoked feelings of similar experiences I have had during the transition process, enabled me to work through them by using reflexive practice.

When I had finished each interview I would as soon as possible write some reflective notes on how the interview had gone, identifying any emerging themes, and any issues that had not been mentioned before. I would also write down anything that made me reflect on my own

transition. Although everyone's experiences are different, there can be some similarities in experiences. Therefore as a woman with a transsexual background, and regarding myself as an insider, there were occasions when something mentioned in an interview would make me reflect on my own transition. This is reflected in the following diary entry of mine from the research study.

*'The research participant felt that she didn't have social recognition in general. She thought that women in general could accept her as a transitioned transsexual woman, but when it came to wanting things such as social recognition as a woman who had a desire to start a family and wanted to conceive a child then this was looked upon very negatively. Therefore to some extent there is recognition of coming under the banner of 'woman', but not necessarily acknowledgement of having the same levels of shared needs, feelings, emotions and rights under that category that biological women have. I may need to explore this issue further although realistically this may not be the place for it to go into any great detail, but certainly it is an issue that may need further investigation in any future research that I do. This highlights the grades of gender identity, social recognition and legal recognition that transsexual people can experience. Interestingly the participant's feelings around this issue were often laughed at by fellow people who had transitioned and were friends of hers. These feelings of wanting children do resonate with my own feelings of wanting to have children and the sadness it causes me to know that I can never conceive or give my partner a child in that way, although I may be able to foster or adopt in future. This is certainly an issue for future research into transsexual people's needs for adoption, fostering, and the psychological and physical distress of not being able to conceive or conceiving before starting hormones during your transition process if you are a woman who wants to transition to be legally and socially recognised as a man.'* (Thursday April 2011).

Godley (1999: 43) suggests that “critical reflections on subjectivity permits us to at least start unpacking the aims, directions, and findings of research and the researcher’s role in their creation.” This was certainly the case for me, as was reflected in the following diary entry.

*‘I thought the interview went really well today with the healthcare professional. Considering I had not anticipated interviewing health care staff at the beginning of this study, I found this to be a rewarding process for collecting rich data on their experiences of working with transsexual patients. By interviewing staff I will be able to examine with the adaption of Frank’s (1991) theory of the body, the complex interactions of the transsexual corporeal body, social discourses and institutions on those interactions staff have with transsexual patients. The two main issues that were raised from this interview were the practicalities and issues of writing file notes in transsexual patients’ files and sending out letters for appropriate screening programs. I found it encouraging that the health care professional wanted to help transsexual patients and didn’t want to offend them by writing inappropriate words in their files. However, this raises issues for healthcare services to be able accommodate the transsexual corporeal body within their institutional systems and practices. It also highlights the need for training in relation to staff being able to talk openly and comfortably about sensitive issues with transsexual patients .This is also an example of the impact social discourses can have within a medical institution on the quality of care given to a transsexual patient.’ (Wednesday February 2011).*

There were also times when what was mentioned in the survey or interviews would also make me reflect, not as a researcher, but as a woman with a transsexual background who was also a user of health care services. This can be seen in the following reflective diary.

*‘Is it down to us (transsexual people) to take responsibility for our health care needs and where necessary to educate health and social care professionals about the issues we can face*



*when accessing their services? Whilst health care staff may be more comfortable and educated about the needs of transsexual people in some practices, their administration systems and health care models of creating services on a bulk perspective are clearly still inadequate to cope with transsexual people's information and individual medical needs in relation to the health services they presently provide.'* (Saturday February 2011).

The use of a reflective diary was an important part of the research process as it enabled me to reflect on how the research was going, the main issues of the study, and any new questions I needed to be asking. This is discussed in the following reflective diary entry of mine.

*'I need to make sure I keep writing these reflective dairies. They are important for helping me to reflect on the main issues that come up during interviews and my own thoughts after the interviews. This process helps me to plan for any new questions that I want to ask in future interviews or topics for further research projects in the future. These documents will certainly be an important source of information when I come to write up my thesis, as they will help to show the things I was thinking about during the research process, my values and ethics, how the research progressed and any new developments to the issues and research questions I want to ask.'* (Monday April 2011).

The insider researcher is also likely to have personal insider knowledge that can provide a sense of the social dynamics of their minority community (Dunne, 1997). For example "knowing where the formal and informal gathering places are, and a greater sensitivity to the diversity of the social circumstances of the community" (Dunne, 1997: 79). Dunne (1997) suggests that the insider knowledge she had of her local community's history and politics was appreciated by her respondents.

Even though a researcher may be from the community they are studying, the process of conducting the research places them in the position of 'other'. Therefore it is essential that they acknowledge this, as it keeps "researchers more objective and reminds them that membership in a group does not give them carte blanche for accessing that group for research purposes, nor does it guarantee the development of a productive working relationship with its members" (Wheeler, 2003: 67).

The insider researcher may have greater awareness of the different sub groups within the minority community that they belong to. For example Meezan and Martin (2003) suggest that often outsider researchers studying the lesbian, gay, bisexual and transgender populations (LGBT) "can make the assumption that they are monolithic, which is clearly not the case as there are many sub groups within the (LGBT) populations" (Meezan and Martin, 2003:7). This was something I was well aware of within my own study, and the research methods I chose, as will be discussed in detail later in this chapter, assisted me in gaining a wide variety of participants from the transsexual community.

Elze (2003) suggests that often research studies on LGBT issues will use small samples which do not include many of the sub groups within these communities. However, this is not to say that research studies carried out by an insider researcher will include all sub groups of a population, just that the insider is more likely to be aware of the different sub groups within their own community. Sullivan and Losberg (2003) mention that there can often be difficulties in creating research samples that are representative of all sub groups within a minority community. This can be especially true in relation to the bisexual and transgender populations who can be hard to locate, and difficult to engage in research studies (Hash and Cramer, 2003; Wheeler, 2003 cited in Meezan and Martin, 2003). Sullivan and Losberg

(2003) suggest that research studies involving the LGBT communities are often inconsistent when reporting details about their research samples, which makes it difficult to compare samples. Wahler and Gabbay (1997 cited in Sullivan and Losberg, 2003: 159) suggest that researchers often join together LGBT communities for the purpose of social research. This can be “both artificial and misleading. Joining them under one umbrella of research... has the effect of diluting our understandings of each and trivializing the experiences of all four communities.” I would argue that this is also the case when you consider studies such as Whittle et al., (2007) who include many of the sub groups within the transgender and transsexual community, and then provide findings that combine them as a collective. This is precisely why my study has focused on one specific sub group, that being transsexual people who want legal recognition as a man or a woman. No other studies within the literature review were found to be based on just this specific sub group.

Sullivan and Losberg (2003) recommend that all researchers should give a full account of how the samples were chosen, and acknowledge any potential sampling bias (Sullivan and Losberg, 2003). That is precisely what this thesis has done by giving a clear account of the sampling process, its successes, and its failings. Gibson and Abrams (2003) suggest that diversity exists within minority communities, therefore it is important that the researcher does not make generalisations about the research participants’ lives and needs to probe to ensure they uncover the participants’ life experiences (Gibson and Abrams, 2003).

Dunne (1997) mentions that her insider knowledge of the diversity of sub groups within her community was vital in helping her to select a sample for her research study (Dunne, 1997). The prior knowledge she had on the politics and tensions within her own community enabled her to organise a joint get together of people from the different sub groups. This helped to

“reduce the tension between lesbian feminists, who emphasised consciousness raising and women’s movement politics, and less political lesbians, whose concerns related more to the availability of more light hearted social get togethers” (Dunne, 1997: 25).

Ghorashi (2005) discusses her somewhat in between position as both an insider and an outsider researcher. She mentions how her position as an ex-political Iranian activist, now in exile, has contributed considerably to her research study on Iranian women in exile living in the Netherlands and United States. The use of reflexivity enabled her to create space in which to explore the issue of positioning. This included issues of identity, home, and belonging, not only as a researcher, but also as a woman in exile (Ghorashi, 2005). She suggests that she wanted to present her research in a way that not only allowed space for her emotions, but also allowed the reader a window into her personal background as a researcher and activist. The life stories of her research participants affected her deeply, and she would often relive her own experiences that she had in common her participants, what she termed the ‘mirroring effect of life stories’ (Ghorashi, 2005). This had the affect of blurring the boundary of the self and other at times during the research process for her. Even though Ghorashi (2005) found this process distressing, she believed that this was necessary as it helped her to become aware of the different identities she brought to the research process, and how this may enrich her research. Using reflexivity had enabled her to reflect on those intense emotional moments she had experienced. This gave her the strength to deal with the difficulties of her research, and also helped her to deal constructively with her own past (Ghorashi, 2005).

There can be a tendency for the research issues evoking an emotional response from the insider researcher due to them being more aware of those issues, and more likely to be sympathetic. This is likely to make the researcher reflect on how they were affected and dealt

with those issues for themselves in the past. For example Dunne (1997) discusses how the issues raised by research participants during interviews about certain aspects of their lives, would often make her reflect on past memories of similar issues she had experienced (Dunne, 1997). This at times left her emotionally and intellectually drained. However this also led for her to greater reflexivity and re-evaluation of interview transcripts. Dunne (1997) believed that the emotional relationship she had with the research study did not discredit its credibility. Instead she states “it forced me to work harder, to immerse myself further in the data, and to probe and question the accounts more carefully” (Dunne, 1997: 32). The similarities Dunne (1997) shared with her research participants often led to ‘counter-transference.’ This is when “emotions are evoked in the field worker whilst listening to respondents’ accounts of their own lives” (Warren, 1988 cited in Dunne, 1997: 32). Although this can happen to an outsider researcher as well, the literature examined in this section so far would suggest that there is an increased likelihood of the research issues evoking an emotional response from the insider researcher. This may be due to the insider researcher being more aware of those issues that participants can face and thus they are more likely to be sympathetic towards them. It is also another reason why reflexivity is important within the research process, as this may help the researcher to reflect on how they themselves were affected by those similar issues in the past, and how they dealt with them. This can help them to be more knowledgeable of the possible causes of those issues the participants are experiencing, and thus may influence the questions they ask related to those issues.

The use of peer debriefing could help guard against bias and can help the researcher to become more aware of their personal feelings, or the generalisations they make before, during, and after the research process and analysis of their research findings (Lincoln and Guba, 1985; Padgett, 1988 cited in Lasala, 2003). Van Heugten (2004) mentions that she

used a tape recorder to interview herself about her research experiences, and spoke to her supervisor and others about those experiences. She found this process useful for helping to distance her from her research position. However, I would argue that there is a danger that the researcher can get preoccupied with reflecting on their own position within the research process, rather than the purpose of the study. For example White, (2001 cited in Van Heugten, 2004: 207) states that “there is, indeed, a danger that we learn little about what is claimed and a great deal about the struggles and torments of the researcher.” Another advantage of using peer debriefing is that, if the researcher interviews participants more than once, then any initially neglected areas may be detected by peer debriefing, and the researcher can discuss those areas with participants in future interviews, thus providing richer descriptions of participants’ experiences (Lasala, 2003).

Hodkinson (2005) suggests that in the presence of someone who they perceive to be informed about their community and an insider, participants may be more likely to give more accurate information. Whereas, “it may be particularly easy for respondents to make exaggerations, omissions, guesses and throwaway statements in the presence of a relatively ignorant professional stranger” (Hodkinson, 2005: 140).

Although the work of Bartunek and Louis (1996) mentioned in the literature review suggested that often it was likely that an insider researcher would not have had the opportunity of a university education, and thus would not have had the researching skills that an outsider researcher would usually have had. This is clearly no longer the case. As recent studies in the literature have shown, university educated insider researchers who have had training in research methods are now present in many minority communities . They may be in smaller numbers than researchers from wider society, but they have the same research skills

that a non minority researcher has. It can also be the case that an insider researcher may belong to more than one minority community, for example, the research could be a black lesbian women or a disabled transsexual woman. Thus the researcher could have personal experiences and knowledge of not just being a member of each community, and the issues and oppression each community faces, but can also have unique experiences and knowledge of being a black lesbian woman or disabled transsexual woman, and what that means to their experiences and inclusion within each community.

The literature mentioned in this section of the literature review would suggest that there are issues for the insider researcher and those participating, or thinking about participating, in research to consider, such as confidentiality, researcher's self awareness, and the potential for dual relationships. It is also important that the insider researcher reflects on why they are doing the research in the first place; what purpose the research findings will hopefully be used for; how the published research finding will affect their position within the minority community afterwards. However, there are steps insider researchers can take to strengthen their position within the research process, reduce researcher bias, and to help to minimise issues for themselves and their research participants. For example, the insider researcher can strengthen their position in the research study by using peer debriefing. This can help the insider researcher enormously to reflect on their position within the research process and to help them become aware of issues they previously did not consider discussing with research participants in the interview situation.

There are now many social researchers that are using reflexivity within their research studies, for example, Dunne (1997), Simmons (2007) and Kanuha (2000). Reflexive accounts expose some relationships between the position of the researcher and the research culture that is

under investigation. Reflexivity can also help to give the insider researcher additional meaning to their research findings. The researcher needs to ensure they use detailed reflection on their subjective position and personal biases to reduce the disadvantages, or potential disadvantages, associated with insider research, and this can help to strengthen their position within the research process. However, as the literature has shown in this section, whether the researcher is an insider or an outsider, their research can be subject to bias. Therefore this would suggest that making their subjective position clear in the research findings may help to reduce researcher bias and increase the validity of their research findings.

The studies mentioned in this section so far, would suggest that there are many advantages in being an insider researcher. For example some of the advantages include participants may feel more comfortable; insider knowledge of the recent history and social dynamics of the community; higher levels of trust; greater awareness of the sub groups within the community; may create questions that might not occur to an outsider researcher. There are many ways that the insider researcher can enhance understanding in relation to their own community that may not be accessible to a non insider researcher.

The insider position the researcher has within their minority community can also cause issues for keeping clearly defined boundaries regarding the researcher and researched relationship. For example Kanuha (2000) and her partner were invited to dinner by one of her research participants. Although it was culturally important that her and her partner accepted the invitation, she was aware of the methodological reasons why she shouldn't accept the invitation as a researcher (Kanuha, 2000). However Kanuha (2000) was also aware that due to the sensitive nature of her research, that this was the most appropriate way to conduct the research within her minority community. During the research process Kanuha (2000) became



aware that some of the traditional guidelines on researcher and researched relationships were not always appropriate or effective when conducting research (Kanuha, 2000). As Kanuha (2000) states “as reported by many ethnographers, the relationship between the researcher and the researched are not always fixed or well demarcated as we are sometimes led to believe by more objective methods” (Geertz, 1973; Harry, 1996; Lincoln and Guba, 1985 cited in Kanuha, 2000: 443-444). Lasala (2003) suggests that it is important for the researcher to evaluate whether accepting an invite from a participant would benefit the research study, but at the same time, if they do accept they need to make it clear that they are still keeping the relationship as researcher-researched, and not leading the participant to believe they are becoming friends (Lasala, 2003). This would suggest that an insider researcher needs to reflect on what are the strengths and weaknesses of the researcher and researched relationship within the context of their own culture, and how this can be best utilised to gain data for their research question.

Certainly within the research process of my own study there were two occasions when I was offered the opportunity to have lunch with research participants I was interviewing. On the first occasion I was travelling from Hull in East Yorkshire to a safe house for transgender and transsexual people in Rhyl, Wales. This was firstly to interview one of the owners of the safe house, who was herself a woman with a transsexual background. Secondly I wanted to visit the safe house and find out more about this important service. Because of the long distance I would be travelling, her and her partner had kindly offered me the opportunity to have a buffet lunch with them. I gracefully accepted this kind offer of hospitality and also considered it to be a further opportunity to gain information from them both about their experiences. This was also a good opportunity for them to find out a little more about me and

my research, which helped to reassure them about the purpose of my research, and to some extent, some similarities in a shared identity and background.

The second occasion I was offered the opportunity to have lunch with a research participant, was when I had interviewed her in a public house, which she had chosen to be interviewed in. After two hours the interview was coming to an end and the research participant told me that her friend would be joining her shortly to have lunch in the public house and would I like to join them. I politely declined the offer, as I thought that I had taken up enough of her time already and that this was a good time to bring closure to the interview. I would agree with Lasala (2003) that it is important for the researcher to evaluate whether accepting an invite from a participant would benefit the research study, as it had done in the example I gave above when I had lunch with the participant and her partner.

Lasala (2003) suggests that because the insider researcher and their participants share similar characteristics and experiences, the researcher “might be tempted to develop social or even sexual or romantic relationships with certain respondents” (Lasala, 2003: 23). Zinn (1979 cited in Lasala, 2003) suggests that it is quite common for participants to invite the researcher to overstep the boundaries of their researcher- researched relationship (Zinn, 1979 cited in Lasala, 2003). Therefore it is important that the insider researcher makes it clear to participants that becoming involved in personal relationships could jeopardise the validity of the research study.

Asselin (2003 cited in Dwyer and Buckle, 2009: 58) suggests that role confusion can happen in any study, but is more “likely when the researcher is familiar with the research setting or participants through a role other than that of researcher.” The insider researcher’s judgements

may be misguided by their own personal experiences, and because they are a member of the community being studied, they may have trouble separating it from those of the research participants'. Therefore, there can be a risk that the research interviews will be guarded by the researcher's own experiences and not those of the researched (Dwyer and Buckle, 2009). There can also be a risk that the researcher's experiences "might affect the analysis, leading to an emphasis on shared factors between the researcher and the participants and a de-emphasis on factors that are discrepant or vice versa" (Dwyer and Buckle, 2009: 58).

Kanuha (2000) suggests that insider researchers may find it difficult initially during the interview process to focus on interviewing their respondents, because they can get distracted by reflecting on their own experiences of similar events that are raised by the research participant (Kanuha, 2000). Therefore it is important that the researcher uses reflexivity to work through those issues that caused them to become distracted. Kanuha (2000) an insider researcher, discusses how by trying to distance herself emotionally during the research process to prevent being distracted by shared experiences, she actually neutralised those benefits of being an insider researcher (Kanuha, 2000). For example by being preoccupied with distancing herself from the personal self during the research process to try and achieve scientific objectivity, she was actually "distancing herself from the process of the research and the ability to attain 'thick' descriptions of complex phenomena" (Kanuha, 2000: 442).

There may be greater expectations from members of the community that the research will benefit them in some way as the researcher is from their own minority community, which can put the insider researcher under more pressure for the project to be a success (Dunne, 1997). Simmons (2007) warns that insider researchers need to consider the impact their position within the research process will have on future relationships within their own community

after the research study is over. This again raises the issue of using reflexivity before, during, and after the research process to analyse the reasons for doing the research in the first place and what is intended to be done and achieved with the research findings. Certainly within small knit communities there could be tensions between the researcher and those in the community who disagree with the research findings, or how they have been portrayed within them. This does suggest that enabling research participants to comment on the research findings can help to clarify issues or misinterpretations before the findings are published. However this needs to be balanced with the possible gains for the community as a whole. Therefore it may be necessary to publish research findings that discuss sensitive issues, in order that a public debate on these issues can proceed. These are concerns every researcher needs to reflect on whether they are an insider or an outsider researching any community, group, or individual.

### **The disadvantages of being an insider researcher**

Desai (2002) suggests that “sometimes an outsider can find it easier to address controversial or sensitive topics or to play the role of the ‘professional stranger’” (Desai, 2002: 1). However no matter what the background of the researcher, it is important that they are knowledgeable about the community understudy, in order to avoid producing a superficial interpretation (Desai, 2002). The outsider researcher may be better positioned to “bring to the surface taken for granted meanings, which tend to be assumed and then glossed over when the interviewer and interviewees are from the same culture” (Rubin and Rubin, 1995 cited in Sands, Bourjolly and Roer-Strier, 2007: 355).

The previous experiences, interactions and opinions of associating with different groups and identities within the community may colour the insider researcher's judgement on who to include in a sample. For example Paxton, Guentzel and Trombacco (2006) were an insider and outsider research team consisting of one male to female transsexual and two biological women, one of whom was an African American, who were studying a local transsexual community. The male to female transsexual researcher was the only one to choose who from her community would attend the first meeting. The male to female transsexual researcher had not invited any female to male transsexuals, because she felt their issues were different to male to female transsexuals, and her previous experience of them had shown that they were less likely to want to be involved in research studies (Paxton, Guentzel and Trombacco, 2006). This highlights that the male to female transsexual's judgement had been coloured by her interest in studying the issues facing male to female transsexuals. It is interesting to add that the two biological women researchers had previously only focused on studying women of colour, and they had not even questioned the fact that no men had been invited to the meeting until the group of participants mentioned it (Paxton, Guentzel and Trombacco, 2006). This suggests that the researchers needed to reshape their focus to be more inclusive of transsexual men. The transsexual community share many similar issues with other minority communities, for example, wanting to be heard and acknowledged by wider society. Therefore it is quite surprising that the insider researcher did not want to include all sub groups within the transsexual community in the research study, to ensure that their opinions were heard. This highlights the problems that can arise from relying on one person who gives you entry to a particular minority community. Paxton, Guentzel and Trombacco (2006) suggest that even though one of them was an insider researcher, this did not mean that she faced the same issues facing all individuals within the transsexual community. It is a common misconception amongst outsider researchers that one individual can speak for the whole

minority community (Paxton, Guentzel and Trombacco, 2006). One of the biological women researchers who was an African American, needed to be more aware of her bias towards African American transsexual females. This was because she shared their culture and was interested in improving research among African Americans (Paxton, Guentzel and Trombacco, 2006). This suggests that different parts of a person's identity can become the focus of research and a shared identity.

Paxton, Guentzel and Trombacco (2006) suggest that several different types of people may be needed from a minority community to ensure full access to that community. However this would add further support to studies such as Sullivan and Losberg (2003) and Berg, Mimiaga and Safren (2008) who suggest that there is a need for improved samples when undertaking research with minority communities (Sullivan and Losberg, 2003; Berg, Mimiaga and Safren, 2008). A comprehensive sample of different sub groups is something that this thesis has strived to achieve.

Paxton, Guentzel and Trombacco (2006) suggest that often the transgender community is seen as one whole group by outsider researchers. However this community can consist on many sub groups, for example, transvestites, cross dressers, pre op transsexuals and post op transsexuals. These groups may or may not come together for political activism or to regularly meet socially (Paxton, Guentzel and Trombacco, 2006). Therefore, an outsider researcher, or an insider researcher, needs to be careful not to make assumptions that all sub groups have shared issues, nor that all individuals within a sub group have the same issues.

Lasala (2003) and Hodkinson, (2005) suggest that even though the insider researcher may be able to establish a good rapport with participants fairly quickly in comparison to an outsider

researcher, interviewee reactivity is still a possibility. For example a participant may be fearful that the researcher will use the information they provide to gossip about them (Aguilar, 1981 cited in Lasala, 2003). Laslett and Rapport (1975 cited in Lasala, 2003: 21) suggests that participants may “also be reluctant to admit vulnerabilities or difficulties to a member of her/his group for fear of ‘loss of face’ or because they want to put forth ‘the best face’ possible.” Some research participants may notice differences between themselves and the researcher, such as economic status and therefore not regard the researcher as a true insider (Lasala, 2003). This could lead some participants to not fully trust the researcher, because they may feel they have joined the dominant group within society by becoming a social scientist and have therefore gained a social position that is less oppressive (Lasala, 2003). Lasala (2003) also suggests that some research participants may also want to impress the insider researcher, because they see them as having higher status within their minority community and may therefore give “socially desirable, rather than honest, responses, which could bias respondents’ reports.” Therefore, being suspicious or fearful of the insider researcher’s position within the community, or wanting to impress them, could lead to some respondent’s interview responses being biased. This could compromise the reliability of the data and the insider researcher’s interpretation of the research findings (Meezan and Martin, 2003).

Kanuha (2000) suggests that insider researchers may find it difficult initially during the interview process to focus on interviewing their respondents, because they can get distracted by reflecting on their own experiences of similar events that are raised by the research participant (Kanuha, 2000). Therefore it important that the researcher uses reflexivity to work through those issues that caused them to become distracted. Kanuha (2000) an insider researcher discusses how, by trying to distance herself emotionally during the research

process to prevent being distracted by shared experiences, she actually neutralised those benefits of being an insider researcher (Kanuha, 2000). For example by being preoccupied with distancing herself from the personal self during the research process to try and achieve scientific objectivity, she was actually “distancing herself from the process of the research and the ability to attain ‘thick’ descriptions of complex phenomena” (Kanuha, 2000: 442).

The disadvantages of being an insider researcher examined in the literature in this section have suggested that, previous experience with the community can colour the insider researcher’s judgement on who to include in a sample; participants may be fearful or suspicious of the insider researcher, and participants may have higher expectations for the research outcomes. The literature would also suggest that there are still some researchers who question the insider’s position within the research process in relation to such issues as objectivity, and the inclusion of the researcher’s subjectivity within the final published report. Dwyer and Buckle (2009) mention what I feel should be the main goals of any research, be it researching a community, or individuals. They state that “the core ingredient is not insider or outsider status, but an ability to be open, authentic, honest, deeply interested in the experiences of one’s research participants, and committed to accurately and adequately representing their experiences” (Dwyer and Buckle, 2009: 59).

### ***Ethical research principles of the study***

The research abided by the ethical research principles of the Economic and Social Research Council, British Association of Social Workers and was approved by the University of Hull ethics committee. Social work research principles are similar to those for social work practice. For example they emphasise social justice, partnership and empowerment, which are all emancipatory values (Thompson, 2005). Some of the main principles which inform social



work research include, establishing a partnership between researcher and researched, respect for human dignity and worth, empowerment, and working together with disempowered groups and communities to achieve research agendas that respect human rights and aim for social justice (British Association of Social Workers, 2002; D’Cruz and Jones, 2004; Brown, 2005). Some of the ways in which social work research can contribute to informing professional practice which are important to the aims of my own research include, finding less oppressive ways of working, influence policymakers, give oppressed groups and individuals a voice (D’Cruz and Jones, 2004). All of which I have aimed to do. Where I have used direct quotes within some chapters to highlight people’s experiences, participants’ names and identities remain confidential. It is important, I would argue, to use research participant’s own words at times, as this helps to not only show respect for research participants, but also helps to express the individuality of experience that different members of the transsexual community can have when accessing health and social care services.

The research involved participants over 18 years of age. I obtained written consent from participants for the research. Due to the research asking some questions of a private and sensitive nature the following was in place to manage the perceived risk:-

1. Participants could refuse to answer any questions.
2. Participants could stop the interview at any time to take a break or finish the interview completely.
3. Research participants were given an information sheet on transgender support groups.

Research participants were informed in writing and verbally before individual interviews started that, if they disclosed anything to me during the interview process that I felt may put them at harm, or another person at harm, then I had a duty to report that concern to the

relevant authority. This is because, as a responsible social researcher, I had to retain a primary concern for the welfare of research subjects and protect them from harm. The measures that were in place for dealing with this risk are as follows:-

1. Inform my supervisors.
2. Inform the relevant authority or agency.

The following measures were in place to help minimise risk to myself :-

1. My supervisors were given a list of my research participants names, where I was interviewing them and the date and times of interviews.
2. I texted my supervisors after interviews.
3. I would discuss with my supervisors any issues, thoughts, or feelings I had about my position within the research process, or concerns I had about the research.

### **Section Two: The three phases in the research design**

The empirical findings that are discussed in chapters 4, 5 and 6 in this thesis, document the impact that research participation had on the transsexual participants and highlights the vulnerability of some participants in the early stages of the transition process. Therefore, for some participants, being able to choose how they participated helped to protect their vulnerability, whilst at the same time, enabling them to express their experiences of their own transition process and accessing health and social care services. The use of a survey, semi-structured interviews, and a focus group for this study were important to its success in attracting participants from the different stages of transition. Some people who had only just started the transition process may not have been confident to meet in public and be interviewed, therefore, the option of an online survey ensured they could still participate in the research and have their say. One participant who had completed the survey did mention

that they would have liked to have had a telephone interview, but felt they wouldn't be able to go through with one because they had concerns about their voice not sounding feminine enough. This was certainly an issue that I had not given any thought to before the research process and it had not been mentioned in any of the research studies from the literature reviewed. Some participants who had initially participated in the survey, got in touch by email to say that they would like to be interviewed, as they had more to say about their experiences of transitioning and their experiences of accessing health and social care services. This, I would argue, is further evidence of the importance of using mixed research methods in order to gain a wide variety of people from a minority group, and gives potential participants some flexibility and control over how they participate in research studies.

Initially the research study was going to take place in England only for the ease and practicality of possibly accessing and interviewing research participants from the cities and surrounding rural areas of Hull, Manchester, Leeds and London. Collecting the data in those geographical areas was thought to be advantageous, as those areas had established transgender communities and local support groups. Therefore, transsexual people from outside those geographical areas, where there was a lack of support groups, would usually be prepared to travel long distances to access them, because they were well established and large numbers of people were likely to attend. It was also thought that because those cities had good transportation networks, it would be easier for those transsexual people from rural areas to be able to travel to them. The disadvantage of using those areas was that, because they had established transsexual communities and support groups, then local health and social care services may be more informed about transsexual people's needs when accessing services, compared to those health and social care services from rural areas that had little experience of transsexual people wanting to access their services. Therefore, it was important that whilst using those established communities and support groups from the cities mentioned, it was

vital to ensure that a wide variety of research participants were found, not only at different stages of the transition process, but also participants from the cities and surrounding rural areas, and those from further away. This would highlight if there were differences in the quality of care, respect, and understanding of transsexualism within different health and social care services geographically. The influence of my own subjective view as an insider has also been expressed within this paragraph, in the way that my own knowledge of the transsexual community has influenced how I originally planned to undertake the research study.

However once research flyers had been sent out to transgender support groups and internet forums it soon became apparent that there were major issues for people transitioning in Wales and the North East of England. This was partly because there wasn't a gender clinic in Wales, and the gender clinic in the North East of England was only a part time service. Therefore, the decision was made to make the research study open to all transsexual people across the UK to ensure that all voices/opinions could be heard.

Research flyers were sent to 37 transgender support groups and 6 transgender internet forums across the UK covering England, Wales, Scotland and Northern Ireland. Access to advertise the research flyer on an official LGBT armed forces forum was denied even after providing detailed information on my background, and the military history of my family. This was seen as a slight set back at the time of starting the research process as I wanted to find out the health and social care experiences of members of the armed forces who were transsexual and had, or were presently in the transition process, as they would have also used military medical personnel as well such as psychiatrists. However later in the research process I was contacted by a transsexual woman who was serving in the armed forces and shortly after I was able to interview her. This participant was using military, private and NHS medical services during the transition process, which meant that data on the experiences of using

military medical services during the transition process could be used in this thesis. This also helped to show any differences in policies, practises, and attitudes of staff between the different types of medical services she accessed.

The research study had three phases in the research design, and used both quantitative and qualitative methods, although greater emphasis was given to qualitative research methods. Leech and Onwuegbuzie (2009: 267) suggest that “in general, mixed methods research represents research that involves collecting, analysing, and interpreting quantitative and qualitative data in a single study or in a series of studies that investigate the same underlying phenomena.” I would argue that this was a useful approach to take, as when researching the experiences of transsexual people in relation to the issues I was exploring, this approach enabled me to have the opportunity to collect data from a minority community who were spread sparingly across a large geographical area. At the same time this approach helped me to gain participants from the different categories that are discussed later in this chapter, such as, age, the year participants started the transition process, the terms used to define themselves, and the country and county they lived in. Using a mixed methods approach also helped me to build on initial responses from one method, and then adapt the questions to cover new issues in the second and third stages of the research process that have been influenced by initial responses in the first research method. The research design started with an online survey, which ran concurrently alongside the sequential phases of the research design, which were semi-structured interviews, followed by an online focus group. Leech and Onwuegbuzie (2009: 267) suggest that “with partially mixed methods, both the quantitative and qualitative elements are conducted either concurrently or sequentially in their entirety before being mixed at the data interpretation stage.” The intention was to interpret the quantitative data from the survey at the beginning of the study, to shape and inform the issues and questions to be asked at the semi-structured interview phase of the research process. Thus

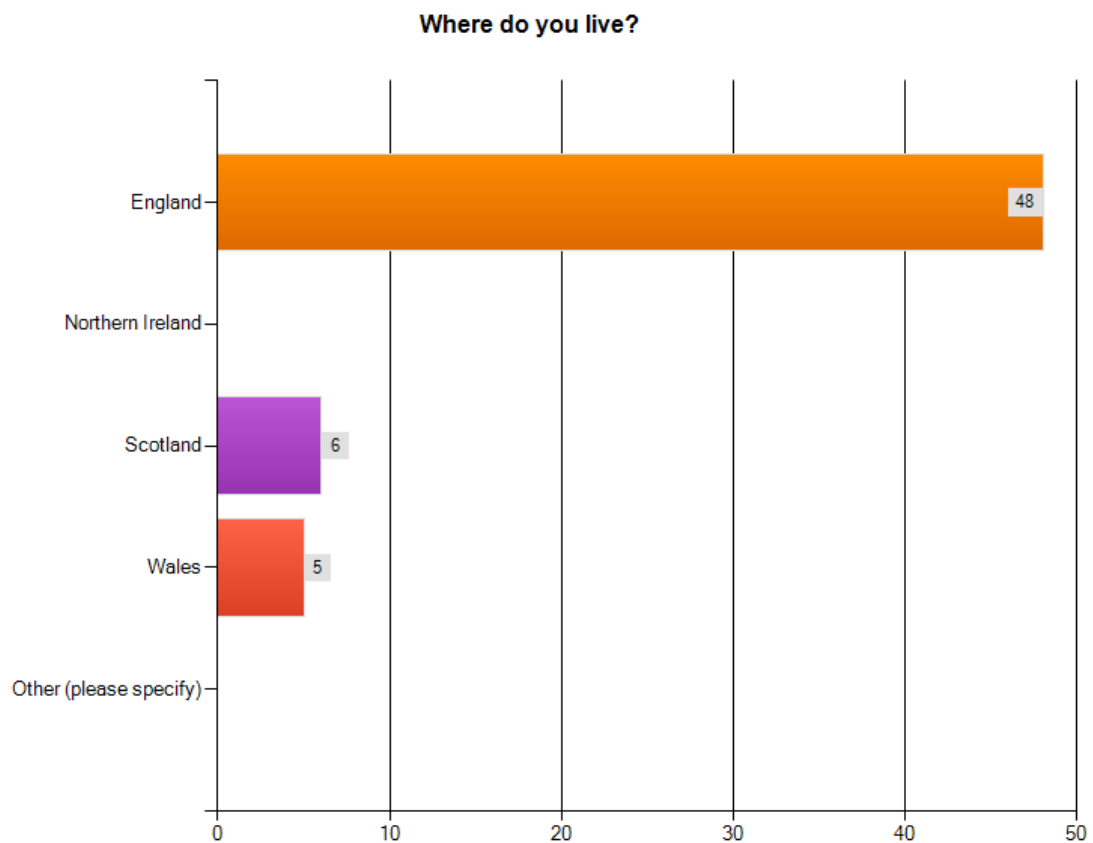
the data from the survey and semi-structured interviews played an important role in shaping and informing the topics for discussion in the focus group, which was the final stage of the research process. Mixed research methods have been utilised to answer questions in this research that could not have been realistically answered by using one method alone, for example achieving a wide variety of views and experiences on the achievability of social recognition in one's new gender at the different stages of the transition process. It was also important to use mixed research methods for this study as it gave participants choices in the way they could participate in the research. Koenig et al., (2003) suggest that when dealing with sensitive topics, qualitative research methods, such as interviews, can be an effective way of collecting data. This was exactly why I wanted to use semi-structured interviews and a focus group to enable me to effectively explore and examine the sensitive issues transsexual participants were discussing.

I will now discuss each research method in turn, starting with the online survey.

## **Survey**

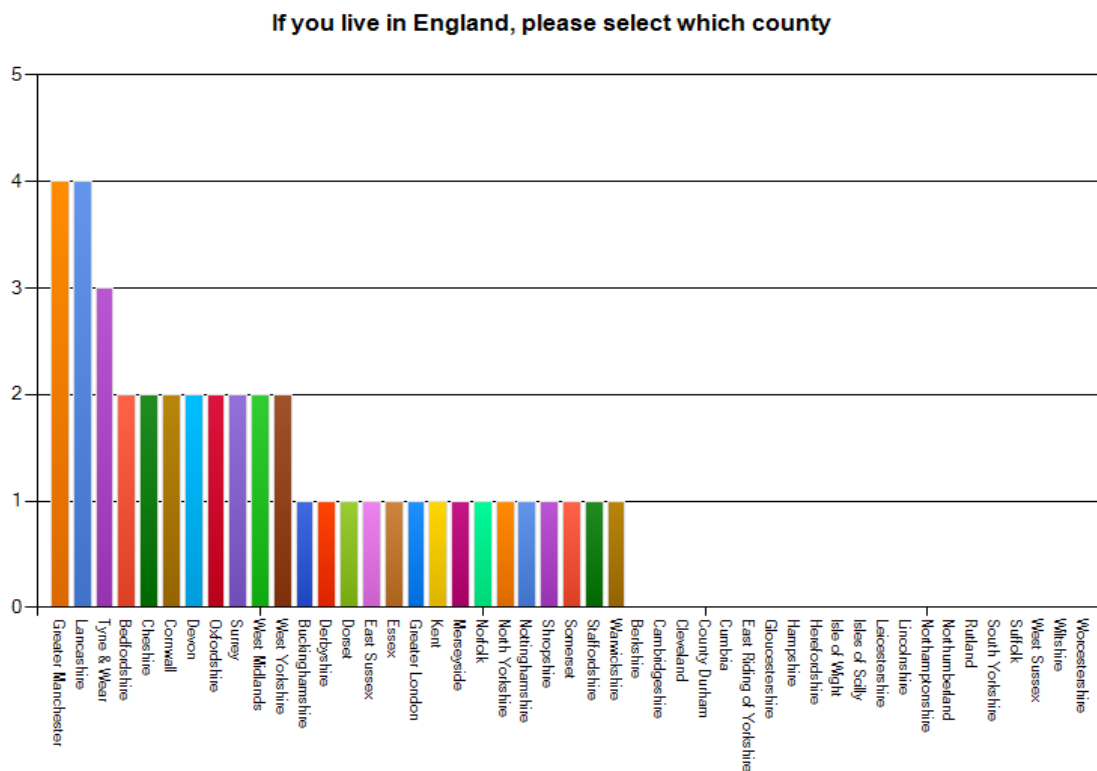
An online survey was created for the research study by using SurveyMonkey. Using this method enabled me to create a professional looking survey with ease and there was a wealth of analysis tools that I could access during and after the survey had been completed. Analysis tools that were invaluable to me included being able to draw out all the answers from individual participants, filtering responses by specific age groups, gender or sexual orientation, downloading responses, and creating various chart types including pie, column, and bar charts. Dillman (2007) suggests that the survey has gone from a face to face conversation to one that has become increasingly impersonal and one that increasingly relies on using technology to gain respondents (Dillman, 2007). Using an online survey can increase accessibility to potential participants, and can be a more cost effective way

compared with the cost associated with paper surveys, and the time needed for data entry (Dillman, 2007; Wright, 2006 and de Bernardo and Curtis, 2013). The online survey was used to obtain data from research participants from across the UK. This included research participants from those geographic areas not covered in the focus group and semi-structured interviews. *Figure 3.1* shows that using the survey research method enabled me to gain responses from 6 participants who lived in Scotland, which were not achieved by the other two research methods used. As mentioned earlier in this study, there were issues for transsexual participants in Wales because of the lack of a gender Identity clinic in that area. *Figure 3.1* shows that there were 5 participants from Wales who participated in the survey.



*Figure 3.1* shows the different UK countries where survey participants lived.

The survey also enabled me to gain participants from many of the counties in England. This was particularly important for establishing if there were any differences between areas in the quality of care given to participants. *Figure 3.2* shows that there were 3 participants from Tyne and Wear who participated in the survey. This area was singled out in the survey and in the interviews as an area of England that had major issues for transsexual people accessing health and social care services there, and in particular, the NHS gender identity service.



*Figure 3.2 shows the different counties that survey participants who lived in England came from.*

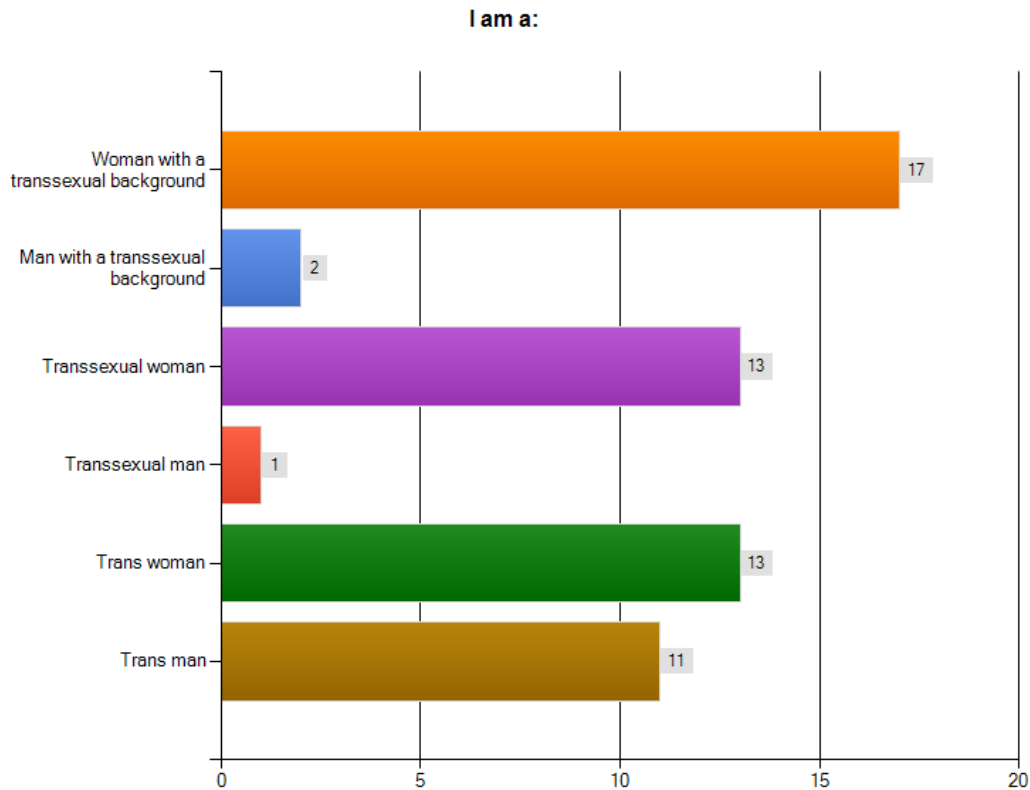
There were no transsexual participants from my own area of the East Riding of Yorkshire, as *figure 3.2 shows*, even though I had contacted a local support group in Hull. This may have just been a coincidence, but it could have also been due to me being an insider researcher. This meant that perhaps I was believed by some potential participants to be too near the local



community, which could have been an issue of trust, and a fear by them, that I may have disclosed something about them within the local transsexual community. As Lasala (2003) suggests, even though the insider researcher may be able to establish a good rapport with participants fairly quickly in comparison to an outsider researcher, interviewee reactivity is still a possibility (Lasala, 2003; Hodkinson, 2005). For example a participant may be fearful that the researcher will use the information they provide to gossip about them (Aguilar, 1981 cited in Lasala, 2003).

A total of 59 participants took part in the online survey, which consisted of 14 FtM transsexuals, 43 MtF transsexuals and 2 participants not disclosing their identity. Figure 3.3 shows that of the 14 FtM transsexuals, 11 used the term 'trans man' to define themselves, followed by 2 using the term 'man with a transsexual background' and 1 preferring to use the term 'transsexual man'. 'Trans man' was clearly the most popular term used by FtM transsexuals, especially amongst those between the ages of 18-25 (4), although it was also used by others in the 30-39, 40-49 and 50-59 age categories as well.

Of the 43 MtF transsexuals 17 used the term 'woman with a transsexual background', followed by, in equal second place, the terms 'transsexual woman' and 'trans woman' with 13 participants each. *Figure 3.3* would suggest that in contrast to the terms used by FtM transsexuals, with 'trans man' been clearly the most preferred term, the three terms used by MtF transsexual to define themselves are relatively equal in their usage across the age ranges. However as will be discussed further in chapter five, some participants tend to change the terms they prefer to use to define them as they progress through the transition process. This was not mentioned in any of the previous literature.



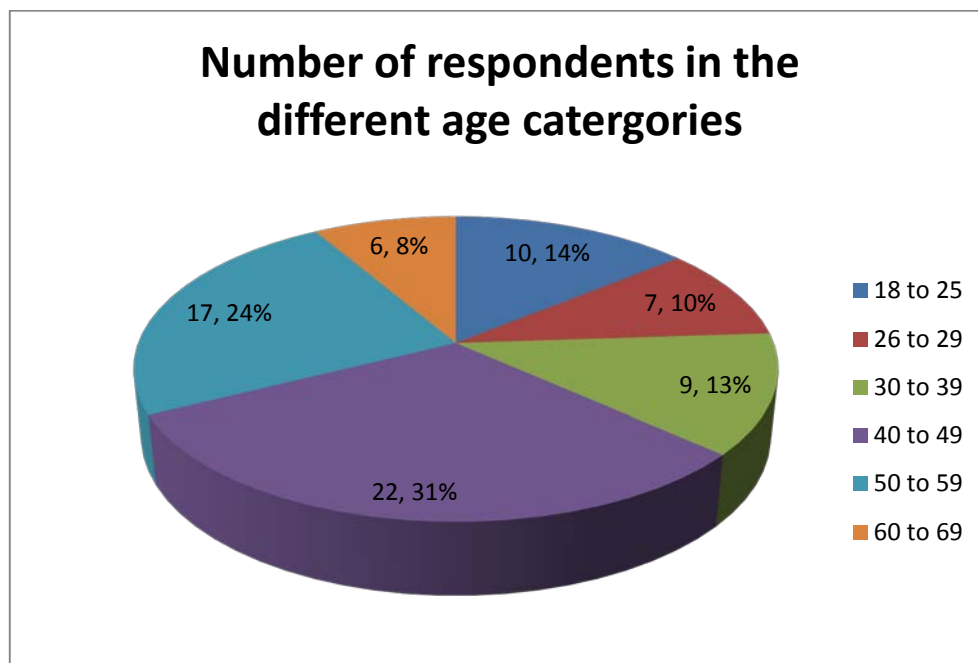
*Figure 3.3 shows how survey participant defined themselves*

This is something that needs further investigation in future research as to why FtM transsexuals tend to use the same term to define themselves throughout the transition process, whereas, MtF transsexuals are more likely to change how they define themselves by using different terms as they progress through the transition process.

This method helped to highlight the differences and similarities in the experiences of participants accessing health and social care services in different geographic areas within the UK.

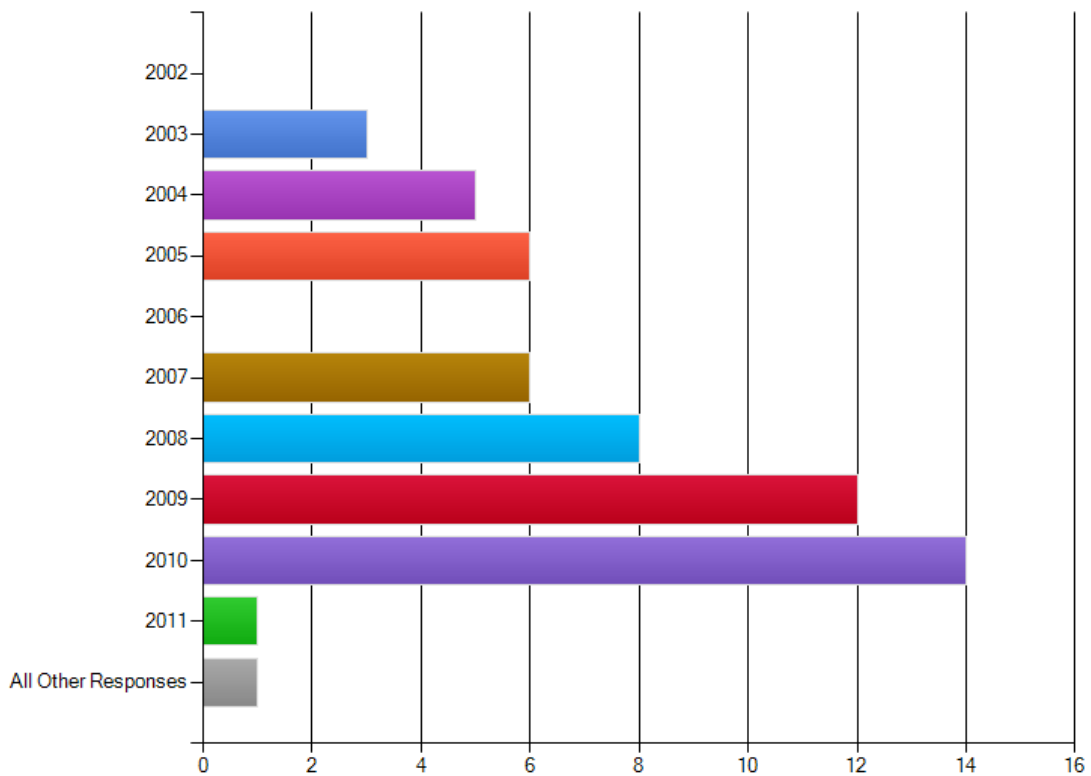
Whittle et al., (2007) suggest that the largest group of respondents in their study of the transsexual and transgender community in the UK who had transitioned permanently in the last ten years were the age group 36-40 (17.50 per cent). Whittle et al., (2007) results would reflect the results of other similar studies such as Weitze and Osburg (1996). In contrast to

this as shown in *figure 3.4*, this study had the age group 40-49 (22.31 percent) as the largest group of respondents followed by the age group 50-59 (17.24 percent). This suggests that although the average age for starting the transition process may generally be thought to be lowering in the UK, in contrast, this study would suggest that the introduction of the Gender Recognition Act 2004, and the gradual changes to attitudes towards transsexual people in wider society in the UK, has meant that many older transsexual people are now taking the option to start the transition process. This issue will be explored further in more detail in chapters five and six of this thesis.



*Figure 3.4 shows the combined figures from the three research methods for the number of respondents in the different age groups.*

**Please confirm which year you started the transition process?**



*Figure 3.5 shows the year survey participants started the transition process.*

It is interesting to add that *figure 3.5* shows that apart from years 2005 and 2007, which had the same number of participants. Year on year from 2003 there was an increase in the number of participants who started the transition process. This may be because of two reasons. Firstly, there has been an increase year on year in the number of people starting the transition process in general in the UK. Secondly, which I would argue is more plausible, is the fact that more participants came from the years 2008, 2009, 2010 consecutively, because these people are presently in the transition process, and are most likely to be accessing transsexual support groups and forums, and keeping links with the transsexual community in general, so would have been more likely to have seen my research flyer.

The charts used in this thesis so far show that the survey was successful in obtaining a diverse range of participants for the categories age, the year participants started the transition process, the terms used to define themselves, and the country and county they lived in. See appendix two for the full survey.

The second research method used in this study was semi-structured interviews, which was used in both face to face interviews and in interviews over the telephone. What follows is a discussion on the advantages of using this method, a reflective account from my research diary, and the process for recording the interviews

### **Semi-structured interviews**

Koenig et al., (2003: S43-S44) suggests that “Qualitative research can identify and describe phenomena that are not known to be important in advance of a research project, can ask questions about meanings that are not easily quantified, and in some cases may provide the background for further studies using other methods.” Semi-structured interviews were used for part of the thesis because it was considered that the flexibility of this method would help participants to discuss topics in depth relatively unrestricted. I took a passive role, only prompting the research participants when needed, to cover the sections in the interview schedule. Whilst having the interview schedule was important for ensuring all sections were covered, the method did allow participants to steer off on to other topics and issues that were not necessarily the focus of the interview topics, such as desires to conceive a child, and the interactions with police due to owning fire arms as a transsexual person. Using this method helped to obtain rich data on the interviewees’ experiences of accessing health and social care services, and the transition process more generally.

I was also fortunate to interview two health care professionals. This was not originally considered when I proposed the research. However, when they heard about my study they

wished to participate and share their experiences of working with transsexual patients. Firstly, this helped to show examples of good practice when working with transsexual patients. Secondly, this helped to draw out the challenges that the corporal transsexual body can cause for medical institution's systems and practices, as mentioned in one of my reflective diary entries -

*'I thought the interview went really well today with the healthcare professional. Considering I had not anticipated interviewing health care staff at the beginning of this study, I found this to be a rewarding process for collecting rich data on their experiences of working with transsexual patients. By interviewing staff I will be able to examine with the adaption of Frank's (1991) theory of the body, the complex interactions of the transsexual corporeal body, social discourses and institutions on those interactions staff have with transsexual patients. The two main issues that were raised from this interview were the practicalities and issues of writing file notes in transsexual patients' files and sending out letters for appropriate screening programs. I found it encouraging that the health care professional wanted to help transsexual patients and didn't want to offend them by writing inappropriate words in their files. However, this raises issues for healthcare services to be able accommodate the transsexual corporeal body within their institutional systems and practices. It also highlights the need for training in relation to staff being able to talk openly and comfortably about sensitive issues with transsexual patients .This is also an example of the impact social discourses can have within a medical institution on the quality of care given to a transsexual patient.'* (Wednesday February 2011).

Crabtree et al., (1993: 142) suggests that "the rule of thumb for conducting in-depth interviews is that it usually requires 8 to 10 interviews although some applications might require 20 or more." 7 MtF transsexuals and 2 health care professionals were interviewed for this research study. The length of the interviews ranged from one hour and forty minutes to

two hours and thirty minutes. Interviews were conducted between March and August 2011. As mentioned earlier in this chapter, initially it was thought that the research process would take place around the cities and surrounding rural areas of Hull, Manchester, Leeds and London, as those areas had established transgender communities for the ease and practicality of possibly accessing, and interviewing, research participants. However, participants were interviewed in Newcastle (2), Rhyl, Hessle, Bishop Burton and Hull. This method helped me to gain a wealth of data from participants from areas that I had not initially anticipated going to, where there were serious issues in relation to accessing gender identity services.

Connell (2010) suggests that some transsexual narratives can often focus in great detail on medical interventions during the transition process. Therefore, a rich source of data on participants' experiences of accessing health and social care services was possible by using semi-structured interviews in this study. Using semi-structured interviews enabled interviewees the opportunity to talk about issues outside of the main topic areas, whilst remaining fairly focused on the main research questions. Prior to starting the research process, it was perceived that the interviews would be done in a quiet and private space, such as a meeting room. However interviews took place in 2 work place staff rooms, an office, a public house, a conference room, an equestrian centre, and a transgender safe house. Apart from one interview in Newcastle, where I made the decision to organise the venue and book a meeting room, all the other interviews took place at a date, time and venue the participants requested. This is further evidence of the values and ethics I have taken from the methodological paradigms mentioned in this chapter, that I have used in my own research study. For example, social work values and reflective thinking has helped me to consider the power relations between myself, as a researcher, and the participants I interviewed. Therefore, where possible, I have tried to let the participants interviewed have the choice of me finding a suitable venue, date and time for their interview or themselves having the

opportunity to be interviewed in a place that they would find comfortable and safe to be interviewed in. I would argue that this was an important factor for participants interviewed, as this gave them a safe, familiar area chosen by them to be interviewed in, where they could be more comfortable discussing the topics of a sensitive nature that were in the interview schedule. I also found that initial contact with potential participants, where I gave them the option of deciding a suitable date and time for interview, was important for successfully getting them to commit to participate in the study. This is another example of the importance of flexibility in the research process, and methods used, to enable a researcher to gain as many participants as possible; it's about giving participants choices in the way that they participate in the study. Using interviews as a research method has also enabled me to have flexibility in modifying the research questions, or adding new ones to the interview schedule, as mentioned in the following reflective diary entry of mine.

*'I have noticed that the data collected so far is raising other questions I want to ask. Therefore although I will not change the questions in the survey, I have today added a couple of questions that I had not asked in a few of the earlier interviews. For example 'do you have a mixture of friends that are transgendered and non transgendered?' and 'do you have more male or female friends since starting the transition process?'* (Thursday April 2011).

A digital voice recorder was used to record the semi-structured interviews. Sharpe (1998) and Dawson (2009) suggest that the use of an audio recorder during the interview process may discourage some participants from taking any further part in the study, or may impact on the trust and rapport between researcher and participant. However, once assurances of anonymity had been given, participants felt comfortable to disclose their personal experiences, some of which were of a very personal and sensitive nature, including details of their previous gender, children, surgery, and relationships. This highlights the trust and rapport that was built up during the course of the interviews with the participants. As discussed earlier in this chapter,



my position within the research process could have been seen by those transsexual participants interviewed as simply a researcher, insider or outsider. However I would like to think that they saw me simply as a researcher/insider as I never had anyone question my authenticity as a transsexual woman. Before the interviews started I would explain what the study was about, and their right to withdraw from the study at any point. I would then give them the opportunity to ask any questions, which would usually evoke a response of asking me what stage of the transition process I was at. I didn't mind answering this question, and it would always put them at ease and comfortable to start with the interview. Even in the three telephone interviews that took place, I would start by asking the participants if they wanted to know a little bit about me, which had the same result of authenticating who I was and putting them at ease. Hash and Cramer (2003) suggest that self disclosure by the insider researcher at the start of the research process can help to create a more trusting and comfortable environment, and that participants may find a researcher from their own community as better placed to understand their daily experiences and challenges (Hash and Cramer, 2003). Those participants interviewed expressed a desire to be heard, finding the interviews themselves to be a good opportunity to have their say on issues important to them. This is further evidence of the values and research principles I share with such paradigms mentioned earlier in this chapter, such as, feminist research principles and emancipatory research that influenced the design of the study and the research methods chosen.

The main advantage of using a digital voice recorder to record the research data was that it enabled me to concentrate on fully engaging with the research participants who were talking about quite sensitive issues, and observe their body language. The use of the digital voice recorder meant that copies of the files could be transferred simply and quickly to a computer

and spare hard drive to work on later, during the transcribing period of the research process, and for safe keeping in a secure place.

Before the research process started, telephone interviews had not been considered at any great length as a research method that would be important for collecting data for this research study. However 3 MtF transsexual participants from Wales were interviewed by telephone. The reasons for this were that they lived in remote rural areas of Wales, so a face to face interview would have been extremely difficult to have achieved. The telephone interviews didn't allow for nonverbal cues to be seen. However it did allow for both me and the participants to hear preverbal cues. This was a flexible research method that allowed the interviews to be set up at a convenient time for the research participants. A venue didn't need to be booked, and no refreshment costs or travelling expenses were incurred. All three interviews took place in the early evening after the participants had finished work, so they were able to participate in the interview process in the comfort of their own homes. Sturges and Hanrahan (2004) suggest including the option of a telephone interview within the research process can provide an opportunity to gain data from participants who are difficult to access in person, or may be reluctant to meet in person for a face to face interview (Sturges and Hanrahan, 2004). With the research study covering sensitive topics, the use of a telephone interview also had the advantage of providing relative anonymity for some participants, rather than having direct face to face contact with me during the interview process. As Sturges and Hanrahan (2004) suggest, using telephone interviews for topics that are sensitive and/or embarrassing may increase data quality from some participants, rather than face to face interviews. The interview schedule consisted of many topics that were of a sensitive nature including family, partners, friends, verbal and physical abuse, social recognition, and legal recognition. These topics included discussing the participant's life prior to starting the transition process, which could be a little upsetting for some of them,

although this could also often evoke a reflective response about looking back at their previous identity and the distress that caused them, and how they were now in a more comfortable place with their present gender identity. See appendix three for the full interview schedule.

What follows now is a discussion of the final research method used in this study, which was an online focus group.

### **Focus group**

The main issues that were raised by participants from the survey and semi-structured interviews were then used as topics to be discussed by the focus group. Originally I had planned to use Ketso for the focus group. Ketso is a tabletop creative tool kit that can help to stimulate discussions and creative thinking, encouraging diverse groups to work together. The kit consists of colourful branches and leaves which can be placed on a felt background in order to encourage creative and effective engagement (ESRC, 2011; Ketso, 2010). Ketso would be a great visual aid at the end of the focus group to allow participants to see the main themes of the discussion.

However, during the research process there were concerns that a focus group may not be achievable due to the difficulties in getting 6 transsexual people together at the same time. This may have been more easily achievable if I had wanted to find participants from the whole of the transgender community and just discuss their experiences of accessing health and social care services. However, as outlined in chapter one, this study was only interested in people who were over 18 years old, had transitioned since 2004, or were presently in the transition process and had or intended to gain a Gender Recognition Certificate to be legally recognised in the UK as a man or a woman in their new gender. These concerns were expressed in the following reflective diary entry of mine.

*‘Triangulation - I really need to try and use all three research methods as these methods combined should enable me to gain a rich data set. The most difficult aspect of the research process I can envisage is gaining at least 6 transsexual participants for a focus group. This is because I am after eligible participants from a small group within the transgender community who need to be in the same location at the same time. I may have to rely on gaining enough participants from one support group as it is likely that some groups members may be from the same area, thus enabling them to be able to attend a focus group venue at the same time more easily.’ (Saturday January 2011).*

However, I gained access to an online voice coaching group for MtF transsexual women after interviewing the group leader for this thesis. This small group of transsexual women were from different parts of England, but could access the group for voice coaching sessions by using Skype group video calling. This seemed an ideal way that I could access enough participants for a focus group and so I gained eight participants for the focus group, which lasted two and a half hours.

Alder and Zarchin (2002) suggest that the use of an online focus group can help researchers to embrace the technology of the internet to connect and study with isolated and understudied patient groups (Alder and Zarchin, 2002). This research method enabled this study to unite research participants from across England and solve the challenges of gaining enough research participants for the focus group from this demographically spread, and often isolated, social group. The participants were not a random sample, but a convenience sample of people who were all members of the same voice coaching group.

I led the focus group as moderator to ensure the topics of interest were covered in depth. A focus group schedule was prepared prior to the focus group to ensure that all topics were

discussed. This helped to allocate allotted time to each topic and to prevent participants from wandering off the main issues.

The online focus group generated rich and detailed qualitative data. This process helped to assess the problems participants had when accessing health and social care services and the levels of social and legal recognition they felt they had. The last topic of the focus group enabled participants to think about the important and useful advice that they could give to someone thinking of starting the transition process.

*“Really support and help with confidence, because without a reasonable level of support you’re never going to manage to get anywhere and struggle. Without some help with boosting confidence you’re just going to struggle all the way through.” (Woman with a transsexual background aged 30-39).*

*“If every local authority gave a room for free with a changing room for transsexual people to use as a support group venue once a month, that would help enormously, but we still haven’t got that and that would cost them virtually nothing.” (Trans woman aged 50-59).*

*“More funding for gender identity services is needed. How can services be improved when staff are only working part time, its madness. You’re dealing with people with serious problems in urgent need of support and you provide a part time service that is over subscribed with patients on long waiting lists. I find that quite outrageous.” (Trans woman aged 50-59).*

This helped to bring closure to the focus group and left the participants on a positive point to a successful, productive, and engaging evening.

Roberts and Wood (2000) suggest that if computer technology is used for research then the cost, time and skills needed to use the technology must be considered. However, I only

needed to create an account and have one practice session with Skype to familiarise myself with its features. I had an initial layout of three pounds for a pair of headphones with a built in microphone. Kenny (2005) suggests that “whilst online focus groups may not be suitable in every situation the potential exists to capitalise on technology to bring together a group of people separated by distance in an online environment that encourages interactive discussion.” (Kenny, 2005: 414). I did have concerns about using a traditional research method in an online setting, as I was concerned that the internet connections of both mine and the participants could be lost during the focus group process. However, I was able to utilise the Skype ‘group video calling’ software successfully, and no one suffered a loss of their internet connection.

The online focus group had many advantages over a traditional focus group. These advantages included collecting the opinions of people from different parts of the UK, or even the rest of the world, at the same time with ease. Online focus groups can also be inexpensive as they do not require a venue, refreshments, and paying participants’ travel expenses (Schneider et al., 2002 and Landreth, 1998). Also as Schneider et al., (2002) suggests online focus groups have many advantages over traditional face to face focus groups, whereby participants all have to be in the same area.

Schneider et al., (2002) suggests that online focus groups can be unrepresentative of the overall population, because only internet users are included. However, in contrast, this thesis would suggest that, with regards to the transsexual and transgender population, this social group are known to be competent internet users of all ages when we consider previous literature (Whittle 1998, 2002). That is precisely why the research methods used in this study were chosen, especially the online survey, as many of the transsexual community are internet users. This is reflected in the representation of participants from all the different age groups, and different stages of the transition process, in the research findings of this thesis.

The online focus group had the same advantages of a traditional focus group as I could see and hear the participants' responses and observe their body language, and probing their responses was not compromised. Participants could log in from anywhere within the UK from the comfort of their own homes. This eliminated the need for both me and the participants to plan travel arrangements to a particular venue. As this was an online focus group, geography as a barrier to gaining research participants was removed. This made recruiting potential participants less complicated and far more efficient.

See appendix five for the full focus group schedule.

### *Analysis of the research transcripts*

Analysis of the transcripts of the semi-structured interviews, focus group, and the completed survey, helped to draw out the research participants' experiences when accessing health and social care services since the introduction of the Gender Recognition Act 2004, and other legislation during the transition process, in three important ways. Firstly, these experiences, and the views of the participants, have been used to assess whether services are meeting the needs of transsexual people. Secondly, to examine the extent to which services are implementing the Gender Recognition Act 2004 and other legislation into their policies, practices, and organisation culture. Thirdly, by adapting and applying Frank's (1991) theory of the body to my analysis of the research findings to show how the complex interactions of corporeality, social discourses, and institutions impact on a transsexual person's health and wellbeing during the transition process, and on the experiences they have of accessing health and social care services.

Analysis of the research transcripts was aided by the use of a colour coding system, which helped to highlight when participants had discussed something that fell into one or more of the three contexts discussed in the empirical chapters of the thesis. A green colour was used

for issues and experiences that related to health and social care and pink was used to highlight issues and experiences that related to the corporeality of the body. The colour orange was used to highlight social recognition and yellow was used for issues and experiences that focused on legal recognition, institutions and policies. What I found through using these codes to analyse the data is examined in detail in the next three chapters, which are the empirical chapters of this thesis.

### ***Concluding remarks***

This chapter has shown how Frank's theory of the body has influenced the research design, by providing a framework for looking at the key determinants through the three contexts simultaneously, and therefore, enabling equal attention and a thorough investigation of each key determinant to be achieved. I have built on the work of Frank's theory of the body by using a survey, interviews, and a focus group to enable me to look at the issues and experiences of participants through the three contexts, which are corporeality, social discourses, and institutions. I have at the same time drawn on the research paradigms discussed in this chapter, which included feminist research methods, emancipatory research and emic and etic perspectives, and applied their values and principles in the research techniques used in this study successfully to gain a diverse range of participants from across the UK. The research paradigms discussed have many values and principles that I share with them as an insider researcher. For example reflexivity, empowering oppressed groups, and reducing the hierarchical relationship between researcher and research participants. The bar, column and pie charts used in this chapter have helped to emphasise the diversity that was achieved in attracting participants from across the UK in categories such as age, country, county, identity, and which year participants started the transition process. The use of a colour coding system enabled this study to build on the work of Frank's and examine the data



within the three contexts which are discussed in detail in the following three chapters of this thesis.

The next chapter will be the first of three empirical chapters that focuses on the issues and experiences of participants, drawn out by the use of the three research methods used in this thesis through the context of corporeality.

## **Chapter Four: Corporeality of the body before, during and after the transition process**

### *Corporeality in Frank's (1991) theory*

For Frank (1991) the body is a corporeal phenomenon which itself affects how people experience their bodies (Shilling, 2003). Therefore the body can be seen as a vehicle, which enables a person to express themselves, but at the same time the body also places constraints on that action. There are three dimensions to the constitution of the body; two of the dimensions will be discussed later in this thesis, (social discourses in chapter five and institutions in chapter six). The first dimension of the constitution of the body is the corporeality of bodies.

Frank (1991) suggests that the corporeal character of bodies “remains an obdurate fact. There is a flesh which is formed in the womb, transfigured (for better or worse) in its life, dies and decomposes. Thus what I am calling the body is constituted in an equilateral triangle the points of which are institutions, discourses, and corporeality.” (Frank, 1991: 49).

For Frank (1991) institutions do not exist prior to bodies, rather there is a need to theorise institutions from the body up. However institutions need to be recognised from the beginning as the action of bodies is often directed to institutional contexts (Frank, 1991). As Shilling (2003) suggests “bodies are the medium and outcome of social ‘body techniques’ (combination of discourses, institutions and the corporeality of bodies), and that society is also the medium and outcome of these body techniques.” (Shilling, 2003: 83).

Shilling (2003) suggests that “Frank’s approach does have the considerable merit of incorporating a view of the body as a corporeal phenomenon. This corporeality does not disappear simply because it is located in society, but becomes taken up and transformed as a result of its engagement with social relations” (Shilling, 2003:87). It is precisely this notion of corporeality remaining present within the various social discourses, and institutions, and transformed because of that engagement, that I consider to be important within the transition process of transsexual people. However the interaction of corporeality within these social discourses and institutions discussed in this chapter should not be confused with embodiment, which would be related to the social promotion of the new gender identity in those discussions in chapter four.

As will be discussed in chapters five and six there is an exclusion of the transsexual body in transition in the remit of institutional culture and social discourses, and a lack of its classification in health care binary computer systems. There is a need to integrate these transsexual bodies, and variations of bodies, into the organisational culture, policy, practices and social discourses within institutions at a macro and micro level, and within social discourses in general.

The transsexual body can be seen as a place of desire and resistance and also a site for violence, abuse, self harm, and loss of who the person use to be in their previous gender. Some research suggests that there can sometimes be higher than normal rates of suicide, abuse, drug abuse, violence and self harm amongst transsexual people compared to non transsexual people (Kenergy, 2005; Bockting, Knudson and Goldberg, 2006). However in this thesis only a few participants had suffered verbal abuse, which was discussed in chapter five, and none of the above deviant behaviours were mentioned by any participants. This is not to say that it was not possible that a participant may have participated in any of these

deviant behaviours in the past, but these behaviours were never mentioned, or even hinted at, during the research process.

### ***Corporeality of the body before transition***

In the pre transitioning body there is often a need to start making visual changes to the body and accommodating them in your previous gender identity without raising too much suspicion from others such as friends, family and work colleagues. Changes in grooming that are usually appropriate for the opposite gender are an important step for both MtF and FtM transsexuals. A MtF transsexual may lengthen their hair style, start to shave their legs, hands, arms and chest, let their finger nails grow long and shape them, and start to pluck their eyebrows in order to give themselves a more feminine look for when they are starting to implement small changes to their body, in order to start going out in public portraying the gender they want to become. A FtM transsexual may start to shorten their hairstyle, keep their finger nails short and let their body hair grow. Although these are visual changes they are often helping to establish positive psychological feelings in the transsexual person about changes and developments to their body, that help to increasingly align their body to that of a body they wish to have and accommodate. One MtF participant mentioned that in their previous gender they use to belong to a cycling club, however for aerodynamic purposes it was common for male club members to shave their legs, so the participant didn't have to worry about people questioning why they had shaven legs. For many MtF transsexual people there is the ongoing process of tucking or binding the genitalia to flatten any unsightly bulges and to reduce the distress a MtF transsexual may have about having a penis. Binding is also an ongoing process for FtM transsexuals who wish to flatten their chests so as to give the impression, under clothes, of a more masculine physique.

Electrolysis and laser treatments can be important for MtF transsexuals in helping to give them more feminine looking faces and bodies. Unsightly facial and body hair can be distressing to MtF transsexuals and can impact on their confidence in their appearance, and confidence in going out in public. Electrolysis, laser treatments, shaving, and plucking can all be time consuming tasks for many, and also expensive in the case of electrolysis and laser treatments. A MtF transsexual will usually have laser or electrolysis treatments before, during, and after transition. There is also the need in most cases to have electrolysis on the genitalia before GRS, which is a specialised area of practice. This means that often there are only a few people in the UK who specialise in electrolysis of the genitalia, which means a transsexual person may have to travel considerable distances to gain treatment, usually twice weekly, for a period of at least six months. Although costly, painful, and time consuming, electrolysis of the genitalia area is important for reducing the chance of ingrown hairs within the vagina, which can create discomfort, distress, and infection (Bowman and Goldberg, 2006).

### ***Corporeality of the body during transition***

As mentioned earlier in the literature review, hormone therapy can be an important part of the transition process for some transsexual people, as it can help them to be more at ease with themselves, both physically and psychologically (Department of Health, 2007; West, 2004 and Namaste, 2000). Some of the physical effects of taking testosterone for a FtM transsexual may include muscle development, deeper voice, beard and body hair growth, increased libido, and menstruation ceases (Department of Health, 2007 and Namaste, 2000). Some FtM transsexual people may also exercise excessively for various reasons including the desire to increase muscle mass, yet struggle to achieve this, reduce hips and breasts, and keeping under weight to prevent menstruation (Bockting, Knudson and Goldberg, 2006). For a MtF transsexual some of the physical effects of taking oestrogen may include the redistribution of

fat, muscle reduction, breast development, softer skin, and facial and body hair may become weaker (Department of Health, 2007 and West, 2004). Hormone therapy does not bring immediate physical changes. As Hines (2007) suggests starting hormone therapy can be a frightening time for some transsexual people as the body slowly changes, they can feel frustration and low self esteem due to the slow development of their body and the mixture of both male and female body characteristics they will have during the transition period. There can also be confusion over their emotional state of mind at certain times, in the sense of, what is down to their natural feelings, and what is down to the effects of the hormone therapy (Hines, 2007). Eating disorders can also be prevalent in both FtM and MtF transsexual people. This can be for various reasons including, pressure to conform to social stereotypes of thinness, an estrangement to the body due to weight gain associated with hormone use, which can cause distress, and an increase in health risks for some people, or developing as a compulsive behaviour to provide relief from stress not associated with the body (Hepp and Milos, 2002; Gapka and Raj, 2003 and Bockting, Knudson and Goldberg, 2006).

It was worrying to hear that a few participants at some stage in the transition process had used hormones bought off the internet, or had bought inferior hormone products over the counter from shops specialising in transgender needs. There was certainly a risk to their health by self medicating, no matter how much they had researched the subject, especially if they were on other medication as well. However, this does highlight the desperation of some people who wish to transition and the risks they will take in fulfilling that wish.

*“My GP refused to send me to an endocrinologist when I told him I was self medicating.”  
(Woman with a transsexual background aged 40-49).*

Starting hormone therapy can thus be seen as a positive and exciting stage of the transition process for many transsexual participants. However, it is clear as Hines (2007) suggests, that

starting hormone therapy can also be a frustrating and distressing time for some transsexual people, who have to cope with a body that consists of both male and female characteristics.

*“I am grateful I am treated on the NHS. But I feel if I was not left in the dark about the timing of the different transition stages, it is very difficult to be a male, with facial hair, and body hair, with a female body. I access my gym, and have to walk through the female changing rooms to get to the pool...takes some guts.” (Trans man aged 40-49).*

This is a common and frustrating experience for some participants when they have started hormone therapy, as their body slowly starts to show development of characteristics associated with their new gender identity, whilst still having many characteristics of their previous gender identity. It’s a time when their body needs to change to align its self with their new sense of self, and also at the same time be a body that portrays their new gender identity in a social context. Certainly, two participants interviewed who were female, were not satisfied with the slow development of their breasts, and therefore, one had already had breast augmentation surgery to speed the process up, and one was going to have it done shortly.

*“I am going to have breast augmentation in a month’s time, I held off having it done, because I was told it takes a while for the hormones to do their job, but they stubbornly held off growing any further so I’m having the surgery now.” (Woman with a transsexual background aged 50-59).*

As mentioned earlier in chapter two, Hines (2007) and Bourke (1994) suggest that GRS for some transsexual people is important, as it enables the coming together of their gender identity and bodily appearance. This can help some transsexual people to gain “physical comfort and wellbeing and emotional confidence” (Hines, 2007: 70). Certainly having a body that matches the person’s sense of self, and also their social identity, may help to alleviate

any distress they may have had about their body. However this study was not able to establish to what extent if any participants felt social pressure to conform to a socially ideal type of body that represented their new gender identity. As mentioned in chapter two, there is no requirement in the UK to have GRS in order that a transsexual person can obtain a GRC to gain legal recognition in their new gender. However for many transsexual people GRS is often regarded as an important step in the transition process for becoming a whole person in body and mind (GIRES, 2010). No participants in the study said that they didn't want to start hormone therapy, and only two participants said that they had started hormone therapy but didn't want to have gender reassignment surgery.

### *Intimacy*

Deciding to have a full Vaginoplasty or a Cosmetic Vaginoplasty, in the case of a MtF transsexual, or a Phalloplasty in the case of a FtM transsexual, or no surgery at all, is a decision the transsexual person has to decide on during the transition process. This may be partly to alleviate the psychological distress and align their body to their new gender and promote physical well being. But also it may be undertaken to promote their sexuality, reach fulfilment sexually, and increase intimacy with a partner, or help to establish a sexual relationship with a new partner if they wish. Attending one support group during the research it was disclosed in discussion that a person wanted to start the transition process shortly as a MtF, with the main aim of having facial surgery to change cheekbone structure, nose shape, and GRS to fulfil a desire to be able to look physically like a certain type of woman, and have sexual intimacy with a butch lesbian. Also starting hormones can sometimes change a person's sexuality. The transition process can be a daunting process at the start, not only in relation to the social and institutional issues that have been mentioned in the previous literature, and will be explored further in chapter five and chapter six of this thesis, but also with experiencing and accepting the physical changes to the body, and mixed emotions that



ensue. Therefore to hear that a person had such clear ideals about their motives for their wish to change gender, was certainly surprising to hear. This may be down to them having unrealistic expectations of the transition process, which could lead them to having a negative experience of the transition process, if what they see in the mirror and feel does not meet their expectations. However this may also suggest that there is a variety of reasons for having GRS, and different levels of expectations of what will be possible, for example sexually, which has not been fully explored in previous literature, and within this thesis. For example

*“Some trans women feel that a sexual relationship with a man validates their identity as a woman. This may be temporary, experimental period that passes, or it may remain that way in which their sexual identity continues to be expressed.” (GIRES, 2010: 32).*

Whilst the experience of penetrative sex with the new genitalia as a MtF or FtM may help some people to gain fulfilment and validation in their new gender, this was not mentioned by participants in this research. This may be a topic for investigation in future research studies, which could assess the reasons for GRS, and satisfaction rates for appearance and functionality of Vaginoplasty (Vagina) or a Phalloplasty (Penis) surgery.

### ***Giving birth***

Transsexual women are unable to bear children due to them not having internal female reproductive organs. Therefore missing out on the chance to experience pregnancy, childbirth and the postnatal body, and motherhood and the relationship this has to the self and the gendered identity of woman, can be seen as a tragic loss for some transsexual women, just as it can be for other infertile biological women who wish to have children. Transsexual people who transitioned at an early age would not previously have had the opportunity to preserve their sperm or eggs prior to transition for future use (De Sutter, 2001). However recent reproductive techniques have made it possible to preserve sperm or eggs so that the

transsexual person can make use of them if they wish after they have transitioned. (De Sutter, 2001). This issue is discussed in chapter six in relation to transsexual people's access to IVF treatments, and present IVF clinic policies in the UK. One more reproductive technology that is on the horizon, which offers the potential to radically transform family formation, is that of Uterus transplant technology (Alghrani, 2013).

Two MtF participants mentioned that they would like to be able to conceive. Yet when they discussed this with friends, they were ridiculed for having such thoughts. This suggests that the extent to which social recognition is given to a transsexual woman is still limited, and in areas such as giving birth, it is still heavily influenced by perceived notions of biological characteristics.

*"I would like to be able to conceive and have a child. When I mention this to other friends they think I am crazy for having those feelings." (Woman with a transsexual background aged 30-39).*

### ***Corporeality of the body after transition***

Dealing with and learning to adapt to a different physicality, for example loss of muscle development and strength for some MtFs after GRS, can be as difficult an experience as it was when starting the hormone process, as mentioned earlier in this chapter.

*"You soon realise that you can't physically do as much as you use to be able to do, you just lose a lot of strength and muscle." (Woman with a transsexual background aged 60-70).*

As discussed earlier in the literature review Lewins (1995); Pfafflin and Junge (1998); Landen et al., (1999) Schorfield (2008) and Weyers et al., (2009) suggest that the majority of transsexual people who undergo sex reassignment surgery are satisfied with the outcome. However a small minority may have regrets which can often be associated with loss of social

support, or disappointment with the surgical results. As Olsson and Moller (2006) mention, persistent regrets after sex reassignment surgery is a possibility for a small minority of transsexual people, and is influenced by many factors including, psychosocial adjustment, cosmetic and functional results, the ability to experience pleasure from sexual relations, and the existence of partners (Olsson and Moller, 2006). It is interesting to add that preoperative factors that seemed to predict a favourable post surgery outcome were emotional stability, successful adjustment in the new role, and an understanding of the limitations and consequences of the surgery (Green and Fleming, 1990 cited in Davison and Neale, 2001). Therefore this suggests that being aware of the risks of surgery and having emotional stability are important factors to the success rates of sex reassignment surgery. However, to what extent is this due to health and social care services? This is an important question to consider in order to ascertain the contribution that the intersection of corporeality, social discourses, and institutions play in the successful adjustment of transsexual people during the transition process.

GRS is often considered a necessary step by many transsexual people, just as is gaining legal recognition by obtaining a Gender Recognition Certificate for some transsexual people. GRS can often bring closure for some transsexuals that they have finished their journey from one gender to the other. However, having GRS does not necessarily mean that people will start treating them differently. They need to have been socialising in their new gender before surgery to ensure they have adapted to their present gender presentation. This was a concern raised by a few participants from the focus group and interviews, who said that they knew people who had started the transition process but were not leaving their homes to socialise or find employment.

*“I know a few people who think because they have had GRS all of a sudden their lives are going to change and although dressed will expect that people in the street will treat them differently now that they have had surgery” (Trans woman aged 60-69).*

There are many different ways to construct a Vaginoplasty (Vagina) or a Phalloplasty (Penis). However this can cause complications to assessing what screening services are appropriate to different transsexual patients, and their increased or decreased risk to different cancers. For example whether a FtM has had a full hysterectomy or not will determine if he needs to have a Pap Smear for cervical cancer. If a MtF has had a Vaginoplasty created which has used the head of the penis to create a Neocervix then they will have to have routine Pap Smears (Bockting and Goldberg, 2006). This links in with the earlier discussion in chapter four on the importance of taking ownership of individual health care needs. Transsexual patients need to ask more questions about the construction of their new genitalia and what screening tests should be appropriate to them.

Feinberg (2001) suggests that physical examinations and screening tests should be offered to patients on the basis of the organs present rather than their perceived gender. Some cancer screening protocols are sex/gender specific based on assumptions about what body parts men and women have, for example screening of cancer of the breast, cervix, ovaries, prostate, penis, testicles, and uterus. It can be difficult to know what to recommend for transsexual people as hormone therapy and sex reassignment surgery can change these body parts, and can also increase or decrease the risk of cancer (Ashbee and Goldberg, 2006). There is further confusion within health screening services as to what screening is appropriate for a transsexual person at different stages of the transition process. For example, is the individual non-operative, pre-operative, or post-operative? These different stages of transition, the different techniques used in sex reassignment surgery, and the biological characteristics at

birth, will all be important factors that determine what cancer screening programmes the individual transsexual person should be included in (Ashbee and Goldberg, 2006).

In addition to advice about integrating transsexual people into population wide screening programs, good advice should also be given to enable the transsexual person and their doctor to agree a healthcare monitoring program specifically addressing the person's individual needs as a result of long term hormone therapy, and/or sex reassignment surgery. For example, the need to adapt hormone regimes as the transsexual person ages, and advice should be provided about screening for Osteoporosis (Department of Health, 2007c). This is discussed further in chapter five.

## **Chapter Five: The impact social discourses have on the transition process, identity and transsexual people's experiences of accessing health and social care services**

This chapter begins by discussing how Frank's (1991) notion of the communicative body for the purpose of his theory of the body, and how it has been adapted in this study. A discussion of the complexities participants had with defining themselves at different stages of the transition process will then follow. This will lead on to an exploration of the types of interactions participants had with other people, and the impact that had on their identity, the transition process, and their experiences of accessing health and social care services. This chapter highlights the importance put on labelling both ourselves and other people in everyday interactions, and how people question those they interact with who don't match what they perceive to be appropriate for their presumed identity, or how they define themselves.

### ***Frank's notion of the communicative body***

Following on from the overview of Frank's theory of the body that was discussed earlier in Chapter Two, this part of the chapter discusses in more detail the importance Frank put on the communicative body for his own theory, and how essential the communicative body concept was for my own adaption of Frank's theory of the body for the analysis of my own research.

To recap, Frank's (1991) theory of the body discusses how embodied consciousness of the self is created and expressed through the body. Frank (1991) suggests that the body becomes

most conscious of itself when it experiences resistance when it is in use and acting (Frank, 1991). This creates four dimensions which are desire, control, self-relatedness, and other-relatedness. These four dimensions then generate four types which represent styles of body usage, which are, the disciplined body, dominating body, mirroring body, and communicative body (Frank, 1991). Whilst the disciplined body, mirroring body and dominating body can be seen as controlled by discourses and institutions, the communicative body can be seen as the site of expression. This is not to say that the communicative body is not formed amongst discourses and institutions, but instead of being constrained by them, the communicative body uses them as a media for its expression, and therefore, they enable more than they constrain (Frank, 1991). Frank (1991) defined the communicative body as

*“The essential quality of the communicative body is that it is a body in process of creating itself.”* (Frank, 1991: 79).

Whilst Frank’s notion of the communicative body was developed in relation to the ill body and losing one level of expression and creating a new one, I would argue that transsexual embodiment can also be seen in a similar way. This is because whether or not a transsexual person has hormone therapy and/or sex reassignment surgery (which is one form of embodied expression), they will be losing one form of expression which has been their previous gender, and in a process of creating a new form of expression in their new gender. It is by using discourses and institutions that social recognition for the new self is created. Another work that Frank (1991) mentions that also considers the ill body and losing one level of expression, is that of Robert Murphy (1987). Murphy (1987) states that

*“The quadriplegics body can no longer speak a silent language in the expression of emotions ... for the delicate feedback loops between thought and movement have been broken.*

*Proximity, gesture and body-set have been muted, and the body's ability to articulate thought has been stilled'* (Murphy, 1987: 101).

Reading Murphy's work resonated strongly with me in relation to my own thoughts for the need to start the transition process. I could recognise similarities with Murphy's personal account and that of my own, and some of the transsexual research participants in my own research study. For Murphy there was the increase in frustration, and a sense of entrapment within his body as his paralysis progressed, and he felt he was losing his previous identity. For many transsexual participants in my own research there was the increasing frustration and entrapment in their previous gender identities that pushed them to make a change and start the transition process. This was especially so when participants had started to experiment and explore their new identity, whilst remaining in their previous gender. The realisation of their true selves, and developing that identity, especially in social situations, and the freedom they felt, only made them feel more entrapped and frustrated in their previous gender.

Zola (1982), Murphy (1987) and Frank (1991) suggest that it is about achieving interpersonal recognition through a combination of one's own efforts, and the narratives we share with others, which are essential for forming relations with others. For Frank (1991) social recognition is the medium of the communicative body. Therefore, I would suggest that the introduction of the Gender Recognition Act 2004 can be seen as a crucial element at the disposal of a transsexual person that can help them to express their newly acquired embodied self. This is because, with the introduction of this legislation, a transsexual person can now have legal recognition and change public documents to express their newly acquired gender in the UK (Office of Public Information, 2004). For example when a transsexual person changes their bank details and has a new credit card and cheque book, these are important items that signify the person's name change and gender, which can be used in many different



interactions they have with people, and for purposes of proving identification. Therefore, this can be perceived as a powerful tool for the transsexual person for expressing their embodied self, and obtaining both legal recognition, and to some extent, social recognition, which can be seen as empowering. Having legal recognition in one's new gender identity was an important part of promoting the self in social situations, and within institutions, for transsexual research participants in this study. The name and pronoun changes participants made to legal documents, such as passports, driving licences, and bank accounts, had an enormous impact on helping to promote the new sense of self for the participants in the research.

*“The second I had a bank card with my proper name on it and miss in front of it, was just brilliant, it was like I finally existed.” (Woman with a transsexual background aged 30-39).*

*“Changing my name and gender details on documents helped to promote my sense of self in public massively.” (Transsexual woman aged 26-29).*

I would suggest that this form of empowerment has helped some transsexual research participants' health and wellbeing greatly. Having positive experiences of expressing their sense of self in social interactions for some participants helped them to gain more confidence in their appearance, and a sense of acceptance at certain levels. However, it should be remembered, that although some documents, such as, a driving licence and changing one's name by deed poll can be changed at the start of the transition process, gaining legal recognition can only be achieved after living full time in role for at least two years. The transition process can be considerably longer than this, and is a journey of becoming the opposite gender for some transsexual people, and gaining social recognition, which is equally as important (Connell, 2010).

*The complexities of defining one's self during transition and the importance of labelling in social discourses*

Terms used by participants to define themselves could change over time depending on what stage of the transition process they were at, and depending on who wanted to know. Some participants from the interviews and focus group had used the terms transsexual woman or trans woman in the early stages of transition, but once they had had GRS they would define themselves simply as a woman. This emphasises the importance that is put on labelling ourselves and others. Certainly for some transsexual people who participated in this research and were interviewed, there was a sense of questioning themselves about how they fitted into certain identity labels at the time of interview, previously and in the future, and what they felt they needed to change or gain in order to feel that they belonged to a certain identity label.

*“At the moment I’m somewhere between the terms ‘woman’ and ‘trans woman’.”(Trans woman aged 30-39).*

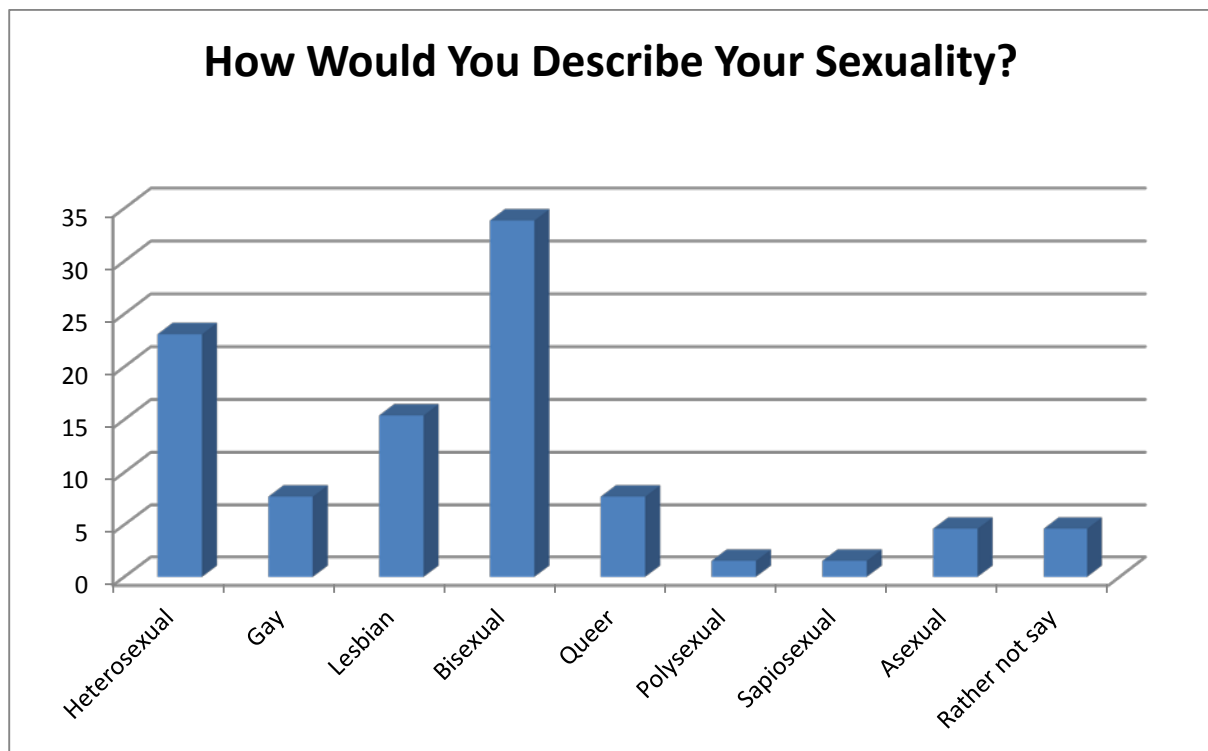
Other participants mentioned that they continually had to define themselves to different people, and different groups, which they found quite frustrating.

*“Depends who asks me and in what circumstances. If someone came up to me on a train and said ‘are you a woman?’ then I would say ‘yes’ irrespective of whether they thought I was or not, primarily because to my way of thinking that’s what I am.”(Trans woman aged 50-59).*

A person's sexuality can also be an important part of their identity. However for some participants there was also confusion about how they would define their sexuality since they had started transition, and whether they could simply put a label to it.

*“When I was a man I considered myself heterosexual as I’m attracted to women, but now I’m a girl that makes me a lesbian right? Nothing has changed it’s the same me. I know who I am*

*attracted to and that's all that really matters to me, ok if people want to call me a lesbian, then fine.” (Trans women aged 50-59).*



*Figure 5.1 shows the terms used by participants to describe their sexual orientation.*

Both MtF and FtM participants showed a broad range of responses in relation to how they defined their sexual orientation. However, what was noticeable was that five FtM participants who were in the age group 18-25, and were 50% of the overall total for the age group 18-25, defined their sexuality as either gay/queer (2), queer (2), or sapiosexual (1)

Three male participants from the survey used two terms each to describe their sexuality. This consisted of one trans man defining his sexuality as gay/queer, one man with a transsexual background defining his sexuality as gay/queer, and one trans man defining his sexuality as

heterosexual/queer. This would suggest that the term 'queer' was possibly used as a statement with socio-political connotations, as they may have seen themselves as oppressed by the heteronormativity of wider society, and/or to show their support of reclaiming the word 'queer' from its previous derogatory meaning to embrace a new positive meaning (Taylor, 2008). Although Haritaworn (2008) suggests that 'queer' is a contested term which could mean many things to different people, such as, a sexual identity that rejects distinct sexual identities, or those who reject traditional gender identities, and by those who see themselves as oppressed by the heteronormativity of wider society. Two participants from the semi-structured interviews had also mentioned two terms to define their sexuality.

*"Heterosexual in my new gender with some possible bisexual bias towards females, was never gay as a guy either."* (Woman aged 60-69).

This may suggest that for some participants there is a period of renegotiating their sexual identity after starting the transition process. This view is also supported by research by Roche, Ritchie and Morton (2010) who suggest that "it can be very difficult for transgender people to work out which term to use if they live in more than one gender at the present time or have remained with the same partner throughout their transition" (Roche, Ritchie and Morton, 2010: 11). Over a quarter of participants in the study by Roche, Ritchie and Morton (2010) ticked two boxes to define their sexuality. These responses from both studies suggest the complex nature of sexual orientation diversity among transsexual people.

A small number of participants didn't really want to categorise their sexuality.

*"Maybe bi but I really conceive myself as just me."* (Transsexual woman aged 40-49).

The labelling that is continually going on within society through social discourses can have an impact on us as individuals, both positively and negatively, with our own identity and the

relationships we have with others. This emphasises the importance that we put on labelling ourselves and others in everyday interactions, and how we may question those we interact with who don't match what we perceive to be appropriate for their presumed identity, or how they define themselves.

participants had a period of renegotiating their sexual identity after transition in this section. The section that follows will also discuss how some transsexual people, and their partners who had stayed with them during the transition process, were renegotiating their relationships.

### ***Relationships with partners during transition***

Roche, Ritchie and Morton (2010) suggest that there are many reasons that make relationships difficult for transsexual people. These may include the isolation for some transsexual people in society, the renegotiating of gender roles within existing relationships that were established prior to one partner starting the transition process, and transphobic attitudes to transsexual people in relationships (Roche, Ritchie and Morton, 2010). There were certainly similarities in the findings of my own study and the findings of Roche, Ritchie and Morton (2010) in relation to renegotiating the gender roles and setting boundaries.

Some participants who had been married or were still married had told their partners early on in their relationships that they had a need to dress as the opposite gender at times. These participants had tried to suppress their needs to dress and act like the opposite gender by focusing on their relationships, or also having children. One participant even had allocated 'me' time where she could be her real self.

Two of the participants interviewed had gone through divorces when they started the transition process, which meant they had to move out of the family home and move into new

accommodation and a new area. One of the participants, after a year apart from their ex partner, has started to form a relationship again with them, although they don't live together. They described their relationship as:

*“Less than partners, more than friends. Although we don't live together I see her every day. It's almost like we were married again. She's very supportive indeed.” (Trans woman aged 50-59).*

For some participants who had remained married to their pre-transition partners, there was the added stress and frustration of now having to decide whether to remain married or divorce their partners in order to achieve a Gender Recognition Certificate.

*“I would like a Gender Recognition Certificate, but I have not even applied as it would involve divorcing my wife and that for both of us is totally unacceptable!”(Woman with a transsexual background aged 40-49).*

*“At present, I do not wish to exchange a marriage for a civil partnership, so will not be applying for a GRC” (Trans man aged 40-49).*

A few participants who were married had mentioned that they knew friends in the same position who had, or were about to, divorce and take up civil partnerships instead in order to fulfil the requirements to gain a full gender recognition certificate. At the time of writing an interim gender recognition certificate can be issued to a person who is still married or in a civil partnership, but it only lasts for six months. Within that time frame the transitioned person has to provide evidence that court proceedings have started for the purpose of annulling their marriage or civil partnership (GIRES, 2011). The reason for this provision is that if the civil partnership or marriage is not annulled “the issue of a full Gender Recognition

Certificate would have the effect of creating a same sex marriage or opposite sex civil partnership which are not allowed under UK law” (Justice.gov.uk, 2011).

It is also important to acknowledge that the partners of transsexual people who start the transition process will have also likely been exposed to transphobia, may be questioning their own sexuality, and may face rejection from family and friends for staying with their transsexual partner (Roche, Ritchie and Morton, 2010).

I would agree with Bischof (2011) that the transgender literature dealing with couple and family relationships in relation to the transition process is limited. There is little information available as to how this type of transition might be negotiated. Certainly as Israel (2005) suggests if there is a lack of family support this can sometimes have a negative impact on the transition process and the transsexual person promoting their sense of self in social interactions. This is precisely why I would suggest that the gender identity clinics have a crucial role to play in supporting those who are transitioning, and need to assess the levels of support clients have, especially if they have a lack of family support, and to encourage clients to access support from many different places. It is clear from the experiences of many of those who participated in this study, that a diverse range of support networks are essential for helping a transsexual person to negotiate a successful transition process, and to develop their confidence in promoting their true identity in social situations.

### ***Levels of acceptance and support within the family***

Family support is very important for a transsexual person during the transition process as they may split up from their partner, lose their home or job(or both), and may lose a lot of old friends (Bockting, Knudson and Goldberg, 2006; Leichtentritt and Arad, 2004). Families can help with accommodation and financial support as well. However, the transition process can be a very hard time for families as well. Family members may disown a family member who

starts the transition process. Some family members may have trouble coping with the transition and may suffer a wealth of emotional feelings whilst coming to terms with it all, such as, confusion, shame, guilt, anger and mourning the loss of what that person who is transitioning once was. Even when a family member at the start of the transition process can't accept the loved one who is transitioning legally or socially in their new gender, the family member is likely to provide social support in some way, according to those interviewed. This was especially the case for some of those who were interviewed in relation to their parents.

*“It wasn't easy for all my family, particularly my mother, but I have had one hundred per cent support from them all from the start.” (Transsexual woman aged 30-39).*

*“Family wise my mother and father are struggling, I think like most parents do.” (Transsexual women aged 40-49).*

One person who was interviewed actually felt that since they started the transition process they had a closer relationship with their family than prior to transition.

*“I am probably closer to my family now than I was before I started transition.” (Trans woman aged 30-39).*

Some of those MtF transsexuals interviewed were in their 50s and 60s and had been married and fathered children before they had started the transition process. In these cases their children were now adults, some with their own children. This had meant a breakdown in the relationship they had with their children for some MtF transsexuals.

*“My son he couldn't handle it at all although we still talk to each other we haven't seen each other now getting on for three years” (Woman with a transsexual background aged 60-69).*

For others there was a period of renegotiating the relationship they had with their children. This included the children using the father's new female name in some cases. Although some



children were really supportive of their fathers during the transition process, there was a period for some children of grieving for the loss of their father's previous identity.

There can be a period of renegotiating the relationships a transsexual participant has with their partner and family. There can also be a period of renegotiating the relationships a transsexual participant has with their friends. This will be discussed in the next section.

### ***Friends old and new since starting the transition processes***

Having support from friends can be an important part of a successful transition process. The majority of those who participated in the semi-structured interviews and focus group said that they would have found it extremely difficult to cope during the transition process without the support of friends, be they online friends from transgender forums, transgender support groups, transgender friends, or biological male and female friends.

All but one participant who had been interviewed said that since they had started the transition process they had found that they had a lot more female friends.

*“In the first year there was a very strange rearrangement of my entire social circle. I suddenly found myself having far more female friends than I had ever had before and who were very sympathetic and supportive.”( Trans woman aged 50-59).*

Those who were interviewed in all cases had lost a few male friends when they started the transition process. It was felt by some that their male friends just couldn't handle the fact that their friends wanted to change gender. Even when some had made an effort to try and get used to their friends in their new gender, contact would gradually diminish to nothing. However, for some participants who had kept some of their old male friends, there was a change in the amount of contact they had with those friends.

*“A lot of my male friends just distanced themselves. They didn’t stop being friends, but stopped seeing me as much.” (Transsexual woman aged 50-59).*

Participants from the semi-structured interviews all had a mixture of transgender friends and biological male and female friends. For some participants there was a clear distinction between spending time with transgender friends within the local transgender community, and spending time away from that environment with biological male and female friends.

*“I see my transgender friends once on a weekend and my non transgender friends on and off during the week.” (Trans woman aged 30-39).*

The stage of the transition process some participants were at had an impact on the extent to which they spent time with their transgender friends and biological male and female friends. For example, when starting the transition process, some participants would rely heavily on transgender friends, transgender forums, and transgender support groups, whereas, if a person was nearing the end of the transition process, they were in some cases more likely to have less contact with transgender friends and have more contact away from the transgender community with biological male and female friends.

It was felt by the majority of those participants from the semi-structured interviews and focus group that they had legal recognition in their new gender from their friends, although most participants said that they had lost some friends who they knew before transition who couldn’t cope with them changing gender. One participant who was interviewed described how some friends they knew wanted them to go around to their house dressed in their new gender, so the friends could see whether they were convincing in their new gender to be seen out with.

*“A couple we use to be friendly with said ‘we want you to come around to our house and we will see how comfortable we feel speaking to you.’ They were quite upset about the fact that I wasn’t prepared to come around to their house and be scrutinised as to whether I was an acceptable person to be seen out with.” (Woman with a transsexual background aged 60-69).*

All of the participants from the semi-structured interviews felt that they had, to some extent, social recognition from their friends, but it could vary enormously depending on whether their friends were transgendered or male or female. In most cases gaining social recognition in their new gender from their transgender friends was regarded as straightforward,. It was felt by some participants that it was far more difficult to gain social recognition in your new gender from biological males than it was to gain social recognition in your new gender from biological females.

*“Not the majority of time, it really depends where I am socialising and which group of friends I am socialising with.”(Trans woman aged 50-59).*

*“If I socialise with a group of female friends then I generally get more social recognition as a woman, then if it was predominately a group of male friends.” (Transsexual woman aged 30-39).*

The next section discusses working relationships and the extent of acceptance for transsexual participants’ in their new identity from work colleagues, and emphasises again the need for both legal and social recognition.

### ***Work relationships and the need for legal and social recognition***

Employment is an important element of the transition process, not only in terms of making a living, but it is also generally a requirement by the gender identity clinics that the transsexual person needs to provide proof of their occupational activity during the transition process, be that paid or voluntary work, in order to successfully pass through the care pathway and gain

Gender Reassignment Surgery, if needed (Leeds Gender Identity Service, 2010). Previous studies such as Whittle, Turner and Al-Alami (2007) and Dietert and Dentice (2009) have suggested that transgender people have often had a poor experience of acceptance within the work place. This has sometimes resulted in a transgender person having to use an inappropriate toilet, suffer verbal abuse or physical harm, and even having to change their job (Whittle, Turner and Al-Alami (2007)).

However this study would suggest that things are slowly improving for transsexual people in relation to employment within the UK. This may be mainly due to the introduction of recent legislation, such as the Equality Act 2010, which requires employers to have due regard to the needs of transgender people by considering the impact on them in relation to the employer's policies and practices (GIREs, 2010). What was apparent from the semi-structured interviews and the survey was, that a large proportion of participants (23) who were working, were still working for the same employer who employed them prior to transition. The majority of these participants had a positive response, to some extent, from their employer and fellow employees.

*“I transitioned in the same professional job with good support from the employer and the people I work with.” (Transsexual woman aged 40-49).*

*“My employer has been exemplary really in how they have dealt with it. There has been no awkwardness.” (Transsexual woman aged 25-29).*

However, even when participants had an overall positive experience within the work place, there were still occasional problems for some of them. This included issues around using appropriate toilets when starting the transition process in the work place. As some participants mentioned, fellow work colleagues, when hearing that a person was due to start the transition process at work, would question whether it was appropriate for that person to

use toilets assigned to people of their new gender, or whether it would be better for all concerned if the person transitioning used a disabled toilet.

*“Somebody asked if I was going to use the ladies’ loos, because the girls would object to a man going in the ladies’ loos.”(Woman with a transsexual background aged 60-69).*

When it is considered that the start of the transition process is not only a time of major physical, social and emotional change for a transsexual person, but they may also have lost their home, partner, and to some extent, even family and friends. The last thing a transsexual person wants to be worrying about is whether they will be able to use toilets appropriate to their new gender without someone complaining about it.

A couple of participants mentioned that occasionally the atmosphere would change when they entered a room if certain work colleagues were present. This was perceived to be for one of two reasons. Firstly, that a work colleague may have known the person prior to them transitioning in the work place and was therefore uncomfortable around them in their new gender. This led to the work colleague always being defensive around them. Secondly, that the person may have had transphobic prejudices.

*“I know that in some cases the atmospheres have changed quite rapidly when I’m around and some people find me intimidating, especially people who use to know me in my past as a bloke.”(Trans woman aged 50-59).*

A continuing theme that was present in the research interviews and the survey was the importance of having not only legal recognition at work, but also social recognition. Whilst legal recognition to some extent was felt to have been achieved at work by the majority of participants, social recognition was perceived by some participants to be harder to gain in the work place. I would suggest that the reason legal recognition maybe easier to achieve in the

work place is that there is a legal duty for employers to implement equality and diversity policies. Employers and employees will generally do what the law requires of them. However, the problem is whether they will go further than what the law says and embrace the spirit of the law, and give the employee who is transitioning social recognition as well.

*“I challenged a work colleague who had become really uncomfortable around me. They replied ‘we accept you coming to work dressed as you are, what more do you want’.” (Trans woman aged 50-59).*

I would suggest that having legal recognition in a new gender within the work place may be sufficient on its own in relation to the contact a person may have with higher management. However, in relation to those employees a person has to work with on a daily basis, they have to be comfortable around you, and better still, give you social recognition in your new gender to enable you to have a good working relationship. It is a very complex situation that can't be achieved by simply having legal recognition. That doesn't help on its own to promote a transsexual person's working identity, self identity, and confidence. What is needed by a transsexual person in the work place is both legal recognition and social recognition in their new gender.

What is apparent from the interviews is that there is generally a period of initial support from work colleagues when a person starts the transition process. Then, for some work colleagues, it is about them becoming comfortable around the person who is transitioning. This is followed by work colleagues generally giving the person who is transitioning social recognition in their new gender to some extent.

*“Some acquaintances at work became close friends after that.” (Trans woman aged 50-59).*

Only one participant, who was working for the same employer that employed them prior to transition, said they were having a very negative experience within the work place.

*“Wish my manager and work colleagues would not gossip about me to all new employees. I have a few closer colleagues who defend me, and tell me what goes on. Being called 'a shim' behind my back is somehow worse than having it said to my face.”(Trans man aged 18-25).*

Ten participants from the survey were still in the same type of job that they had done before they transitioned. However, it wasn't clear whether this was due to a negative response from their previous employer with regards to their forthcoming transition, or whether the participants felt they needed a fresh start working somewhere else.

Ten participants from the survey were, since transition, doing a different type of job than that prior to transition.

*“I work in the IT sector now, ranging from servers to networking, web design and pc repairs. I used to work as a manual labourer, lots of heavy lifting very manly job.”(Transsexual woman aged 40-49).*

No one who participated in the survey felt there was pressure on them to conform to a more traditional gender specific occupation. One participant, who was a transsexual woman, was working for the same employer that employed her prior to transition as a research and development technical assistant in a factory based laboratory, which was a very male dominated environment.

### ***Interactions with health and social care staff***

Some participants questioned whether they should have a more engaging role in working in partnership with their GPs and surgery administration staff, with regards to their health care

needs, and what clinics and screening services are actually appropriate to them. Words such as ‘ownership’ and ‘taking responsibility’ were often used by participants in relation to this issue. These participants also felt that the trans community had a responsibility to educate, help, and support health and social care staff that they came in to contact with in regards to what transsexualism was, and what transsexual people’s needs are, when accessing their services and mentioning any issues they have when they access their particular services. This was certainly a positive attitude to health and social care staff and services. The participants certainly had a realistic view that not all health and social care staff would know what transsexualism was, and what transsexual people’s needs were, when accessing services.

*“It’s maybe the case that we as patients need to take responsibility to educate the NHS about transsexualism.” (Woman with a transsexual background aged 30-39).*

When a person takes the first steps to starting the transition process then the first medical person they are likely to contact is their GP. A GP’s role in the transition process can be an important one as they are usually responsible for not only making a referral to a local mental health team to see a psychiatrist, and following that a referral to the gender identity service, but are also responsible for monitoring a patient’s general health throughout the transition process, and after. However the experiences of participants in relation to this issue showed a broad range of responses from extremely positive through to extremely negative.

Some participants had really positive experiences when they first went to see their GPs about starting the transition process. This, in some cases, was due to the GP having previous experience of transsexual patients and so being fully aware of the referral process and who in their local area to make the referral to.

*“Fantastic GP knew who to contact and who to refer me on to” (Woman with a transsexual background aged 40-49).*



One participant interviewed actually had a GP who was a transsexual woman, so she had confidence in the GP being able to answer her questions and concerns.

*“My GP is a transsexual woman, so she understood all of my questions and put me at ease with things I wasn’t sure about.” (Trans woman aged 60-69).*

A few participants had bad experiences when they first saw a GP about their Gender Dysphoria, which resulted in them leaving one GP’s surgery and registering with another GP’s surgery in the local area. Some of these participants had asked advice from local friends who were transsexual or transgendered to find out which GP’s they used, or would use transgender internet forums to see if anyone knew of a transsexual friendly GP in their area.

*“I took some advice from friends living locally near me, who knew a doctor who knew a little about Gender Dysphoria, so I went and saw her instead.” (Woman with a transsexual background aged 30-39).*

Two participants mentioned that their GPs had confused transsexualism with being gay, and an issue of sexuality rather than gender. This would support research findings by Shapiro (1991) and Fee (2006) in relation to transsexualism being misunderstood by health care professionals, and sometimes confused as a form of disguised homosexuality.

### ***Authenticity***

Whilst some participants may have often expressed a very early sense of confusion with their gender identity in early childhood, it is common in those who participated in this research to have made the transition well into adult life. Thus, while there was an early sense of one’s true self identity, this was often internalised and not dealt with until much later in adult life.

*“I was sent to see a psychiatrist at the age of 6 years old for gender inappropriate behaviour. It wasn’t until I was in my late fifties that I started the transition process” (Trans woman aged 60-69).*

*“I knew there was something wrong with me from the age of 7, but could never put my finger on what it was. It was only when I went to university and you start to explore the world, that’s when you start to think shit there’s this thing called Gender Dysphoria that fits in with everything I have been feeling” (Transsexual woman aged 25-29).*

Yet internalising this identity could cause great distress for participants in many ways, and the relationships they had with others.

*“You suppress this for years and years and you tend to keep people at a little bit of distance, because you don’t want to actually give anything away” (Woman with a transsexual background aged 60-69).*

For most participants interviewed, the decision to start the transition process had come about due to them being unable to carry on in their previous gender and living a lie about who they actually were. For others it was due to a major event in their lives such as a divorce, bereavement, or retirement.

Whilst coming out as transsexual and receiving social support in your new gender can be a rewarding time for some transsexual people, at the same time there can also be a sense of loss for the person that transsexual person use to be in their previous gender. During the research study some participants talked about their previous identities’, remembering past embodiment, and the positive and negative parts of that previous identity. For all of those participants interviewed there was a sense of fondness and admiration for who they used to be. In contrast to the work of Kanuha (2000) who suggested that insider researchers needed

to be aware of the positive spin that some participants may want to put on their experiences, and not mention the negatives experiences they have had previously. The participants interviewed in this study seemed open and comfortable to discuss their previous identities.

Many of those who participated in the research had been involved to some extent with the transsexual community. This included supporting others, raising awareness of transsexual issues, and working with local communities and local health care services. Some participants felt they were reshaping their identity in a more positive light. They were growing in confidence and expressing who they were. For some participants the interview process was an opportunity to reflect on how far they had come with the transition process, and to some extent, reevaluating their identity and experiences, and recognising some of the oppression they may have faced in the past. For example, reevaluating levels of verbal abuse they may have faced, and whether that had reduced now due to their confidence, or was that due to the level of acceptance of transsexual people now in wider society?

Some literature had previously questioned the impact medical discourse had on the authentic status of transsexual people in relation to their identity, thus suggesting that transsexual people were mimicking the gender norms of the time, and the symptoms of transsexualism set out by medical discourse, in order to gain treatment (Raymond, 1979). Yeadon (2009) suggests that “Transsexual authenticity is treated as neither determined through medical discourses nor as interior to the self, but rather as a live interactional accomplishment” (Yeadon, 2009: 243). Yeadon (2009) sees transsexual people as ‘constructing subjects’, and thus, social interactions are essential for promoting ones identity and reevaluating it. Whilst I would agree to some extent with Yeadon (2009) that social interactions are very important in

the promoting of one's self, I think she discredits the importance of medical discourses in helping to promote a transsexual person's true identity.

### ***Concluding remarks***

This chapter has discussed the impact social discourses can have on the transition process, identity, and transsexual people's experiences of accessing health care services. Frank's theory of the body (1991) in relation to the communicative body has been discussed, adapted, and applied for analysing the experiences of transsexual people accessing health and social care services in this thesis. Whilst Frank's notion of the communicative body is in relation to the ill body and losing one level of expression and creating a new one, I would argue that transsexual embodiment can also be seen in a similar way. Transsexual people starting the transition process will be losing one form of expression, which has been their previous gender, and in a process of creating a new form of expression in their new gender. It is only by using discourses and institutions, that legal recognition and social recognition for the new self can be created. This was demonstrated in the interactions research participants had with partners, family, friends, health care staff, and work colleagues, although there was varying levels of social recognition and legal recognition given to transsexual participants in relation to these interactions. This chapter also discussed the complexities research participants had with defining themselves, and the importance of labelling in social discourses. For example, how the terms used by participants to define themselves could change over time depending on what stage of the transition process they were at, and who wanted to know. There was also questioning by some participants about how they fitted into certain labels, such as sexual orientation, during the transition process. Therefore, for some participants, there was a period of renegotiating their sexual identity. This emphasises the importance we put on labelling ourselves and others in everyday interactions, and how we may question those we interact

with who don't match up to what we perceive to be appropriate for their presumed identity, or how they define themselves.

In chapter six the impact institutions have on the transition process and transsexual people's experiences of accessing health and social care services is examined.

## **Chapter Six: The impact institutions have on the transition process and transsexual people's experiences of accessing health and social care services**

The previous chapter discussed the importance that Frank (1991) placed on discourses as an important form of expression for the communicative body in his theory of the body. This chapter starts by discussing the importance Frank (1991) placed on institutions for the expression and promotion of the communicative body in his theory of the body.

“Although I have theorized discourses and institutions only in their barest terms, bodies are the foundation of discourses and institutions as well as their product. Institutions are only formed through the labour of bodies, and are only reproduced through this labour. These bodies are real, lived experiences and institutions cannot be understood apart from those experiences” (Frank, 1991: 91).

Frank's (1991) theory of the body is derived partly from his critique of Turner's (1984) typology of the body (Hancock, 2000). For Turner (1984) the starting point for his theory of the body is to view the body from the perspective of the structural problems it creates for the government of stable social systems (Shilling, 2003). Turner (1984) argues that every society is confronted by four tasks in relation to the government of the body (Turner, 1984). These tasks are “1. The reproduction of populations through time. 2. The restraint of desire as an interior body problem. 3. The regulation of populations in space. 4. The representation of bodies in social space as a task facing the surface of ‘exterior’ of bodies.” (Shilling, 2003: 78). The institutional subsystems used to manage the tasks are patriarchy, asceticism, panopticism, and commodification (Turner, 1984).

Turner's (1984) theory of the body suggests that bodies are influenced by institutional and structural constraints, whereas, Frank's theory of the body examines the relationship between the body and human action (Frank, 1991). Shilling (2003) suggests that Frank's theory of the body "adopts a social constructionist approach to the body in so far as he views the significance and development of bodies as inextricably related to social forces and social relationships." (Shilling, 2003: 82). However Frank goes further than this as he discusses the existence and the importance of corporeality within his theoretical framework, and how it affects how people experience their bodies. Corporeality will be discussed further and in more detail in Chapter Six. As discussed in Chapter One there are "four questions which the body must ask itself as it undertakes action in relationship to some object" (Frank, 1991: 51). These four questions concern self-relatedness of the body, relation to others, desire, and control (Frank, 1991). Frank identifies four types of body usage, and their respective media of activity, which can solve these action problems. These are disciplined (regimentation), mirroring (consumption), dominating (force) and communicative (recognition).

The theoretical focus of chapter four and this chapter has been on the adaptation of Franks (1991) theory of the body and the importance of the communicative body for the promoting of the transsexual person's new identity in social discourses and institutions, and therefore, in helping them to achieve legal and social recognition.

"The body continues to be formed among institutions and discourses, but these are now media for its expression. For the communicative body institutions and discourses now enable more than they constrain, while in the other body styles the opposite prevailed." (Frank, 1991: 80).

Frank (1991) suggests that the dominating, mirroring, and disciplined bodies could be discussed on a level of empirical description, whereas, the communicative body is less a

reality (Frank, 1991). The communicative body could emerge perhaps in dance, performance, and the caring practices of medicine in the future, suggests Frank (1991).

“The essential quality of the communicative body is that it is a body in process of creating itself. Theory cannot describe such a body, nor can it prescribe it. The task is rather to bring together fragments of its emergence.” (Frank, 1991: 79).

However, I would suggest that the experiences of participants’ transition processes, and their discussion of their transsexual identities discussed in this thesis, provides empirical evidence to support the reality of the communicative body in society. Frank (1991) suggests possible fragmentations of the communicative body in the future. However, this thesis would suggest that the theoretical framework used in this study draws together the strands of corporeality, institutions, and social discourses in order to be able to analyse the complex interactions these have on each other, and their promotion of the transsexual identity. This could be the ideal type of communicative body Frank (1991) was looking for.

As previously discussed, the introduction of the Gender Recognition Act 2004 has meant that transsexual people can now gain legal recognition in their acquired gender under the law of the United Kingdom (Office of Public Information, 2004). Therefore institutions have played an important role for enabling the expression of transsexual research participants’ new identities through the interactions they have had with different institutions, such as health and social care services, local government departments, and banks and building societies. However, the interactions that transsexual people have with members of those institutions also helps to show the complications the transsexual identity and body can represent for an institution’s systems, policies, and practices.



### *The views of health care professionals*

Two health care professionals were interviewed for this research study. This was an important part of the research process as there was little evidence of the experiences of health or social care professionals working with transsexual patients within the existing literature. It was important that this study was able to show the issues health care professionals face when working with transsexual patients, and their views on some of the problems treating a transsexual patient generates for their policies, practices, and computer systems. Participant A was a Sister Nurse in a large GPs' medical practice. Participant B had worked in a hospital as a Clinical Specialist in Ultrasound. She dealt with referrals from GPs and outpatients, which would be paper referrals with the patient's details on and reason for the examination, but nothing else.

In this thesis the term 'patient' will be used to refer to a person who uses health care services. Within social work practice and social work services there are many ways to describe the relationship between those who provide services and those who receive them (McLaughlin, 2009). A variety of preferred terms to describe this relationship are in use within social care services and in social work literature, such as, customer, client, consumer, expert by experience, friend, and service user (Parker and Bradley, 2003; D'Cruz and Jones, 2004; and Adams et al., 2005). Different social care services may attach different assumptions to a certain term to define the social work relationship between those who provide a service, and those who are in receipt of the provided service. The term chosen can be important to services as it may help to indicate to a person using their service how the service perceives them (McLaughlin, 2009). However, terms used in social work to describe the people who use those services can have a shelf life in their popularity of use by different services, or can be hotly contested by individual social workers (Dole, 2012). The term 'service user' will be used in this thesis to describe a person who uses social care services. Although the term

'service user' can be contested by many in the social care profession, the term is considered appropriate in this thesis for differentiating those participants' experiences of accessing social care services, whilst at the same time, discussing their experiences as patients accessing health care services.

### ***The referral process from GP surgeries and outpatients***

Participant B mentioned that the amount of information provided by the referral process may be sufficient for health care staff, in most cases, to efficiently carry out scans on biological males and females, but transsexual people are likely to have a mixture of biological characteristics of both sexes, and may have the opposite genitalia to the gender they currently present in. This can sometimes lead to confusion for health care professionals and administration staff in relation to whether the scan the transsexual person has come for is appropriate to them, or whether there has been a mix up with the paperwork.

Participant B received a referral for a patient with a female name to have a scan that was usually only appropriate for male patients to have.

*"I thought what's going on here, have we got the wrong patient as this does happen sometimes. They put one patient's name on and it's a different clinical referral reason and the doctors have got it mixed up."* (Participant B).

Participant B felt that when they received a referral, if the patient was transsexual then that information should be made available to them in some way by the refer, whether they are the patient's GP or specialist, prior to the scan appointment date.

*"There's just the patient's name, reason for ultrasound and nothing else that would alert you to anything different or something you needed to be a little bit careful about perhaps."* (Participant B).

Participant B also mentioned that having some information that could alert you to the fact that the patient was transsexual would help to mentally prepare staff to be able to treat that patient with respect.

*“Patients would be brought into the room by somebody else and you can’t help being a bit surprised if the person is transgendered and that would then be a bit offensive to them to see you being slightly surprised.” (Participant B).*

Therefore this would suggest that more needs to be done in relation to health care staff and different health care services sharing information about a patient who is transsexual in order to provide a more respectful and efficient service that meets the needs of the individual transsexual patient.

*“There needs to be away were this sensitive information is flagged up from the referrer. I don’t think it would warrant a special list or anything, but it does need addressing. Having that sensitive information on the paper would make that initial face to face with somebody easier to know how to deal with them.” (Participant B).*

The experiences of Participant B would suggest that more needed to be done in future to ensure the appropriate information was shared between those services if another transsexual person required a referral for screening services. However, this raises data protection issues over the disclosure of the transsexual person’s identity and past identity. One way around this would be to gain written consent from those transsexual patients to enable the GP surgery to share that sensitive information with the screening service. This would help to provide a better experience of accessing the screening service for transsexual patients and would cause less time wasted by staff trying to ensure that the patients are there for the appropriate screening. This may also suggest that the lack of appropriate information is down to policy makers within those services needing educating about the issues transsexual people may have

about accessing their services. The personal views, values, previous social discourses, and their culture can all impact on the judgements policy makers make within services. It is likely, in some cases, that policy makers would still have a dichotomous view of gender when writing policies, and not be aware of the implications a transsexual person would have to that policy when accessing their service. The next section of this chapter discusses Integrated Care Pathways, which may have helped if they had been implemented in the cases discussed by Participant B.

### ***The formation and changing structures within the National Health Service (NHS)***

The NHS was formed in the UK with the aim of providing publicly funded free comprehensive health care services to all citizens (Harker, 2012). There are also many private health care providers including those who are charity funded operating in the UK. The state not only provides the NHS but also regulates those health care services provided by others (Thompson, 2005). The term NHS is commonly used to refer to the National Health Service across the UK. However officially there are four publicly funded independent health care systems in place within the UK, with different management operating systems, structures, rules, and policies (Harker, 2012). These four different healthcare systems are as follows:- NHS (England), NHS (Scotland), NHS (Wales) and (HSENI) Health and Social Care in Northern Ireland. Therefore, where possible, if there has been a significant issue discussed in this study that has been raised by participants in a particular country, then the appropriate NHS term will be used for that particular country.

At the time the fieldwork was undertaken for this thesis, Primary Care Trusts (PCTs) were still in place within England, and were responsible for commissioning health and social care services to meet the needs of local populations. Harker (2012) suggests that whilst most commissioning still took place within the NHS, it was not uncommon for PCTs to be

increasingly purchasing services from private and charity sectors of healthcare, and from local authorities (Harker, 2012). This was certainly the case for some participants in this study who were accessing NHS gender identity services and wanted Gender Reassignment Surgery. These participants were referred to a private specialist and hospital for the surgery. This was partly because of the agreements in place between those services, and funding from patients' local PCTs, and due to the small number of surgeons in the UK performing Gender Reassignment operations. Since April 1st 2013, PCTs in England have been abolished. Their functions have been taken over by Clinical Commissioning Groups (CCGs) and Local Area Teams (LATs). There are 229 planned CCGs and 27 LATs that share the responsibilities of commissioning services for their local communities in England (NHS Choices, 2013). Therefore, at this time, it is not clear what impact these new structures will have on prioritising and purchasing services for those who are transitioning through the NHS care pathway. It is recommended that this is an area that may require further research beyond this thesis as the CCGs and LATs are established.

In the same way that social policy requires interpreting and implementing the law into policy, so does health and social care policy require making sense of broader legal and policy issues and relating them to a certain service and its own practices (Thompson, 2005). Therefore as Thompson (2005) suggests, a service's policies reflect interpreting broader concerns and issues on a certain topic, and then applying them to the specific circumstances of the particular service concerned (Thompson, 2005). When considering a service's policies, it is also important to consider the extent to which policies are implemented into practice. Thompson (2005) suggests that "unfortunately, it is not uncommon for policy to exist on paper only, in the sense that they form part of the official policy of the agency concerned, but are not actually acted upon." (Thompson, 2005: 45).

A service's policy guidelines and procedure are important factors for shaping the translation of policy into practice. Thompson (2005) suggests that another important factor to consider is the impact organisational culture has on implementing policy into practice. Organisational culture refers to the set of beliefs, values, and assumptions that become established over a period of time, that determine how an organisation conducts itself (Shahzad et al., 2012). Organisational culture can be very influential in subtle ways over time, on the habits and patterns of working within a particular service. Therefore the patterns of working that develop as part of an organisation's culture can have a significant impact on how law and policy are implemented into everyday practice of the organisation (Thompson, 2005).

Multidisciplinary working may also create conflict and tension between one organisation's culture and that of another's, because of different styles of working. Hodgson (2005) suggests that multi-disciplinary working can be seen as many different professionals working with a patient each on their own, whereas, interdisciplinary working can be seen as many different professionals actually talking to one another and planning together. Inter-professional practice "describes the working together of two or more professionals, implying that there is some level of collaboration between them" (Wilson, Ruch, Lymberg and Cooper, 2008: 694). Hodgson (2005) suggests that inter-disciplinary working is not only collaboration between different professional people, but also one where the views and opinions of patients and their families are being listened to (Hodgson, 2005). There may be a blurring of the different professionals roles within the team, but individual professional identities are still present. I would suggest that this form of working can help different professionals to gain a better understanding of the working practices, values, and prioritising of needs, that different health and social care services have.

It is clear that in order to provide seamless services, best practice and comprehensive attention to patients' and service users' needs, health and social care agencies need to work effectively in collaboration with each other. This includes a high degree of communication, co-operation, flexibility, common goals, and rejection of hierarchies of power (Korner, 2010; Hall and Weaver, 2001; and Jones, Cooper and Ferguson et al., 2008). It is also vital to work in partnership with patients and service users, because this helps to form trust and co-operation. Also, working in this way can enable patients and service users to have more control and power over their lives, and therefore, can empower them. However, what is also apparent is that across health and social care services "different cultures, policies, agendas and funding all have the potential to make the day-to-day experience of inter-agency collaboration extremely frustrating, time consuming and, all too often, unsuccessful" (Glasby and Littlechild, 2000: 87).

Collaboration between different professionals and different health and social care services can help to provide better services to meet the needs of patients and service users. It is a far more efficient way of working, both cost wise and time wise. For patients and service users, collaborative working between services can help them to feel less frustrated, as they do not have to repeat the same information through duplicate assessments. Professionals can become more sensitive and understanding to the values, ways of working, and prioritising of different professionals and agencies (Korner, 2010). However, different working practices, policies, and funding all have the potential to be barriers to successful collaborative working, and can leave individual professionals frustrated in their practice. The next section of this chapter explores the experiences of Participant B working with transsexual patients, and highlights the problems she encountered with the lack of communication and collaborative working practices between primary and secondary health care services.

### *Integrated Care Pathways (ICPs)*

“Care pathways describe the route that a patient will take from their first contact with an NHS member of staff to the completion of their treatment. They help ensure that consistent care is provided throughout the NHS.” (Public Health England, 2013). When a transsexual person accesses an NHS gender identity service, or a private gender identity service, then the care pathway should include all the stages of gender reassignment, assessment, social gender transition, hormone treatment, and surgery (Leeds Gender Identity Service, 2013).

An ICP can be used to create locally agreed multidisciplinary and multi-agency practice, using guidelines and research where available, to provide care and services for a specific patient/client group (Overill, 1998). “ICPs developed in the late 1990s as a basis for plotting and agreeing pathways of care for particular conditions or procedures. Pathways are designed to reduce variation in practice and allow the same quality of care to be delivered to patients across multi-disciplinary and multi-agency teams and in different care settings.” (NHS Scotland, 2007). However on a national level there was a wide variation on practice, appointment waiting times, and quality of care given to research participants who attended gender identity services. This was certainly one of the main issues raised by many research participants.

Ritzer (2004) suggests that “medicine has moved away from human towards nonhuman technologies. The two most important examples are the growing importance of bureaucratic rules and controls and the growth of modern medical machinery.” (Ritzer, 2004:110). Ritzer (2004) suggests that the care pathway can raise issues for multidisciplinary working as the standardized series of steps of working may not account for the different ways of working that require different information and different working practices dehumanizing the control a doctor has over their work. (Ritzer, 2004). Previously doctors would have had a large degree of control over their work with the main constraints on practice being the needs and demands



of patients. “In rationalized medicine external control increases and shifts to social structures and institutions.” (Ritzer, 2004: 155). Doctors and other healthcare professionals are not only more likely to be controlled by these structures and institutions, but also by managers who are not doctors themselves (Ritzer, 2004).

Like doctors and other health care professionals, Ritzer (2004) suggests that patients are increasingly feeling dehumanised and treated like a number when accessing health care services, and by the structures and bureaucracy that are controlling these services, which appear to patients as distant, uncaring, and impenetrable (Ritzer, 2004). A lack of communication from health care services, and in particular, a lack of follow up contact after initial contact with patients, was an issue raised by some research participants in this thesis. When it came to gender identity services, for example, some participants felt that, because the waiting time for a first appointment could be a considerable amount of time, then a follow up call by staff to patients could help to put them at ease; that they were on the waiting list and would be seen shortly.

*“Just to know you haven’t been forgotten about and that you would be seen shortly, would at least go some way to putting you at ease” (Transsexual Woman aged 40-49).*

The lack of communication from staff at one gender identity service in the UK to some research participants was a concern, which caused them frustration and distress.

*“I had not heard anything for ages after my first appointment at the gender clinic and it was only after my GP had sent them a letter to tell them that I would be having Breast Augmentation shortly, that the psychiatrist at the gender clinic contacted me to arrange an appointment.” (Woman with a transsexual background aged 30-39).*

## **Health care professional's experiences of treating transsexual patients and wanting to act in a sensitive way that does not offend**

During the interview with Participant A, the practicalities and issues of writing notes in a patient file of somebody who was transitioning were discussed.

*"I think a person like yourself who is going through the transition process is far more aware of the problems and confusion that this (the transition process) can create for health care staff and the systems we have in place, so you are probably more comfortable to talk about any issues. Whereas I think we are a little more uncomfortable in general, as we don't want to be seen as insensitive, as we are not always sure what to write in a patient's file who is transitioning, or when talking to a person who is transitioning about such issues as screening services." (Participant A).*

The issues raised by participant A in her interview were later discussed in other interviews and the focus group with the transsexual participants. This included the confusion transsexual patients can cause to the systems in place within health care services, such as, appropriate screening services, and the difficulties some medical staff could have in engaging with transsexual patients in a way that was not perceived as insensitive. Some transsexual participants questioned whether they should have a more engaging role in working in partnership with their GPs and surgery administration staff, with regards to their health care needs, and what clinics and screening services were actually appropriate to them. Words such as 'ownership' and 'taking responsibility' were often used by participants in relation to this issue.

*"It's maybe the case that us as patients need to take responsibility to educate the NHS about transsexualism." (Woman with a transsexual background aged 30-39).*

These participants also felt that the trans community had a responsibility to educate, help and support health and social care staff that they interacted with in regards to what transsexualism was, and what transsexual people's needs are, when accessing their services. For example, one trans man was taking ownership of his healthcare needs by ensuring that he had educated himself with the relevant information about his upcoming need for an hysterectomy, and what he may or may not need in relation to screening services after that as a trans man.

*“I have not had any screening services since starting FtM transition. I will need a hysterectomy soon, though. I have best-practise guidelines to present to healthcare provider when the time comes.” (Trans Man aged 40-49).*

The transsexual participants certainly had a realistic view that not all health and social care staff would know what transsexualism was, and what transsexual people's needs were, when accessing services.

### **Confusion over appropriate screening services**

Screening services can be an issue for some participants when they start the transition process. This is generally in relation to them changing their title details at their GP surgery, which causes the surgery computer to send out a standard letter for screening services appropriate in their new gender. As mentioned in the literature review, a transsexual person may need to use some screening services throughout their life that are appropriate for females only as well as some screening services that are appropriate for males only, due to their mixture of biological characteristics (Department of Health, 2008; Feinberg, 2001 and Ashbee and Goldberg, 2006).

However this raises two main issues for health screening services, that need to be dealt with in a sensitive manner. Firstly, the transsexual person's GP surgery needs to be able to flag up

on their computer system that the patient doesn't need certain screening services in their new gender, and at the same time, needs certain screening services from their previous gender. This needs to be done in a sensitive manner, which at the same time protects the patient's identity as a transsexual person, and their name details in their previous gender.

*“The problem is letters are sent out in bulk, so if a mammogram test is needed everybody who is listed as female and falls in the age group for screening gets a letter.” (Participant A).*

Participant A felt it was important that she added extra notes within a transsexual patient's file with regards to what was appropriate, and what was not appropriate, in relation to screening services for the transsexual patient.

*“When I see a patient who has started transition I type notes into the patient's file on the computer such as, ‘this patient does not have a cervix, so no screening is needed’ or ‘this patient no longer has a cervix’.” (Participant A).*

However, this is reliant on the person sending out the screening letters (administrator/receptionist) seeing this information on the computer. For example, they may collect information off the computer by just asking the computer to search for females aged between 50 and 70.

Secondly, if a transsexual person needs to access a screening service appropriate to their previous gender, does the screening service give them an appointment time out of hours, so they are not sitting with other patients of the opposite gender, and therefore, giving them more privacy? However, this may have the opposite effect of alienating the transsexual person further by treating them differently, and why should they have to have a less convenient appointment time to other patients?

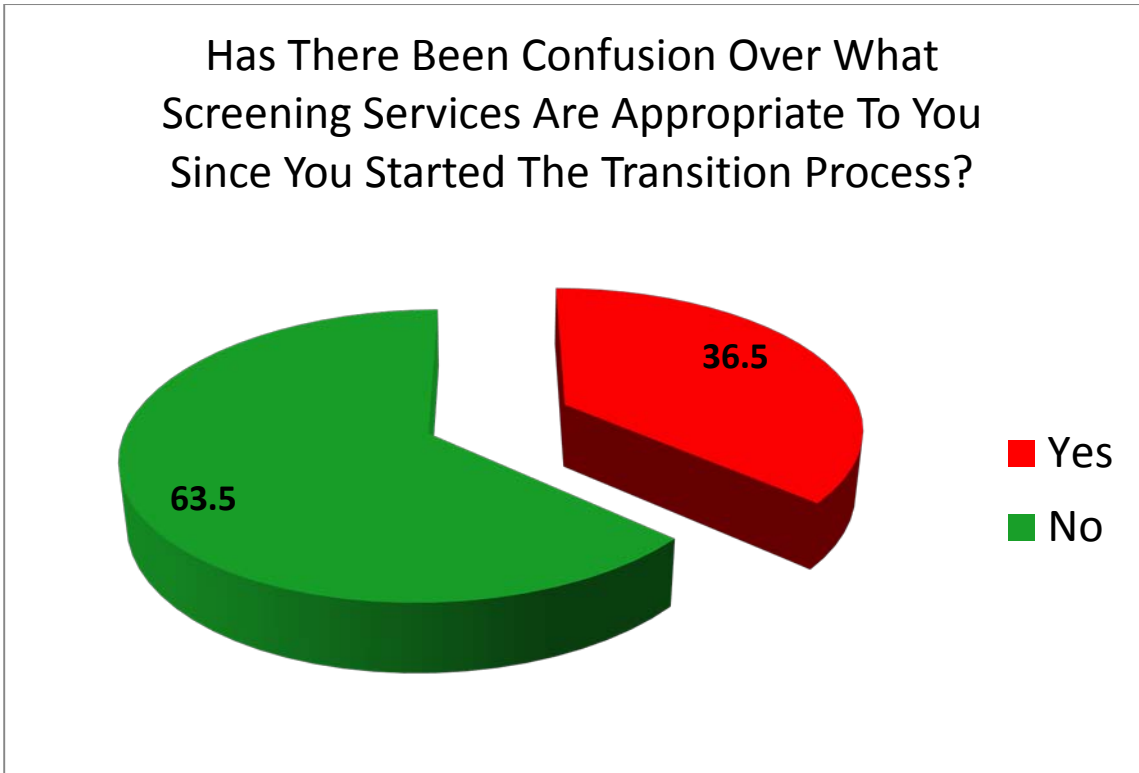
*“I hit 24 in a few months and am not sure if I'll get the usual pap-thingy reminder/recommendation. I don't want it but I realise I ought to.” (Trans man aged 18-25).*

*“I have had 4 requests now for cervical screening and on each time I advise them I don't have a cervix. I do have a sense of humour and in one sense I take the letters as a compliment; however I am sure the real reason for sending these is perhaps my title prompts the computer system to print a standard letter.” (Woman with a transsexual background aged 40-49).*

Transsexual research participants were asked if they had ever experienced confusion by their GP or screening services in relation to what screening services were appropriate for them now that they had changed gender. As *figure 6.1* shows, over a third of participants out of 67 participants who had answered the question had experienced some confusion by screening services or their GP as to what screening was appropriate, which is quite worrying as this would suggest that the health of a large number of participants could be put at risk.

In some cases male and female participants who were over fifty years old, and on hormones for over five years, had not received any screening services for breast cancer. It was the same for some male participants who were over twenty one years old and had not had a cervical smear test.

*“I have not had any screening services since starting FtM transition.” (Trans man aged 40-49).*



*Figure 6.1 shows whether there was confusion about what were appropriate screening services for transsexual participants by health care professionals.*

For some participants, confusion over appropriate screening services for them was quickly resolved by their GP surgery or local Primary Care Trust. In the case of Cervical Cancer screening, transsexual women would sometimes receive a letter that said they didn't need a Cervical Smear test as they never had a Cervix, or that they had recently had their Cervix removed.

*“My doctor’s surgery sent me a letter pretty quickly to say I had been removed from the Cervix screening programme.” (Woman with a transsexual background aged 30-39).*

This issue of confusion over what are appropriate screening services for a person who has transitioned is an important area of practice that needs addressing to improve services that meet the requirements of transsexual people’s health care needs. The use of binary health care computer systems within health care institutions is the source of many of the difficulties

in relation to transsexual people's experiences of gaining access to appropriate screening services.

### ***Gender Reassignment Surgery***

In total 9 participants had undergone Gender Reassignment Surgery (GRS), whilst 14 participants were presently waiting to have GRS. Surgery was provided either by the NHS or private health care insurance, and in some cases participants had gone abroad to Thailand to have their surgery. At the time of the research process there were only 2 surgeons in the UK performing GRS. A participant from one interview who had GRS done on the NHS, and then had breast augmentation and facial surgery done privately, mentioned the differences in the quality of care, especially after care, or the lack of it, between the NHS and private surgery. The NHS gender clinic had not gone into any great detail about the operation, and there was little time made for a discussion about the proposed surgery with the participant. There was very little aftercare, and no information leaflets about female hygiene were given to the participant after her Gender Reassignment Surgery.

*“If you have your Gender Reassignment Surgery at the NHS gender clinic, there is no information given out about female hygiene after your surgery and if you don't understand what you need to do then often you will end up with a urine infection. A simple handout by the gender clinic would avoid that in most cases.” (Trans woman aged 60-69).*

Yet when the participant had private surgery she was given time to ask questions before her surgery, and was given lots of information leaflets about aftercare when she left the hospital after her surgery.

*“The post operative care was really good, not only did I have follow up checkups, but the surgeon rang me up to see how I was and went through all the aftercare things I needed to do again with me.” (Trans woman aged 60-69).*

There are many different ways to construct a Vaginoplasty (Vagina) or a Phalloplasty (Penis). However this can cause complications in assessing what screening services are appropriate to different transsexual patients and their increased or decreased risk to different cancers. For example, whether a FtM as had a full hysterectomy or not will determine if he needs to have a Pap Smear for cervical cancer. If a MtF has had a Vaginoplasty created which has used the head of the penis to create a Neocervix then they will have to have routine Pap Smears (Bockting and Goldberg, 2006). This links in with the earlier discussion on taking ownership of health care needs. Transsexual patients need to ask more questions about the construction of their new genitalia, and what screening tests should be appropriate to them.

### ***Confusion reading blood test results***

When a transsexual person is taking hormones they need to have regular blood tests done. This not only helps to show the effectiveness of the medication and whether the hormone dosage needs increasing or decreasing, but also whether the medication is having a negative impact on physiological and biochemical states and organ function. When the blood samples are sent to the laboratory for testing they only say male or female on the label. This can create a problem for determining the results for a transsexual patient because the results will show whether the transsexual person’s blood levels are within a healthy range for somebody who is in the gender that the transsexual person now presents in. However, a transsexual patient’s blood tests may still need to be measured in the ranges that are appropriate for their previous gender. So, for example, a FtM patient’s blood tests may need to be measured in relation to



normal levels for a female and a MtF patient's blood tests may need to be measured in relation to normal levels for a male.

*“The problem is female or male is put on the label for the blood tests and then when the samples go to the lab they are checked by computer and the results are automatically printed, so there is no human input for testing them.” (Participant A).*

Some participants had difficulty having their gender marker changed by the NHS, which caused problems for having their blood tests processed.

*“My GP had to intervene to have my gender marker changed and this was important for instance when I needed to have my blood tests done to check my oestrogen levels. The computer wouldn't issue the test form because I was still male on the system and men didn't need oestrogen testing.” (Trans Woman aged 60-69).*

This is further evidence that medical institutions rely heavily on a binary classification system for patients and their needs, and therefore this excludes the transsexual corporeal body and other corporeal bodies.

The NHS state that “all parts of the NHS need to establish working practices that effectively deliver patient confidentiality, as this is required by law, ethics and policy.” (Department of Health, 2003: 3). This includes where possible informing the patient about how information about them may be used within health care services. Certainly, when patient information is shared between different health care services, it is presumed that staff would have gained the patient's explicit consent. Meaning that the patient “has made a clear and voluntary indication of preference or choice, usually given orally or in writing and freely given in circumstances where the available options and the consequences have been made clear.” (Department of Health, 2003: 5). Guidelines for practice in Department of Health (2003) highlight that a

patient who does not give consent to their confidential information being shared with different members of care teams, and between different organisations involved in their health care provision, risk having implications on the provision of the care that is provided to them. Gaining a patient's explicit consent is often possible within services. I would certainly argue that informing a patient about the consequences of not allowing their confidential information to be passed on to others, and how this may affect their care, is rare. This study would suggest that there have been issues in relation to sharing information about a patient's identity between health services, which has caused confusion, time wasting and embarrassment for both the patient and staff.

*“The patient had already given their name to three different people in the hospital who all showed confusion and checked she was down for the correct scan.” (Participant B).*

Protecting a patient's confidential information from unwanted disclosure is very important within health care services. However, I would suggest that in the case of transsexual patients, there should be a process of informing the transsexual patient that certain information about their identity or previous identity may be necessary to disclose to certain parties, in order to provide effective and efficient health care to them. This should also include possible implications that might arise in relation to their health care provision, such as confusion over patient records, and issues they may face from having certain treatments that are usually associated with patients of the opposite gender to them, if they refuse to allow disclosure.

Therefore, institutions such as the NHS are challenged by the presence of transsexual people as patients, as they help to show the weaknesses in the practices and policies of care services. Transsexual people highlight the failings within the legal requirements of health care services, because, whilst protecting transsexual peoples' rights and identities within a health care service, this can impact in a negative way on the quality of care they receive.

The health care professionals' experiences of working with transsexual patients in this study would suggest that the NHS is still failing to adequately meet the needs of transsexual patients when accessing health care services in certain important aspects. This includes confusion over appropriate screening services and problems correctly measuring blood samples. The use of and reliance on gender markers within health care systems, rather than focusing on biological factors, is also highlighted when we consider the issues and confusion a transsexual patient creates for policies, practices, and computer systems within a health care service when they access it. For example, letters sent out in bulk for screening services by a computer focusing on the gender marker of a patient, and an age range.

However the experiences of the health care professionals working with transsexual patients interviewed in this study would suggest that health care professionals do want to treat transsexual patients in a respectful manner and provide appropriate treatment. It also highlights the difficulties health care professionals can face when writing notes in a transsexual patient's medical file, and how they can be uncomfortable to discuss with a transsexual patient the screening services that are appropriate to them. This would suggest that more needs to be done in relation to training and supporting health care staff about the correct wording that needs to be written in transsexual patients' files, and how to approach transsexual patients with regards to discussing health care services that are appropriate to them.

Poor communication between some GP surgeries and screening services was raised in this study as having a negative impact on the quality of service provided to some transsexual patient referrals. The lack of information disclosing the patient as transsexual from GPs was considered the main problem that created confusion, embarrassment, time wasting, and a poor quality patient experience of care provided by screening services. This study suggests that the implementation of the data protection act within health and social care services

policies and practices is important for protecting the identity and previous identity of transsexual patients and service users. However, this puts pressure on services and staff in relation to what is and isn't disclosed to other staff and services. This can have a negative impact on the quality of service and care provided to transsexual patients and service users.

It was worrying to hear that a few participants at some stage in the transition process had used hormones bought off the internet, or had bought inferior hormone products over the counter from shops specialising in transgender needs. There was certainly a risk to their health by self medicating no matter how much they had researched the subject, especially if they were on other medication as well. However this does highlight the desperation of some people who wish to transition, and the risks they will take in fulfilling transition.

*“My GP refused to send me to an endocrinologist when I told him I was self medicating.”  
(Woman with a transsexual background aged 40-49).*

The experiences of participants in this study changing their names by deed poll and changing personal documents to reflect their change in name would suggest that, generally, participants don't have any problems with changing documents such as passports, driving licences, and their bank account details. However when it comes to insurance premiums, pensions, national insurance and tax, then there can often be problems, such as correspondence still showing previous titles, which participants have found frustrating and offensive.

*“My previous male title is still appearing on pension and tax correspondence, even though I transitioned three years ago and have informed the relevant departments.” (Transsexual woman aged 60-69).*

When a person has started the transition process, changed all their name and gender details, and is trying to get on with their life in their new gender, to then be confronted by posted

correspondence addressed in their previous name can be quite upsetting for them and something they may not be mentally prepared to deal with.

There is also a lack of consistency between different government departments as to what personal details can be changed and whether they need a Gender Recognition Certificate or not before changing those personal details, and what evidence they need to provide in order to have those documents and records amended.

This study would suggest that more could be done to allow those people who are yet to obtain a Gender Recognition Certificate to be able to have their name and gender details changed on pension, national insurance, and tax records, as they are presently allowed to do in relation to their driving licences. The following is an example of the issues that a transsexual person's personal details can cause to an institution's computer system, and the use of gender as a risk factor when assessing care insurance premiums.

One MtF transsexual participant interviewed had difficulty renewing their car insurance policy when they went to the insurance broker with their deed poll to prove they had changed their name. They explained that they were still married, but were now living in their new gender. When the insurance brokers tried to put this information into their computer system, the computer would not accept it. The broker rang the insurance company and explained the situation, which resulted in the insurance company agreeing to insure the participant, but they lost their married person's allowance.

*“The insurance company agreed to insure me, but I lost about £17 of the married person's allowance part of the car insurance policy.” (Woman with a transsexual background aged 40-49).*

This is an example that highlights the issues that transsexual people can cause to an institution's policies, practices, and computer systems. It also shows the extent to which society relies on gender and marital status specific information to make assessments such as insurance premiums. For example, gender has been used as one of the main risk factors in pricing insurance products in the UK that have covered risks which differ by gender. These have included motor insurance, private medical insurance, life insurance, and pension annuities (Association of British Insurers, 2010). There has been an ongoing policy debate between the European Parliament and the insurance companies as to the impact that a potential ban on using gender as a risk rating factor might have on insurers and consumers (European Parliament, 2011). A European Directive already lays down a general prohibition on taking gender into account when pricing premiums and benefits for insurance products bought after 2007. Although article 5 (2) of the Gender Directive 2004 still allowed European Member States to opt-out of the requirement not to use gender as a risk factor, providing they published yearly data that provided evidence that there were differences in gender in relation to calculating risks (Association of British Insurers, 2010). The UK implemented this opt-out clause in the Equality Act 2010, which insurance companies in the UK relied upon to differentiate premiums on the basis of gender. However, a change in the Gender Directive 2004 now means member states can no longer use the opt-out clause on new insurance contracts issued on or after December 2012 and must be based on gender neutral pricing (Legal and General, 2012). The majority of car insurers use marital status as a factor when pricing their products. Being married or in a civil partnership can reduce insurance premiums on average by 7 percent (MotorQuote, 2012). Whilst this reflects another situation whereby gender and marital status information has been very important within UK institutions when making assessments and judgements, such as on pricing insurance policies. It also emphasises the impact transsexual people's details can cause to institutions' computer

systems, practices, and policies and highlights the weaknesses of those systems, practices, and policies.

### ***What it means for participants to obtain a Gender Recognition Certificate***

The introduction of the Gender Recognition Act 2004 enables a transsexual person on obtaining a Gender Recognition Certificate to have legal recognition in their new gender identity in the UK. As mentioned earlier in this thesis, a transsexual person who has written supporting evidence from two health care professionals to state that they have been in role full time for at least two years, can apply for a Gender Recognition Certificate if they wish, which means they have the same legal rights as anybody else in their new gender. They can have a new birth certificate to match their new sex and can marry someone of the opposite sex if they wish (Equality and Human Rights Commission, 2010).

Legal recognition is really important for helping transsexual people to promote their new identities, as is social recognition. Gaining legal recognition was an important part of the transition process for many of the transsexual participants.

*“The reason why I want one is for authenticity sake, for legal recognition and to give myself a sense of security. I also want to tie up loose ends, so there are no bits of your life that are still hanging over into the old male environment, so I can close off those areas.” (Trans woman aged 50-59).*

*“I can probably live without a Gender Recognition Certificate, but it would be nice to have the final tick in the box if you like or to finally be able to underline everything.” (Transsexual woman aged 25-29).*

For a few participants there was strong resentment towards the process for obtaining a Gender Recognition Certificate in relation to cost, rights, and time.

*“It took too long. I disagree with the fee structure; people shouldn't have to pay to gain legal gender recognition.” (Trans man aged 25-29).*

*“Appalling transsexual discrimination, of what should be you right once you have made the irreversible step of Surgical Gender Reassignment, there is only one word to describe it and that is obscene that people still have to jump through unnecessary hoops, many get very distressed by the process.” (Woman with a transsexual background aged 60-69).*

For some participants who had remained married to their pre-transition partners, there was the added stress and frustration of having to decide whether to remain married or divorce their partners in order to achieve a Gender Recognition Certificate.

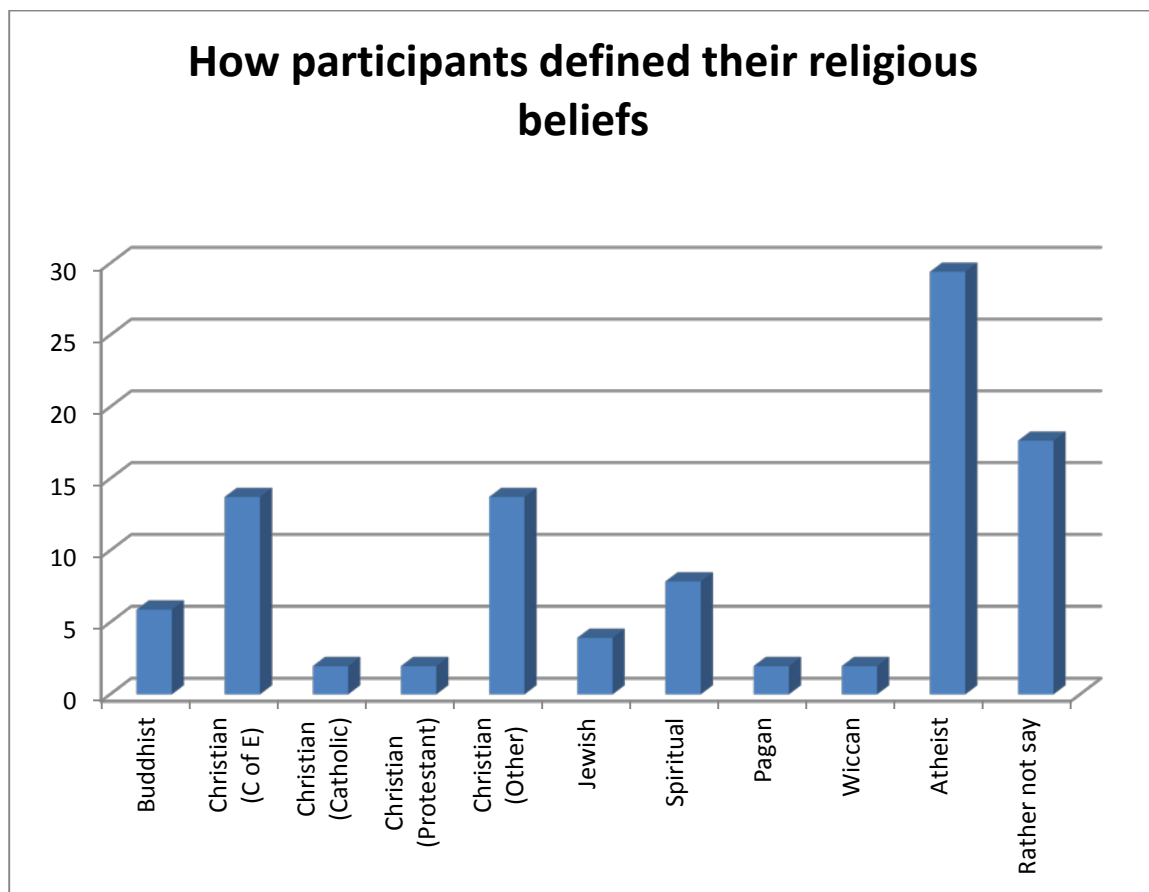
*“I would like a Gender Recognition Certificate, but I have not even applied as it would involve divorcing my wife and that for both of us is totally unacceptable!”(Woman with a transsexual background aged 40-49).*

A few participants who were married had mentioned that they knew friends in the same position who had, or were about to, divorce and take up civil partnerships instead in order to fulfil the requirements to gain a full gender recognition certificate. At the time of writing an interim gender recognition certificate can be issued to a person who is still married or in a civil partnership, but it only lasts for six months and within that time frame the transitioned person has to provide evidence that court proceedings have started for the purpose of annulling their marriage or civil partnership (GIREs, 2011). The reason for this provision is that if the civil partnership or marriage is not annulled “the issue of a full Gender Recognition Certificate would have the effect of creating a same sex marriage or opposite sex civil partnership which are not allowed under UK law” (Justice.gov.uk, 2011).



*The importance for some transsexual people to merge their faith with their new gender identity*

There was not sufficient data from this study in relation to religion, but what was discussed emphasises the importance of incorporating religion into your new gender identity for some participants. However there will be a discussion on the importance of religious institutions for one participants progression through the care pathway.



As *Figure 6.2* shows there was a diverse range of religious beliefs amongst research participants.

For some transsexual people who are religious, bringing their faith and transsexual identity together can be very difficult and stressful.

*“I went to a Christian Brothers’ school that hadn’t much time for what they saw as a little boy with a lot of female attributes. I won’t say they tried to beat it out of me, but it was quite close to that, which made it very difficult for me to bring together my faith and being trans.”* (Trans woman aged 60-69).

*“When I first started going to church in my new gender I would get awful guilt trips afterwards. I would be in church and think oh yes god is quite happy with me being here and then afterwards I would think no you’re just fooling yourself, how dare you go to church dressed like that.”*(Trans woman aged 60-69).

The participant mentioned the importance a national trans Christian group (Sibyls) had on helping her to come to terms with being trans and a Christian.

*“They helped me to understand that being trans was just a diversity and god loves creatures no matter how they are created.”* (Trans woman aged 60-69).

This particular participant has since taken on pastoral leader duties at the church that the Sibyls group introduced her to. She also helps the Sibyls group with their work of going to other churches to help those churches understand more about transgender people. Having a strong faith and being trans can be a challenging and conflicting issue for people before, during, and after the transition process. However it is good to see that there is now some support for transsexual people who are finding it difficult to come to terms with their trans identity and their faith. It is also encouraging to see that some people from the transgender community are helping churches to understand more about transgender and faith. This study has only briefly focused on religion as an issue for transsexual people during the transitioning process. I would suggest that more research needs to be done on this issue, and in particular, on non Christian beliefs, and the issues this can cause for a person during the transition process. This was highlighted in the following reflective diary entry of mine, which also

reflected on two other cases of participants having difficulties merging the transition process and their faith together.

*The participant also discussed the issues they had faced trying to come to terms with finding a way to merge the transition process and their faith together. This had similarities with the discussions I had with two people during the research process. One had started the transition to be a FtM transsexual and was Jewish. The other one was a Sikh man who wanted to start the transition process to become a MtF transsexual. Thursday June 2011.*

### ***Transphobic verbal abuse and threats of violence or actual violence in social situations***

Although no participants had mentioned that they had suffered actual physical violence for being transsexual, a few participants mentioned that they had experienced verbal abuse on occasions whilst out in social situations.

One participant mentioned that whilst waiting for a taxi at a railway station she was verbally abused by a young man who was calling her a 'fucking tranny'. She said "*if you carry on using that language I will call the police as I feel threatened and it's totally inappropriate.*" He replied "*why don't you act like a man, fuck women and enjoy yourself.*" She replied "*that's totally inappropriate you wouldn't say that to any other woman.*" He replied "*but you're not any woman you're a fucking tranny.*" (Trans woman aged 60-69).

The participant reported the transphobic incident straight away to the police whilst she was at the train station and got an immediate response from them.

*"The stupid idiot who had verbally abused me at the train station hung around whilst I called the police and he was still there when they arrived to arrest him."* (Trans woman aged 60-69).

Another participant who was travelling back home from work on the local metro train service was verbally abused by a group of teenage school children.

*“These kids got on the metro and gave me a right mouthful of obscene abuse” (Trans woman aged 50-59).*

When the participant got home she contacted the local hate crime reporting line.

*“I rang the hate crime reporting line and they contacted the police. The police were great they went to the school and arrested the ring leader who had verbally abused me on the metro. He ended up in court and had to do community service.” (Trans woman aged 50-59).*

These two participants felt that their calls to report transphobic incidents had been taken seriously by those they reported the incidents to, and that they had been treated with the upmost respect by the police. This is a positive example of two local agencies working in partnership to tackle hate crimes efficiently and having the upmost respect for the two transsexual participants.

### ***Important institutions for promoting one’s transsexual identity.***

The gay village in Manchester was a place that was mentioned by a few participants as a place where they had first gone out in public in their new gender, or where they had first gained support from a transgender support group. Some participants who had been transitioned for a while would arrange trips to the gay village in Manchester to help support trans people from their local area, and first-timers who wanted to go out in public dressed in their new gender to experience a night out in the Manchester gay village. The term ‘puppy walking’ was used by some participants to describe the support they had provided to first timers who wanted to go out in public dressed in their new gender.

During the research process a support group in Rotherham and a safe house for transgender people in Wales were visited. The transgender support group in Rotherham was a small group using a local community centre, which had members from Rotherham and the surrounding rural areas. Attending the group helped to make me more aware of the issues around access to transgender support groups and the need for them within rural communities. For example time and cost of travel was a factor for some transsexual people from rural communities who wanted to access transgender support groups.

Another issue was that many of the big transgender support groups in major cities and towns were often based in public houses or nightlife areas. This was a concern for some transsexual people, especially in the early stages of transition, as they had not had much experience of going out in more populated public spaces. Therefore, the small town support group or rural support group in a community centre was a more favourable venue for some transsexual people from rural areas, as it could provide more privacy.

An issue that was raised initially from attending the support group in Rotherham, and supported later by some research participants, was the issue of raising funding from local councils to set up transgender support groups. Some local councils had provided initial funding for transgender support groups to be set up in their areas, but would not provide further funding to create a second transgender support group in another part of their area. It was felt by some that two or more support groups were needed in some areas controlled by the same local council, as there was a demand for them especially from people from rural areas who were starting transition. Even though a group may only have a few members at a time, it was felt that this should not be a reason for refusing to fund a group, and local councils should be more flexible about funding and supporting transgender support groups. One way this could be achieved would be in helping the transgender community to find safe spaces to hold support group meetings, and to establish support groups when and where there

is a need. However, this research would suggest that, whilst some local councils have been supportive of transgender support groups and established good working relationships with them, some other local councils' enthusiasm for setting up a transgender support group in their area has been interpreted by some research participants as nothing more than a tick box exercise to comply with their equality and diversity policies.

*“The local authority is diabolical in the sense that it says it’s doing a lot, but in reality it’s doing bugger all. The transgender group it set up exists in name only.” (Woman with a transsexual background aged 50-59).*

The transgender safe house in Wales that was visited during this research study provides temporary accommodation for those transgender people who have become homeless or have suffered domestic violence. The safe house is also registered with the prison service as a contact for transgender prisoners who are due for release and may be homeless, or can be used as a fixed contact address for transgender prisoners released early on licence. Whilst these are all positive types of support for transgender people in their own right, what has been gained most from visiting the transgender safe house is recognising the support the safe house can provide to people who are thinking about starting the transition process. A person who is thinking about starting transitioning can go to the safe house and spend a couple of days there in role, and venture out in public with support from the staff. This can be a crucial couple of days for the person as they can come to a decision as to whether they want to pursue transitioning full time, or whether this is actually the right time for them to start the transition process. The safe house can also provide makeup lessons and hair styling tips to a person who is contemplating the transition process, which can give them more confidence in their appearance when they start the transition process. This is an important form of support that has been overlooked by support groups and other organisations working with transgender people, and should be provided in more areas to help facilitate a person contemplating

transitioning. This could especially be used as a service by the gender identity clinics when they are monitoring, assessing, and supporting a person who wants to start the transition process.

### *Accessing social care services*

Ten participants needed to access social care services with various needs. This consisted of 2 having social workers, 3 accessing disability services, 3 using local social care services, 1 as a visitor in a care home and 1 using adoption services. Although social care services were accessed for various reasons, most participants were satisfied with the levels of service and respect they had received from social care professionals. However, a small minority of participants were dissatisfied with the levels of service and respect they had received.

*“Social services don't care about those of us who are harassed and forced from our homes due to Transphobia and the Department of Work and Pensions' doctors think smashed windows and nightmares about the attacks on my home are unrelated so therefore signed me off Employment and Support Allowance.” (Woman with a transsexual background aged 40-49).*

It was quite worrying to find out that one woman who had mobility issues after having GRS was unable to gain any appropriate support from her local social care services.

*“Apparently post op problems are not recognised as being something social care services can handle.” (Woman with a transsexual background aged 40-49).*

Certainly, recognition of the needs of transsexual people accessing social care services was something that was hardly mentioned in the literature review. Later life care is especially missing from the literature, and as the transsexual population grows there is going to be an

increasing need for health and social care services to be aware of those needs, whether that is health care needs, mobility issues and/or transsexual people living as residents in care homes.

The literature review discussed the work of Ross (1994) who suggested that localised support networks should be implemented during transition to decrease the anxiety at this traumatic time for the transsexual person. For, even though the transsexual person will be attending a gender clinic, they may be isolated many miles away with no local support (Ross, 1994). Even though this issue was recognised in the literature by The Leeds Gender Identity Service (2009) who suggested there was a need for local support for those service users attending the service from outside of the West Yorkshire area, and suggested that those service users have additional local support mechanisms in place (Leeds Gender Identity Service, 2009). This research study found that in some parts of the country, and especially in rural areas, there was a clear lack of support from transsexual people's local primary care trusts. Some participants interviewed who were from rural areas were actually providing one to one support to other transsexual people who were starting the transition process, and may have lived in nearby villages or small towns.

*“What I try to do now is there's a lady in the town near us who's transitioning, so I try and help her and there's another lady who I have been put in touch with who needs some local support during the transition process, so I am trying to help her as well.” (Woman with a transsexual background aged 50-59).*

This is an example of local and non local health care services, that in shared policy agreements, both have a duty of care to support the patient transitioning, yet in practice, fail to carry out that shared agreement.

The theoretical focus of this chapter has been on the adaptation of Franks (1991) theory of the body and the importance of the communicative body for the promoting of the transsexual



person's new identity in institutions, and therefore in helping them to achieve legal and social recognition. This thesis would suggest that this theoretical framework draws together the strands of corporeality, institutions and social discourses in order to be able to analyse the complex interactions these have on each other and their promotion of the transsexual identity. Institutions have played an important role for enabling the expression of transsexual research participants' new identities through the interactions they have had with different institutions, such as health and social care services, local government departments, and banks and building societies. However it is also the interactions that transsexual people have with members of those institutions that helps to show the issues the transsexual identity and body can cause to an institution's systems, policies, and practices.

Interdisciplinary working and Integrated Care Pathways were discussed in this chapter. Collaboration between different professionals and different health and social care services can help to provide better services to meet the needs of patients and service users. It is a far more efficient way of working cost wise and time wise. For patients and service users collaborative working between services can help them to feel less frustrated as they do not have to regurgitate the same information through duplicate assessments. Professionals can become more sensitive and understanding to the values, ways of working and prioritising of different professionals and agencies. Yet all too often the experiences of research participants highlighted that many services were not effectively communicating with each other, which would then lead to some participants having a poor experience of accessing services. The lack of communication and information between services was also highlighted by the two healthcare professionals, which caused them frustration and wasted time.

The NHS is often seen as a monolithic, all encompassing entity that is impenetrable. Yet by using and adapting Frank's (1991) theory of the body it can help to show the complexities of institutions such as the NHS and the influence these institutions can have on shaping the

experiences of people accessing them. In turn these institutions can be shaped on both macro and micro levels by the values and experiences of those who work in them, an organisational culture, and those who create the management infrastructures, policies, and practices. However, officially there are four publicly funded independent health care systems in place within the UK with different management operating systems, structures, rules, and policies. The experiences of research participants accessing services funded and run by these four independent health care systems highlighted the inconsistencies in the provision of gender identity services and support across the UK.

The issues raised in this chapter would suggest that more needs to be done to help improve the collaborative working processes between different health and social care services working with transsexual people, especially during the transition process. Realistically though, because of the small number of transsexual people that are likely to access individual health and social care services across the UK, it is unrealistic to presume that all services are going to be able to work equally successfully in a collaborative way. However, this does not mean that the services a transsexual person accesses can't work at improving the quality and relevance of the information they share between themselves in order to provide a more appropriate, quality, and efficient service and experience to transsexual people.

## Chapter Seven: Learning from this holistic approach to transsexualism: Conclusions and recommendations

This final chapter will conclude the findings of this thesis and make recommendations for future research and practice in relation to the transition process and transsexual people's health and social care needs. Firstly, recommendations for improving practice within health and social care institutions that recognise and meet the needs of transsexual people are then discussed. Secondly, there will be a discussion of the importance of examining transsexual people's experiences of accessing health and social care services within corporeal, social discourse, and institutional contexts simultaneously, which this thesis was able to successfully achieve. There has been a failing within previous literature on transsexualism to explore issues within these contexts together that this study has done. It is disappointing to think that in nine years, since the introduction of the Gender Recognition Act 2004, health and social care institutions are still failing to recognise the needs of transsexual people accessing their services. There is still a lack of understanding of what transsexualism involves by health and social care workers and those that interpret legislation into policy. Support groups for transsexual people are then discussed with recommendations for a buddy system to be implemented for supporting those starting the transition process in remote rural areas. The limitations of this study are then discussed. Finally, recommendations for future research raised by the issues in this study are made.

Chapters four, five, and six have identified that there is an exclusion of the transsexual body in transition in the remit of institutional culture and social discourses and a lack of its classification in health care binary computer systems. This study has identified that there are major issues with the use of binary ICT systems within health care institutions, and that these systems are often the root problem of much of the misunderstandings that staff have about the

health needs of transsexuals and the impact this can have on the practice they provide to transsexual patients. This has often lead to inappropriate and misinformed communication in letters for screening appointments that are not appropriate for the transsexual patient. Not only does this put the transsexual patient's health at risk, but emphasises the need for two appropriate interventions. Firstly, the need for transsexual patients and their GPs to discuss and plan appropriate health care tests and screenings that they will need in the future, due to starting hormone therapy and/or having had GRS. This is still not happening in the case of many of those transsexual participants who were interviewed, and those who completed the survey. Secondly, there is a need to integrate these transsexual bodies and variations of bodies into the organisational culture, policy, practices, and social discourses within institutions at a macro and micro level, and within social discourses in general. The use of a coding system for highlighting appropriate screening services and blood tests for different patients, and the incorporation of different body types within ICT systems besides binary notions of bodies may help to reduce some of the confusion that has been highlighted in this study. This has often lead to inappropriate and misinformed communication in letters for screening appointments that are not appropriate for the transsexual patient. The inadequacies of binary gender identification systems that underpin institutional computerised systems negatively impact on the experiences of transsexual identities and embodiment in practice settings, and fail to accommodate the particular complex needs of transsexual people, especially during transition and post surgery. Therefore, this study would argue that the binary system of gender is a significant issue that needs addressing for the needs of transsexual people to be better recognised.

The health department has produced numerous documents on the needs of transsexual and transgender people over the last eight years with the assistance of community members, health professionals, and academics, and these documents are often taken up on a voluntary

basis. This study would recommend that it may be beneficial for all parties concerned if NICE's health indicator models could include, for instance, a health indicator for ensuring that appropriate screening services are planned for that accommodate the corporeal bodies of transsexual patients, instead of judging screening requirements based on a person's gender prefix. The NICE health indicators are used to encourage GP's to carry out medical assessments or tests for certain at risk groups or conditions, such as hypertension. The incentive for doing this is twofold. Firstly, there is the financial incentive that each practice receives annually, depending on the amount of times a health indicator has been used. Secondly, the financial incentive stops once the health indicator becomes part of everyday health assessment. At the present time NICE are also considering introducing social care indicators. I would therefore argue that this is a perfect opportunity for the introduction of health and social care indicators that promote services to be more aware of the needs of transsexual people accessing their services, and ensure that the transsexual corporeal body can be implemented into such things as their screening programs.

The contribution of this research as a response to the research questions is that there is inconsistency across the UK when it comes to service provision and practice that meets the health and social care needs of transsexual people. Specialist health services for transsexual people, such as the gender identity services provided by the NHS and the private sector vary enormously when it comes to waiting times and the services they provide.

A universal approach to delivering services locally and nationally is needed to ensure seamless, effective, and cost efficient provision of services that meet the needs of transsexual people during the transition process. The provision of access to psychiatrists specialising in Gender Dysphoria, and occupational therapists within existing local health institutions in the form of satellite clinics, could be a solution to some of the issues raised in this thesis. This would not only ease the waiting times on referral to gender identity services and local mental

health teams, but could also ease the distress and cost to those transsexual patients who generally have to travel considerable distances from their local area to access those specialist services for initial and follow up assessments through the transition process. There is a need to train more surgeons within the specialised field of GRS for two main reasons. Firstly, due to the rise in increasing numbers of transsexual people requiring GRS in the UK and secondly, to make up for the loss in recent years of surgeons in the UK who have either retired or have decided to no longer specialise in this field of surgery. This would help to reduce both the length of the average waiting time for GRS surgery and the distress a transsexual person may have of living in a body that does not match their new gender identity.

As mentioned previously in the introduction to this thesis, legislation such as the Services Directive 2004 and the Equality Act 2010 have strengthened the law for transsexual people in a number of areas. For example, there has been a need to eliminate unlawful discrimination and harassment on grounds of gender reassignment in the provision of goods, facilities, and services, which includes health and social care services (Office of Public Sector Information, 2007). Public bodies now have to consider how their policies and practices affect people with protected characteristics and “take positive action so as to enable existing or potential employees or customers to overcome or minimise a disadvantage arising from a protected characteristic” (Office of Public Information, 2010: 15). However, as this thesis has evidenced, there is often a lack of recognition of the transsexual corporeal body within the policies, practices and institutional culture of health services.

Prior to 2004, transsexual people were not recognised in their acquired gender under the law of the United Kingdom. The purpose of the Gender Recognition Act 2004 is to provide transsexual people with legal recognition in their acquired gender. This is an important and positive step forward for the existence and recognition of transsexual people by wider

society, yet as this thesis has evidenced, there are varying grades of gender recognition at legal and social levels that transsexual participants have experienced. The workplace has often been seen, by some previous studies mentioned in the literature review, as a place of rejection, discrimination, and potential unemployment for those people who wished to start the transition process. However this study would argue that the majority of transsexual participants were still working for the same employer, or were doing the same type of work for a new employer. Discrimination in the work place was still an issue for a small number of participants, which was generally around verbal abuse. However, as mentioned in one of the interviews, there was generally legal recognition in the work place, but gaining social recognition would seem harder to achieve, as mentioned in one of the interviews. This would suggest that legal legislation implemented into policy and practice within an institution could be easier to achieve as it was a statutory duty, rather than the more difficult area of social recognition. Incidentally no transsexual participant felt pressurised to take a more traditionally gender appropriate job.

The introduction of the Equality Act 2010 means that public bodies now have to consider how their policies and practices affect people with protected characteristics and “take positive action so as to enable existing or potential employees or customers to overcome or minimise a disadvantage arising from a protected characteristic” (Office of Public Information, 2010: 15). Therefore, gaining knowledge of the experiences of transsexual people accessing health and social care services, since the introduction of the Gender Recognition Act 2004 and other legislation, has been vital in order to assess whether transsexual people are still facing discrimination and a lack of understanding when accessing these services. I would argue that the Equality Act 2010 has not been implemented successfully into the policies and practices of many public bodies in relation to them being aware of transsexual people who have protected characteristic status. However, as identified and evidenced in this thesis, there is

still confusion within some services as to what transsexualism is, and a lack of awareness of the needs of transsexual people when accessing health and social care services. I would therefore argue that some health and social care institutions cannot be expected to make provision for transsexual people accessing their services if they are not even aware of their existence and needs. This suggests that the Equality Act 2010, and other legislation mentioned earlier, are still failing to be implemented into many institutional policies and practices within health and social care services when recognising gender reassignment as a protected characteristic. It would be a recommendation of this thesis that future research is done that focuses on the extent to which those different groups of people who come under the different protected characteristic categories of the Equality Act 2010 are being recognised within policies and practices of health and social care institutions. I would argue that it is likely that few services will have made provision for the likelihood of transsexual people accessing their services when compared to those who will have made provision for the protected characteristic terms of age, race, religion, disability or sex, for example.

I have to say that the two health care professionals interviewed for this thesis showed a genuine desire to help transsexual patients, but at the same time, both were aware of the failings within their institutions to accommodate the transsexual corporeal body into their systems and practices. These health care professionals did have concerns that they sometimes felt inadequate to address sensitive issues with transsexual patients in relation to appropriate screening services, as they did not want to offend the patients. They also felt there was a need to have further training around the medical needs of transsexual people; examining transsexual patients due to the possibility of a mixture of biological characteristics, and guidance on how to write notes in transsexual patients' files in a sensitive way.

There is a general consensus amongst transsexual participants that they have had varying degrees of legal and social recognition within different institutions and through social



discourses. There is no ‘quick fix’ solution here in achieving full legal and social recognition for transsexual people in their preferred gender as their biologically assigned at birth counterparts have enjoyed on a daily basis. Nonetheless, I do believe that there are areas where genuine progress could be made in helping to increase levels of legal and social recognition for transsexual people. The increasing visibility of transsexual people within society in the UK should help to educate more individuals within institutions of what transsexualism is in two ways. Firstly, from a macro perspective, an institution’s culture can influence individuals through policy and practice. Secondly, from a micro perspective, the individual staff members can become more likely to challenge their previous assumptions about transsexual people and those views of other staff on an individual basis, which will also help to influence and change institutional culture within health and social care services over time. This study has highlighted that some transsexual participants thought that realistically, many GPs and staff in primary health care were unlikely to have had experiences with transsexual people accessing their services, and were unlikely to know at first hand the process for referring them to a local mental health team and a gender identity service. Therefore, these transsexual participants felt that they had a responsibility to help educate and support their GPs as to what transsexualism was, the process for entering the care pathway to gain access to the gender identity services, and the different stages of transition in order to gain legal recognition if they wanted it. This emphasises the importance of establishing those channels of communication between health care professionals and patient in order to gain the most effective and efficient service and treatment for the individual. To actually feel that their GP has empathy and wants to help, even though they may not have all the information to hand straight away, can often reassure the transsexual patient who is starting off on this process of transition that their GP does want to help, and that their initial visit to them was not a waste of time.

This study has highlighted that the delivery of the NHS's clinical governance guidelines to achieve consistency in the quality of healthcare services across the UK with sensitivity to the individual needs of the patient and local community, remains problematic in relation to transsexual patients. I would suggest that clinical governance has been used to assess the risks of negative consequences in healthcare outcomes to make sure they are reduced. The ongoing monitoring of clinical performance within healthcare, and the introduction of explicit guidelines and standards, has created a culture of openness in the reporting of near misses. However, I would argue that the issues raised by research participants in this study in relation to Clinical Governance supports the work of Churchill (2010) who suggested that the bureaucracy and tick box exercises surrounding Clinical Governance had diverted attention away from the real aim of it, that being, the continuous improvement of providing quality health care.

As mentioned previously in this study, health economic data is increasingly used within health and social care services to inform allocation of resources that meet the needs of different populations. However, there is little data on the health care needs of minority groups, so general data is used to assess the needs of the local population, which may not meet their requirements. Therefore there is an urgent need to collect data on the health care needs of minority groups, such as transsexual people, in order that more appropriate resources can be allocated to meet the needs of different minority groups.

An issue that was raised initially from attending the support group in Rotherham, and supported later by some research participants, was the issue of raising funding from local councils to set up transgender support groups. Some local councils had provided initial funding for transgender support groups to be set up in their area, but would not provide further funding to create a second transgender support group in another part of their area. It was felt by some that two or more support groups were needed in some areas controlled by

the same local council as there was a demand for them, especially from people from rural areas who were starting transition. Even though a group may only have a few members at a time, it was felt that this should not be a reason for refusing to fund a group, and local councils should be more flexible about funding and supporting transgender support groups. One way this could be achieved would be in helping the transgender community to find safe spaces to hold support group meetings, and to establish support groups when and where there is a need. However, this research would suggest that, whilst some local councils have been supportive of transgender support groups and established good working relationships with them, some other local councils' enthusiasm for setting up a transgender support group in their areas has been interpreted by some research participants as nothing more than a tick box exercise to comply with their equality and diversity policies. I would argue that within the UK, transsexual support groups are either providing services due to a shortfall in health or social care services within their local area, or they are struggling to survive due to a lack of support from local authorities to help them find suitable venues. Some of the big transsexual and transgender support groups in major cities and towns were often based in public houses or nightlife areas. This was a concern for some transsexual participants, especially in the early stages of transition, as they had not had much experience of going out in more populated public spaces. Therefore, the small town support group or rural support group in a community centre was a more favourable venue for some participants from rural areas, as it could provide more privacy. A lack of local support, or barriers to accessing local support for some transsexual people, was identified by this study. Firstly, within some rural areas there is a need for some form of buddy system to be implemented to help support those transitioning in remote areas. This may take the form of members from a regional transsexual support group being a point of contact that can perhaps support a person transitioning by having regular phone calls or visits.

### **The limitations of this study**

The literature review had been dominated by studies that examined transsexualism from a medical context, yet very little literature in relation to the experiences of transsexual people accessing social care services. This study has achieved a small amount of data on transsexual participants' experiences of accessing social care services, which included using them for adoption, mobility issues, and mobility issues after GRS as service users, and accessing care homes as visitors. This may, in hindsight, be the result that should be expected when the literature review in this thesis is dominated by medical studies on transsexualism. However, I would recommend that a future study looks at both the experiences of transsexual people's experiences of accessing social care services, and the experiences of social care staff working with transsexual service users. This would firstly, enable comparisons to be made with my own study in relation to the difficulties social care staff may have with writing notes in transsexual service users' files in a sensitive manner which does not offend, just as the health care staff had found in this study. Secondly, it would enable comparisons to be made with this study as to the extent to which transsexual people felt respected by social care staff when accessing services, and the levels of legal and social recognition they felt they received from those staff.

This study was also unable to attract participants from the following ethnic minority groups, Asian, Black, Chinese, or Mixed Background. It is therefore vital that future studies try to ascertain the views of those transsexual people from the above mentioned ethnic minority groups in order to have a more accurate view of the interaction of corporeality, social discourses, and institutions on the transition process and transsexual people's experiences of accessing health and social care services. I would therefore recommend that there is a need for insider researchers from those minority groups mentioned to undertake future studies in relation to this topic, as this may help to increase participation from people from these

backgrounds and there may be an increased sense of shared experience between researcher and participants from the same ethnic background.

### **Proposals for future research**

This study has touched upon the issue for some transsexual people of accommodating the transition process with their religious beliefs. I would suggest that further research is necessary in this area as this thesis has highlighted not only the complexities of negotiating the transition process with a person's faith, but also the impact the transsexual corporeal body can have on making it extremely difficult to explore changing gender part-time due to one's faith. This was certainly the case for the Sikh gentleman who wanted to start the transition process, but on a practical level was unable to fully immerse themselves part time in their desired gender identity.

For some transsexual people, the experience of penetrative sex with the new genitalia as a MtF or FtM may help them to gain fulfilment and validation in their new gender. This was something that was briefly mentioned by a person at the support group I visited, but was not mentioned by any participants in this thesis. This may be a topic for investigation in future research studies, which could assess the extent to which the appearance and functionality of the genitalia, having had a Vaginoplasty (Vagina) or a Phalloplasty (Penis) surgery, contributed to the fulfilment and validation of the person in their new gender.

A sensitive subject for some of the transsexual participants was the issue of being unable to bear children. Uterus transplant technology is also likely to raise awareness within health institutions of the possibilities of a diverse range of bodies that are far more complex and diverse, allowing the intersex and transsexual to conceive a child if they wish to. I would recommend that this issue is explored in future research as it is likely that uterus transplantation is going to be available in the near future. This may raise ethical issues in

relation to who can access this treatment, and the major implication that this has on the legal system and healthcare and social care institutions' policies and practices in relation to the corporeal bodies that we already have, when we consider men and transsexual women might be able to give birth.

The message that this study carries forward is that there is a need within future research on transsexualism to ensure that the corporeal body is included in analysis alongside social discourses and institutions, to ensure that a more holistic approach and rigorous investigation can be achieved.

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## **Appendix One**

### **Research Flyer**

## Participants wanted for research project

Hi I am a transsexual woman who is undertaking a PhD at the University of Hull. My research project is interested in the experiences of people accessing health and social care services who have transitioned since 2004 or are presently in the transition process. It is vital that research is undertaken in this area as without it we will not know the issues people can face when accessing services and the extent to which people feel they are respected and supported by services.

Do you wish to be legally recognised in your newly acquired gender under present legal reforms in the United Kingdom and have or are wanting to obtain a Gender Recognition Certificate?

Are you over 18 years old?

Could you spare two hours for a one to one interview?

If you answered yes to all the above questions you're the type of person I am looking for to participate in this research project.

Interviews will be taking place in London, Manchester, Leeds and Hull between March-August 2011.

Interviews will be audio-recorded and take place in a safe and confidential environment. All personal information about the research participants will be kept completely confidential. Participants are free to withdraw from the research at any time.

If you are interested in learning more about this research project with a view to participation please contact:

Miss Martina Kirlew

c/o Mrs Eileen Palphramand

Department of Social Sciences

Wilberforce Building

University of Hull

Cottingham Road

Hull HU6 7RX

East Riding of Yorkshire

Email – [m.i.kirlew@2004.hull.ac.uk](mailto:m.i.kirlew@2004.hull.ac.uk)

# **Appendix Two**

## **Survey**



## Health and Social Care Service Provision for those who have Transitioned Post 2004

**Q1. Please confirm that you live in the UK.**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Yes - Please continue with this survey	100.0%	59
No - Please DO NOT continue with this survey	0.0%	0
	<i>Answered</i>	59
	<i>Skipped</i>	0

**Q2. Please confirm which year you started the transition process?**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
2002	0.0%	0
2003	5.4%	3
2004	8.9%	5
2005	10.7%	6
2006	0.0%	0
2007	10.7%	6
2008	14.3%	8
2009	21.4%	12
2010	25.0%	14
2011	1.8%	1
Before 2002 please DO NOT continue with this survey	1.8%	1
	<i>Answered</i>	56
	<i>Skipped</i>	3

**Q3. I am a:**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Woman with a transsexual background	29.8%	17
Man with a transsexual background	3.5%	2
Transsexual woman	22.8%	13
Transsexual man	1.8%	1
Trans woman	22.8%	13
Trans man	19.3%	11
	<i>Answered</i>	57
	<i>Skipped</i>	2

**Q4. My ethnicity is:**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
White British	93.0%	53
White Irish	1.8%	1
Irish Traveller	0.0%	0
Other White background	5.3%	3
Mixed White and Black Caribbean	0.0%	0
Mixed White and Black African	0.0%	0
Mixed White and Asian	0.0%	0
Other Mixed background	0.0%	0
Asian or Asian British Indian	0.0%	0
Asian or Asian British Pakistani	0.0%	0
Asian or Asian British Bangladeshi	0.0%	0
Asian or Asian British Other Asian Background	0.0%	0
Black or Black British Caribbean	0.0%	0
Black or Black British African	0.0%	0
Black or Black British Other Black Background	0.0%	0
Chinese	0.0%	0
Comments		0
	<i>Answered</i>	57
	<i>Skipped</i>	2

**Q5. My age group is:**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
18-25	17.5%	10
26-29	8.8%	5
30-39	10.5%	6
40-49	33.3%	19
50-59	24.6%	14
60-69	5.3%	3
70	0.0%	0
I would prefer not to say	0.0%	0
	<i>Answered</i>	57
	<i>Skipped</i>	2

**Q6. How would you describe your sexuality?**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Heterosexual	27.1%	13
Gay	10.4%	5
Lesbian	14.6%	7
Bisexual	41.7%	20
Rather not say	6.3%	3
Comments		12
	<i>Answered</i>	48
	<i>Skipped</i>	11

**Q7. Which of the following best describes your religion?**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Buddhist	10.3%	3
Christian (Church of England)	24.1%	7
Christian (Catholic)	0.0%	0
Christian (Protestant)	3.4%	1
Christian (other Christian denominations)	24.1%	7
Hindu	0.0%	0
Jewish	6.9%	2
Muslim	0.0%	0
Sikh	0.0%	0
I would prefer not to say	31.0%	9
Comments		29
	<i>Answered</i>	29
	<i>Skipped</i>	30

**Q8. Where do you live?**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
England	81.4%	48
Northern Ireland	0.0%	0
Scotland	10.2%	6
Wales	8.5%	5
Other (please specify)	0.0%	0
	<i>Answered</i>	59
	<i>Skipped</i>	0

**Q9. What kind of area do you live in?**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
City	34.5%	20
Town	46.6%	27
Rural Area	17.2%	10
Other (please specify)	1.7%	1
	<i>Answered</i>	58
	<i>Skipped</i>	1

Q10. If you live in England, please select which county (from the drop down menu below)

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Bedfordshire	4.8%	2
Berkshire	0.0%	0
Buckinghamshire	2.4%	1
Cambridgeshire	0.0%	0
Cheshire	4.8%	2
Cleveland	0.0%	0
Cornwall	4.8%	2
County Durham	0.0%	0
Cumbria	0.0%	0
Derbyshire	2.4%	1
Devon	4.8%	2
Dorset	2.4%	1
East Riding of Yorkshire	0.0%	0
East Sussex	2.4%	1
Essex	2.4%	1
Gloucestershire	0.0%	0
Greater London	2.4%	1
Greater Manchester	9.5%	4
Hampshire	0.0%	0
Herefordshire	0.0%	0
Isle of Wight	0.0%	0
Isles of Scilly	0.0%	0
Kent	2.4%	1
Lancashire	9.5%	4
Leicestershire	0.0%	0
Lincolnshire	0.0%	0
Merseyside	2.4%	1
Norfolk	2.4%	1
North Yorkshire	2.4%	1
Northamptonshire	0.0%	0
Northumberland	0.0%	0
Nottinghamshire	2.4%	1
Oxfordshire	4.8%	2
Rutland	0.0%	0
Shropshire	2.4%	1
Somerset	2.4%	1
South Yorkshire	0.0%	0
Staffordshire	2.4%	1
Suffolk	0.0%	0
Surrey	4.8%	2
Tyne & Wear	7.1%	3
Warwickshire	2.4%	1
West Midlands	4.8%	2
West Sussex	0.0%	0
West Yorkshire	4.8%	2
Wiltshire	0.0%	0
Worcestershire	0.0%	0
	<i>Answered</i>	42
	<i>Skipped</i>	17

**Q11. What is your employment status?**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Employee	43.1%	25
Self-employed	19.0%	11
In receipt of benefits (income support, job seekers allowance, incapacity benefit etc.)	17.2%	10
Retired	1.7%	1
Student in full-time education	10.3%	6
Apprentice, trainee	0.0%	0
Never had a job	0.0%	0
Other (please specify)	8.6%	5
	<b>Answered</b>	<b>58</b>
	<b>Skipped</b>	<b>1</b>

**Q12. If working are you:**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Working for the same company that employed you before transition	48.7%	19
In same type of job as prior to transition	25.6%	10
In a different type of job than that prior to transition	25.6%	10
Or in a different type of job than that prior to transition due to pressure to conform to a more traditional gender specific occupation	0.0%	0
Comments		12
	<b>Answered</b>	<b>39</b>
	<b>Skipped</b>	<b>20</b>

**Q13. At what stage of the transition process are you presently at?**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Have been to GP and awaiting appointment with local psychiatrist	5.4%	3
Have seen local psychiatrist and awaiting first appointment with gender identity service	8.9%	5
Attending gender identity service	10.7%	6
Attending gender identity service and have started hormone therapy	17.9%	10
Attending gender identity service and do not wish to have hormone therapy	0.0%	0
Have started hormone therapy but do not wish to have gender reassignment surgery	3.6%	2
Awaiting gender reassignment surgery	25.0%	14
Have had gender reassignment surgery	10.7%	6
Applied for a Gender Recognition Certificate	0.0%	0
Have a Gender Recognition Certificate	17.9%	10
	<b>Answered</b>	<b>56</b>
	<b>Skipped</b>	<b>3</b>

**Q14. Which health care services have you accessed since starting transition?**

<i>Answer Options</i>	<i>NHS</i>	<i>Private</i>	<i>Response Count</i>
Gender Identity Service	37	6	43
GP	54	1	54
Psychiatrist	40	7	44
Hospital as a patient	29	9	33
Hospital as a visitor	15	2	15
Dentist	26	4	29
Physiotherapist	11	4	14
Screening services (Cervix, Breast, Bowel, Prostate)	10	0	10
Optician	19	12	30
Chiropodist	0	0	0
Hospice as a patient	0	0	0
Hospice as a visitor	0	0	0
Comments			4
		<i>Answered</i>	55
		<i>Skipped</i>	4

**Q15. Which social care services have you accessed since starting transition?**

<i>Answer Options</i>	<i>NHS</i>	<i>Private</i>	<i>Charity</i>	<i>Resp. Count</i>
Social worker	2	0	0	2
Disability services	2	0	2	3
Local social services	2	0	1	3
Local children's services	0	0	0	0
Care home as a service user	0	0	0	0
Care home as a visitor	0	1	0	1
Drug and Alcohol Dependency services	0	0	0	0
Comments				5
			<i>Answered</i>	9
			<i>Skipped</i>	50

**Q16. In general, how satisfied are you with the care and support you have received from the health and social care services you have accessed since starting the transition process?**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Very satisfied	28.6%	16
Fairly satisfied	41.1%	23
Neither satisfied nor dissatisfied	12.5%	7
Fairly dissatisfied	12.5%	7
Very dissatisfied	5.4%	3
Comments		16
	<i>Answered</i>	56
	<i>Skipped</i>	3

**Q17. Are you satisfied with the levels of privacy, dignity and respect you have been shown by the health and social care professionals that you have seen since starting transition?**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Very satisfied	50.0%	28
Fairly satisfied	32.1%	18
Neither satisfied nor dissatisfied	7.1%	4
Fairly dissatisfied	7.1%	4
Very dissatisfied	3.6%	2
Comments		10
	<i>Answered</i>	56
	<i>Skipped</i>	3

**Q18. Has there ever been confusion by healthcare professionals as to which health screening services are appropriate to you since you started the transition process (for example cervix, breast, prostate test)?**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Yes	36.5%	19
No	63.5%	33
Comments		16
	<i>Answered</i>	52
	<i>Skipped</i>	7

**Q19. Do you have any long-term health conditions, disability(ies) or infirmity?**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Yes - please specify in the text box below (optional)	35.2%	19
No - Please go to Q21	64.8%	35
Comments		16
	<i>Answered</i>	54
	<i>Skipped</i>	5

**Q20. Since starting the transition process, have you had enough support from health and social care services and/or organisations to help you manage your long-term condition(s), disability(ies) or infirmity?**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Yes, definitely	26.1%	6
Yes, to some extent	39.1%	9
No	17.4%	4
Don't need any support	17.4%	4
Comments		6
	<i>Answered</i>	23
	<i>Skipped</i>	36

**Q21. Are you a parent or a legal guardian for any children under 16 living in your home?**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Yes	7.4%	4
No	92.6%	50
Comments		1
	<i>Answered</i>	54
	<i>Skipped</i>	5

**Q22. Do you have carer responsibilities for anyone with a long-term health condition or disability?**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Yes	5.6%	3
No	94.4%	51
Comments		1
	<i>Answered</i>	54
	<i>Skipped</i>	5

**Q23. How could the health and social care services you have used be improved in relation to transsexual people and transgender people accessing them?**

<i>Answer Options</i>	<i>Response Count</i>
Comments	33
	<i>Answered</i>
	33
	<i>Skipped</i>
	26



**Q24. Have you ever used a support group for transsexual people and transgender people?**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Yes before transition	25.9%	14
Yes after transition	9.3%	5
Yes before and after transition	46.3%	25
No	18.5%	10
Comments		21
	<i>Answered</i>	54
	<i>Skipped</i>	5

**Q25. Any comments on the process for obtaining a Gender Recognition Certificate and/or what it means to you to obtain a Gender Recognition Certificate?**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Yes (please use the box below for your comments)	48.0%	24
No	52.0%	26
Comments		26
	<i>Answered</i>	50
	<i>Skipped</i>	9

**Q26. Any further comments you would like to make about your experience of accessing health and social care services since starting transition?**

<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Yes (please use the text box below for your comments)	34.7%	17
No	65.3%	32
Comments		17
	<i>Answered</i>	49
	<i>Skipped</i>	10

**Appendix Three**

**Interview Schedule**

**Interview date:**

**Length of Interview:**

**Personal Details**

Age

Ethnicity

Sexuality

Any religious beliefs?

Occupation

What year did you start the transition process?

Do you live in a city, town or village?

Do you live alone or with a partner or family?

Do you belong to any social groups and have any hobbies and interests?

Are you a carer for anyone?

**Family and social support**

When you started the transition process were your family and friends supportive?

Has work colleagues been supportive?

Have you ever used a support group for transgender people?

If so what did you gain from using the support group?

Have you ever suffered verbal abuse, threats of violence or even violence in social situations?

Do you feel you have social recognition as a woman?

### **Legal recognition**

Were the procedures for changing your name and other details straight forward when you started the transition process?

Was the process of changing your name details on your bank account, driving licence and utility bills an important step in promoting your sense of identity in public?

Do you feel you have legal recognition as a woman?

Do you have or are you wanting to obtain a Gender Recognition Certificate?

What do you think about the process for obtaining a Gender Recognition Certificate?

What does having a Gender Recognition Certificate mean to you?

### **Health and social care services**

What health and social care services have you used since starting the transition process?

Have you used an NHS gender identity service or a private gender identity service?

If you used a private gender identity service, what were your reasons for using that service instead of an NHS service?

Did you have to wait a long time for your first appointment at the gender identity service?

Overall how satisfied are you with the care and support you received from the gender identity service?

How could that service be improved?

Has there ever been confusion by health services as to what screening services are appropriate to you, i.e. cervix, breast or prostate?

Have you had gender reassignment surgery?

Did you suffer any post surgery blues?

Overall how satisfied are you with the care and support you have received from health and social care services since starting the transition process?

Overall how satisfied are you with the respect and privacy you have been shown by health and social care staff since starting the transition process?

How could the health and social care services you have used be improved to meet the needs of transgender people accessing them?

What would you say are the most important factors that can help a person to have a successful transition process?

## **Appendix Four**

### **Focus Group Questions Schedule**

### **Focus group questions**

Do you feel you have social recognition as a woman?

Do you feel you have legal recognition as a woman?

Overall how satisfied are you with the care and support you received from the gender identity service?

What do you think about the process for obtaining a Gender Recognition Certificate?

Overall how satisfied are you with the respect and privacy you have been shown by health and social care staff since starting the transition process?

Has there ever been confusion by health services as to what screening services are appropriate to you, i.e. cervix, breast or prostate?

How could the health and social care services you have used be improved to meet the needs of transgender people accessing them?

What would you say are the most important factors that can help a person to have a successful transition process?

## **Appendix Five**

### **Research Participant Information Sheet**



**Full title of Project:** Health and Social Care Service Provision for Transsexual People Post 2004

**Name of Researcher:** Martina Kirlew

Dear research participant are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

**What is the purpose of the study?**

This study will address two central questions that will be the focus of the research. Firstly, what are the experiences of transsexual people accessing health and social care services since the introduction of the Gender Recognition Act 2004? Secondly, to what extent are health and social care services implementing and enforcing this legislation in their policies and practices? One to one interviews, a focus group and an online survey will be used to collect the data over an 8 months period in 2011.

**Why have I been invited to participate?**

You have been invited to take part in this research because you have transitioned after 2004 or are in the process of transitioning and want to be legally recognised in your acquired gender and are wanting to obtain a Gender Recognition Certificate in the UK.

**Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

**What will happen to me if I take part?**

You will either be asked to take part in a one to one interview lasting up to 2 hours, or a focus group consisting of 6 research participants lasting up to 2 hours. You will be asked to talk about your experiences of accessing health and social care services and to give a little background information about yourself, for example interests, employment, relationships and family. However you do not have to answer any question you feel uncomfortable to talk about.

**What are the possible benefits of taking part?**

At present transsexual people have legal recognition as male or female in the UK, thus it is important to ascertain to what extent those rights are being implemented in the policies and practices of health and social care services and if implemented to what extent is this of value to transsexual service users. Therefore your participation in this research study should help to assess the extent to which services are respecting your legal rights and providing services that are appropriate to meet your needs.

**Will what I say in this study be kept confidential?**

All information collected about you during the research process will be kept strictly confidential. Data generated in the course of the research will be kept securely in paper or electronic form within the Department of Social Sciences at the University of Hull. The research findings will be used in the researcher's PhD thesis and may be used in future publications, reports, journal articles and presentations after the data collected about yourself has been fully anonymised. You will also be asked when filling in the consent form if you will allow anonymised quotes you have said can be used in future publications. If you disclose anything to me during the interview process that I feel may put you at harm or another person at harm then I have a duty to report that concern to the relevant authority. This

is because as a responsible social researcher I have to retain a primary concern for the welfare of research subjects and protect them from harm.

## **Appendix Six**

### **Consent Form**

**Full title of Project:** Health and Social Care Service Provision for Transsexuals Post

2004

**Name of Researcher:** Miss Martina Kirlew

**Position:** PhD Student in the Department of Social Sciences at the University of Hull

**Please initial box**

1. I confirm that I have read and understand the research participant information sheet for the above study and have had the opportunity to ask questions.
  
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.
  
3. I agree to take part in the above study.

**Please tick box**

**Yes      No**

4. I agree to the interview / focus group being audio recorded
  
6. I agree to the use of anonymised quotes in publications.
  
7. I agree that my data gathered in this study may be used in future publications, reports, journal articles and presentations after it has been fully anonymised.

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

When completed, 1 copy for research participant and 1 copy for researcher's office file.

Contact details of the researcher are:

Miss Martina Kirlew

c/o Mrs Eileen Palphramand

Department of Social Sciences

Wilberforce Building

University of Hull

Cottingham Road

Hull HU6 7RX

East Riding of Yorkshire

Email – [m.i.kirlew@2004.hull.ac.uk](mailto:m.i.kirlew@2004.hull.ac.uk)

Telephone no: