TRANSGENDERS, HEALTH SERVICES 
AND DESIRE FOR RECOGNITION: A 
REPORT FROM THE TRANZNATION SURVEY

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ABSTRACT
The TranZnation Survey, conducted online from October 2006 to February 2007, was completed by 253 transgender respondents, 229 from Australia and 24 from New Zealand. The survey, designed in consultation with a number of transgender communities focused on health, and access to health services. Respondents described their gender identity in categories that commonly fell beyond conventional binary categories, while preferred words for sexual identity were more traditional. The general level of health and well being among the sample, on a number of measures, was not as high as that of the general population in Australia and New Zealand. Transgenders have health insurance, and regular GPs, at levels similar to the general community. The nature and quality of interactions with general practitioners and specialist gender services show variation, both between respondents and within the experience of individual respondents. Accounts of interactions within health services provide examples, to use Axel Honneth’s terms, of the experience of injustice through the refusal of recognition, and misrecognition, and the positive consequences of the experience of an ethics of recognition. Gender affirmation surgery was often found to be in use as the necessary threshold for legitimated recognition, particularly in the amendment of formal documents.

1 INTRODUCTION

I am a complete person now....now I just need the rest of society to see us as such, as I am publicly open about my life..... Society needs to see us as the men and women that we ARE....and not as how we were born physically. [Respondent 260]

I feel the Department of Births Deaths and Marriages should amend the law to allow people with transsexualism to be recognised as their correct sex, regardless of if they have been able to obtain surgery or not, since money is the prohibiting cause. (Respondent 76)

Transgender people typically express a strong desire for the recognition of themselves and their identity. Many of the strategies they use to achieve this recognition are brought into play in their interaction with health services and health professionals. Commonly, transgenders have an ambivalent relation to medicine: on the one hand resisting the over-medicalisation of their lived experience; and on the other, recognising their need of the interventions of medicine - such as hormone treatment and surgery - in achieving the desired social and inter-personal recognition.
1.1 RECOGNITION, SELF-CONFIDENCE, SELF-RESPECT AND SELF-ESTEEM
This report from the TranZnation Survey, follows a thread of ‘recognition’, and the lack of congruence that is sometimes in evidence between the complexity of the lived transgender life, its ‘recognition’, and the systematisation required by health services. This thread begins with Axel Honneth’s ethics of recognition (Honneth, 1995) elaborated in dialogue with Nancy Fraser (Fraser & Honneth, 2003), which encompasses both the recognition of rights and cultural appreciation. As Denrante & Renault (2007) argue, Honneth moves from a hermeneutic of experiences of injustice to an ethics of recognition, ‘because the various feelings of injustice point to three main spheres of recognition’ (p.97): recognition through intimacy by which affective needs are fulfilled, leading to self-confidence; recognition of the equal dignity of persons, granting self-respect; and recognition of the individual’s contribution to the social division of labour, which provides self-esteem.

This report provides examples, to use Honneth’s configuration, of the experience of injustice through the refusal of recognition, and misrecognition, and consequences of the experience of an ethics of recognition.

2 DISCUSSION
2.1 THE TRANZNATION SURVEY
This survey investigated the health, well-being and use of health services by transgender people living in Australia and New Zealand. It was conducted online between October 2006 and February 2007 and completed by transgenders aged 18 years or older. The survey was in English, and designed after consultation with a number of transgender communities in Australia. A mix of quantitative and qualitative questions was used to provide participants opportunity to give an account of their lives and their experiences with health services. Approval for the survey was granted by La Trobe University Human Research Ethic Committee.

The quantitative data collected were analysed using SPSS version 14 and alpha was set at 0.05 for all analyses. The analysis of qualitative data was managed using NVivo version 2. Open and axial coding was used to identify themes and their interconnection (Strauss, 1990).

2.2 THE RESPONDENTS
253 respondents completed the study: 229 (90.5%) from Australia and 24 (9.5%) from New Zealand. The distribution of the Australian sample was similar to census data (ABS, 2006a), with the exception of an overrepresentation of participants from Victoria. The majority of New Zealand respondents were living on the North Island (55.8%) and Auckland was the most common city of residence. Mean age of the sample was 41.1 years (SD 13.7).

Respondents reported the sex recorded on their original birth certificate. Within the total sample, 191 (75.5%) reported ‘Male’ and 62 (24.5%) ‘Female’. This ratio of 3:1 ascribed males to females approximates the ratios reported in prevalence studies of Gender Identity Disorder (GID)¹ and transsexualism conducted recently in European countries (De Cuypere et al., 2007; Garrels et al., 2000; van Kesteren, Gooren, & Megens, 1996; Weitze & Osburg, 1996; Wilson, Sharp, & Carr, 1999). Participants whose sex was

¹ Gender Identity Disorder (GID) was included as a diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV in 1994, replacing the diagnostic category of ‘transsexualism’ used in the DSM-III-R
assigned female at birth were, on average, significantly younger than those who were assigned male at birth (30.6 years and 44.6 years respectively; t(125.2) = 8.55, p < .0005).

2.3 GENDER IDENTITY
Participants provided the word (or words) they prefer to be used to describe their current gender identity. Two researchers examined the wide range of responses obtained and identified major themes. Each term for gender identity used by a participant was coded according to these themes. Thirteen labels were identified in total (Table 1), with multiple terms of gender identity being able to be coded for a single participant.

These findings concur with Sally Hines’ findings (Hines, 2006) that transgender people ‘articulate gender identities that fall beyond a traditional binary framework’ (p.63). According to Hines, such identities are contingently situated, constructed in relation to temporal factors of generation and transition, through and in opposition to medical discourse, and ‘are negotiated within affective relations and intimate networks’. (p.64)

2.4 SEXUAL IDENTITY
Participants provided the word (or words) they preferred to be used to describe their sexuality or sexual identity. Unlike their terms for gender identity, most chose one of four conventional sexual identities: Bisexual, Heterosexual, Gay or Lesbian.

2.5 GENERAL HEALTH OF THE RESPONDENTS
The majority of the sample rated their health as ‘good’ or ‘very good’ (35.2% and 28.9% respectively) on a five-point scale, ratings lower than for those reported in the Australian National Health Survey (ABS, 2006b). The general health subscale of the SF-36 is a five item scale that assesses perception of general health function. The average TranZnation score was 65.06 (SD 20.82), which is lower than the population norm for Australia (71.6; ABS, 1995) and New Zealand (73.8; SNZ, 1999).

Depression was assessed by the Prime MD, a short 9 item scale that has been used to measure depression in the Australian general population (Goldney, Fisher, Wilson, & Cheok, 2000) and in Australian non-heterosexual samples (Pitts, Smith, Mitchell, & Patel, 2006). Participants were asked to indicate whether they had experienced symptoms of depression in the past two weeks. Overall, 53.4% of respondents answered affirmative to at least one of the two screening questions and just over one third (36.2%) met the criteria for a current major depressive episode.

2.6 HEALTH SERVICE USE AND EXPERIENCES
The health service experience of transgender people is shaped in ways similar to that of the general population. For example, transgenders have health insurance and regular GPs at levels similar to the general community.

Apart from general practitioners, respondents used a wide range of health services in the previous 12 months, with a small proportion accessing services directly related to being transgendered, e.g. speech pathology and gender presentation services. Hospitals had been accessed by 15%-20% of participants in the past year and a minority had used number of other specialist services (e.g. endocrinologists, speech therapists). The most commonly accessed health services were mental health professionals, which was used by almost half the sample.

2.7 EXPERIENCES WITH HEALTH SERVICES
Participants described their best and worst experiences with a health practitioner or health service in relation to being transgender. The specific experience of respondents in relation to questions concerning hormone treatment and surgical procedures will be
reported elsewhere. What follows is based on responses to general questions about health services.

Respondent’s accounts detail pleasure in modes of recognition from health services akin to Honneth’s configuration: appreciation at being treated in ways which contribute to intimacy and self-confidence; being approached with dignity and encouragement of self-respect; and recognition of the social division of labour leading to self-esteem. This last aspect will receive particular attention later in this paper, when matters dealing with amendments to formal documentation are discussed.

For many respondents, feeling accepted and supported by a practitioner counted as their best experience with a health service. Practitioners were particularly valued for being understanding, empathetic, and compassionate. Professionalism was important, often linked to a practitioner’s non-judgmental approach, and to a participants experience of being treated like ‘an everyday, “normal” person’ (TN262 ²). Some participants took pleasure in practitioners appearing to be ‘oblivious’ (TN25) to their transgender status, and in the fact that they “didn't even bat an eyelid” (TN04) when they learned about it.

For some respondents recognition was negative. Some reported being met with curiosity and surprise in their encounters with health services. This ranged from ‘just the odd raised eyebrow, nothing serious’ (TN18), to feeling like ‘a bit of a novelty or freak show ‘(TN262). Sometimes respondents felt that they were not respected as individuals, and that health professionals were ‘more interested in (a client’s) “gender dysphoria” than in the person who they were treating’ (TN26).

Respondents’ worst experiences with health services usually involved encounters where they were met with hostility. These ranged from instances where participants sensed discomfort, contempt and resentment, to occasions of being refused treatment, laughed at, ridiculed, and met with outright displays of disgust. Examples included ‘being told that (she was) the filthiest most perverted thing on earth’ (TN11), while another’s was being told that he ‘needed to find god not hormones’ (TN132). For some, prejudice and contempt came to be expected and sometimes participants were grateful simply for the absence of explicit displays of these: ‘Most males in the health service try not to show their distaste for my condition, and I appreciate that’ (TN73).

Practitioners were greatly appreciated if they were knowledgeable and experienced in transgender issues, and if they were sensitive to gender diversity and to the difficulties that transgender people face in health care settings. Of course, knowledge about appropriate hormone treatment and surgery is also important. Many participants, however, found that their doctor had little experience in treating transgender people, and needed to gain new skills in order to take them on as patients. This situation was not necessarily experienced negatively. While some people wished that their doctors had been taught how to treat transgender patients in medical school, and not need to be educated by their patients, others were happy to have open-minded doctors who ‘learned with (them)’ (TN127), and who showed an interest in transgender issues.

Some participants enjoyed being an ‘equal partner’ (TN166) in the doctor-patient relationship, ‘involved in the process rather than just being told what to do’ (TN69). They liked practitioners who respected the transgender patient’s own knowledge about their body, and trusted their ability to make their own decisions about what they wanted. For one participant, her best experience with a health service was the first time her ‘views on (her) gender (were) accepted as authoritative’ (TN211).

² Each respondent was ascribed an individual number
My psychiatrist treated me like a rational adult and didn't make me go through various silly hoops. (TN85)

The majority of participants (52%) said that the practitioners and services they used gave them the opportunity to express their views and opinions on the services they receive. A significant proportion (21%) said that this was the case in certain circumstances but not in all: ‘some do and others don’t’ (TN115), ‘my doctor does, my hospital does not’ (TN277). Twenty seven percent said they were not given the opportunity to express themselves, although many participants indicated that they would express their opinion whether or not it was asked of them. Others noted that it was difficult to do so when doctors acted as the gatekeepers who controlled access to hormone treatments and surgery. These participants were aware of needing to meet certain criterion, and often felt like they had to “jump through hoops” (a commonly used expression in the data). To make the process easier for themselves, participants sometimes modulated their opinions, as to do otherwise was to do so ‘at (one’s) own peril’ (TN225):

Many people I’ve spoken to are too scared to say anything that doesn't fit “the standard story” because they’re worried they’ll be denied services (which is understandable) (TN04)

Some felt pressure to present themselves in particular ways, in order to fit into tight gender categories that did not necessary reflect their experience of gender identity. Participants pointed to a need for a more complex and diverse understanding of gender within the health system, and expressed frustration about constantly feeling like they were being forced into gender binary categories. One participant noted that his specialists ‘didn't seem very interested in (him) as a person’ and were only interested in ‘mak(ing) sure that (his) life experience matched that of the “typical” FtM\(^3\)’ I felt like I was being put through a “tranny factory”(TN199).

Some participants reported being told that they were not a ‘classic case of a transsexual’ as they ‘didn’t fit the text book description’ (TN176). Others experienced anxiety over whether or not they would fit the “textbook description” and feared being told that they were “not trans enough” (TN38). One participant said:

I have on occasion censored aspects of my experience for the fear of being denied treatment. (TN21)

In their interactions with health services, participants reported that they often felt like they were being interrogated. Some participants felt exposed and humiliated by the process which for some involved ‘invasive questions’ about their bodies (TN206), and feeling like their lives were being ‘ripped to pieces by a psychiatrist’(TN77).

The psychiatric consult to confirm I was transgendered was an awful experience. I felt grilled and mistrusted and attacked. (TN140)

I had an appalling psychiatrist, as was his replacement at his clinic. All they wanted to know about was my sexual practices and fantasies. They were not interested in anything else. To the extent that I was asked about what positions I took in sexual conduct, whether I enjoyed penetration and specifically what kind, and whether I lay face up or face down when masturbating. (TN162)

\(^3\) Female to Male
Participants’ comments about diagnosis, which represent specific moments of recognition, differed. One participant described being ‘finally diagnosed as gender dysphoric and being prescribed hormones’ (TN232) as a significant and happy milestone. Others gave accounts of struggle to have health professionals take them seriously; one even refused assistance, because the health professional ‘didn’t believe in transgenderism’ (TN163).

Experiences of recognition identified by respondents included the appropriate use of pronouns, using the participants’ chosen names, and changing medical records to fit with gender identity.

3 CONCLUSIONS

So far, we have shown how transgender people, in their encounters with health services experience various responses to their desire for recognition, especially recognition which enhances self-confidence and self-respect. The third outcome, in Honneth’s scheme, provides self-esteem, through recognition of a contribution to the social division of labour. For many of the respondents this was the most significant form of recognition, and the responses concerning changing documentation were among the spirited and passionate in the survey data.

In some cases, the very aim of engagement with health services, including hormone treatment and surgery, was to reach the point of formal and legitimated recognition, through alterations to foundational documents. Half of respondents (50.6%) reported that they had tried to amend public documentation to reflect their current gender identity. Respondents expressed frustration at not being able to change gender or sex on their documentation unless they had had surgery, particularly given the cost and other barriers to gender related surgical procedures.

I want to change my passport to say male, but they won’t let me till I’ve had chest surgery or a hysterectomy.... f***heads!!! (TN102)

I've had a legal name change, but am disappointed that the [state] government requires I undergo surgery to recognise my gender. I think diagnosis from one or perhaps two psychiatrists should be enough to amend sex on one's birth certificate, as it makes things very difficult when using a birth certificate with a female name which state male gender (TN279).

These two transgender voices conclude the paper, expressing what is for them, an unsatisfactory articulation between health services on the one hand, and just recognition of the lived experience of their body and gender on the other.
### Table 1: Terms used to describe current Gender Identity

<table>
<thead>
<tr>
<th>Term used</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opposite sex to sex on birth certificate (e.g. Male with birth certificate sex of female)</td>
<td>120</td>
<td>47.4</td>
</tr>
<tr>
<td>Same sex as on birth certificate (e.g. Male with birth certificate sex of male)</td>
<td>7</td>
<td>2.8</td>
</tr>
<tr>
<td>Transgender or Transgendered</td>
<td>54</td>
<td>21.3</td>
</tr>
<tr>
<td>Transsexual</td>
<td>28</td>
<td>11.1</td>
</tr>
<tr>
<td>‘Trans’ and a gender (eg. Transman, woman suffering transsexuality, transgendered woman)</td>
<td>35</td>
<td>13.8</td>
</tr>
<tr>
<td>Changed sex (eg. FtM, MtF)</td>
<td>11</td>
<td>4.3</td>
</tr>
<tr>
<td>Abbreviated Trans (eg. Tranny)</td>
<td>8</td>
<td>3.2</td>
</tr>
<tr>
<td>Crossdresser</td>
<td>12</td>
<td>4.7</td>
</tr>
<tr>
<td>Transvestite</td>
<td>2</td>
<td>0.8</td>
</tr>
<tr>
<td>Sistergirl</td>
<td>2</td>
<td>0.8</td>
</tr>
<tr>
<td>Harry Benjamin Syndrome (HBS)</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Queer (eg. Genderqueer)</td>
<td>13</td>
<td>5.1</td>
</tr>
<tr>
<td>Gender Challenging (eg. androgenous, gender variant)</td>
<td>19</td>
<td>7.5</td>
</tr>
</tbody>
</table>

Note. Percentages do not add up to 100 as multiple responses were possible. \( N = 252 \)

### 4 ACKNOWLEDGEMENTS

Sunil Patel, Christopher Fox
5 REFERENCES


