Chapter 1. Trans research: Of gender ambiguity, gender dysphoria and gender recognition

The interest in trans issues has increased significantly between my two field research periods, which is reflected, for example, in the rise of corresponding publications in the academic field. Newly theorising and newly emerging topics foster a continuing interest. The increased attention on trans topics has also found (and continues to find) inclusion in the political agenda of a growing number of nations and supra state organisations (e.g. the European community), and in the health-related sector (e.g. the World Health Organization) (see Chapter 6). In 2018, Halberstam states:

> In the last decade, public discussions of transgenderism have increased exponentially. What was once regarded as an unusual or even unfortunate disorder has become an accepted articulation of gendered embodiment as well as a new site for political activism. (Halberstam 2018: 17)

This increased 'public discussion of transgenderism' has also occurred in my field research area (Andalusia), and 'the articulation of gendered embodiment' (especially concerning medical and legal obligations) has become more diverse. However, many available academic publications dealing with the situation in Spain or Andalusia consider the phenomenon from a medical point of view. This was especially true at the time of my first field research trip in 2003. Among the scientific publications *in* and *about* Spain, it was striking to note the dominance of medical contributions. Publications in endocrinology told about hormonal treatment options, andrology elaborated about men's reproductive functions and their disorders, and publications in psychiatry and the neurosciences dealt with 'the transsexual phenomena'. The supremacy of the medical literature reflected the fact that the term 'transsexualism' emerged (from the 1950s onwards) together with the focus on the possibilities of medical treatment, which remained a dominant perspective (Chiland 2003). One exception was a qualitative sociological study that compared the situation of transsexual and transgendered persons in Scotland (Aberdeen, Edinburgh) and Northern Spain (Barcelona), and which focussed on their legal, social, and political situation (Soley-Beltran 2007). Soley-Beltran linked the spare theo-

rising and sparse empirical research on 'transsexualism' in Spain to its history of repression (dictatorship), which impeded their visibility. She states: "Given the repression and public invisibility of transsexuals in Spanish history, most papers on transsexualism currently published in Spain tend to be either a general introduction to its definition, its history and to the debates developed in English-speaking countries, or governmental reports advising on its legal situation" (Soley-Beltran 2007: 11).

Another exception is the ethnographic research conducted by the Andalusian anthropologist, Fernando Tena Díaz (2008), which can be attributed to an *anthropology at home*. This is, to my knowledge, the only research that approached the topic of transsexuality in Southern Spain from a social anthropological perspective based on in-depth conversations and participant observation. I learned of Tena Díaz during my first field research stay in Seville in 2003 and contacted him. We met to exchange ideas, and just as he drew my attention to a few academic references in Spain, I provided him with insights and literature obtained during my meeting with a surgeon in the UTIG in Malaga (detailed information about the UTIG will follow later in this chapter). It happened on several occasions that interesting documents concerning the topic of my research emerged only through personal communications during the field research stays, and did not show up, e.g. in literature research. I met Fernando Tena again during my second fieldwork trip, and although he had finished his thesis in the meantime, it has not yet been published. It was, therefore, not available. However, he provided me with two articles stemming from his work (Tena 2010, 2013) and which reflected his focus on the interplay between medical practice and sex/gender identity constructions.

In the meantime, some faculties of psychology in Andalusia had started to engage in trans topics as well. The Faculty of Psychology at the University of Malaga conducted a first quantitative study in 2011 that focussed on the living situation and experiences of transsexual people in Spain. In collaboration with the *Federación Estatal de Lesbianas, Gays, Transexuales y Bisexuales* in Madrid, who helped to recruit the target population, they questioned 153 persons all over Spain. The majority stemmed from Andalusia and Catalonia (141 persons). Trans women and trans men were asked about their work situation, experiences of discrimination and social exclusion, the age of consciousness about their transsexuality, and the age of their 'coming out', clinical and chirurgical interventions and the supporting social network. Another aim of the study was to capture the level of life-satisfaction in relation to other psychosocial variables (Dominguez Fuentes et al. 2011).

Edelman points out that "[t]rans studies – or research on the experiences, identities, and practices of transgender, transsexual, trans*, or gender nonbinary communities of practice – is a relatively new area of focus within the discipline of anthropology" (Edelman 2019: 1). Thus, nevertheless (or because of) the above-mentioned studies, research in social anthropology, with its in-depth and participative

methods, is needed to contribute to the increasing public discussions of trans topics, and the potential implications this might have upon the life experiences (and their possible transformation) of the people concerned within their local environment.

In the following, I first outline the contributions of anthropological research on gender non-conforming persons (in the broadest sense) from a 'historical' perspective. However, anthropology itself has been enrichened by interdisciplinary research over time. Thus, it must be noted that "[t]rans studies in anthropology has both relied on interdisciplinary research but also, importantly, emerged from a focus on sexuality or 'queer studies' within anthropological research" (Edelman 2019: 1). In a second step, I will focus on Andalusia and provide a first overview.

1.1 Gender non-conforming people from an anthropological perspective: A few selected cases

In the 1990s, feminist theories experienced a growing and controversial discourse by starting to question in depth not only the social constructivist character of the gender binary men and women (gender role, gender identity etc.), but also the biological dimorphism of the two-gender system itself (Becker-Schmidt and Knapp 2011). The physical sex-dualism as natural, given and unambiguous was questioned, and increasingly viewed as a culturally specific classification and/or a semiotic construct (cf. Butler 1991, 1997; Hagemann-White 1988). Thus, the sex-gender distinction, which has served for many decades as a political tool in feminist theory, was also called into question (consequently abandoning sex/gender categories). Becker-Schmidt and Knapp (2011) point out that former research in cultural anthropology served to support this change of perspective. They note that questions of different conceptualisations concerning the relationship between nature and culture, and the socio-cultural meaning of sex as a category of order and classification had always been of more significance in anthropological research than in other disciplines. An excerpt from Ortner's and Whitehead's edited book, *Sexual Meanings* (1981), serves as an example:

> It has long been recognized that 'sex roles' – the differential participation of men and women in social, economic, political, and religious institutions – vary from culture to culture. It has also long been recognized that the degree and quality of social asymmetry between the sexes is also highly variable between cultures. What has not been generally recognized is the bias that often underlies studies of both sex roles and male dominance – an assumption that we know what 'men' and 'women' are, an assumption that male and female are predominantly natu-

> ral objects rather than predominantly cultural constructions. (Ortner and Whitehead 1981: 1)

Thus, to examine this bias of 'natural objects', the authors asked the contributors to the book to

> [...] share a commitment to the proposition that male and female, sex and reproduction, are cultural or symbolic constructs, whatever may be the 'natural' bases of gender differences and human reproduction. (Ortner and Whitehead 1981: 6)

Various social anthropological studies showed that forms of sex/gender classifications which exceeded the western-occidental understanding of a rigid, binary, two-gender system and were less bounded to physical features as 'Western culture', existed in some cultures (Becker-Schmidt and Knapp 2011). Herdt states that "[i]n anthropology's encounter with the traditional societies – especially the exotic cultures of the non-Western world – myriad examples of divergent sexualities and gendered classifications have emerged over the past century" (1996b: 12). A classic anthropological case are the *berdaches* from native North American societies. Roscoe (1998) points out that Europeans have encountered these cross-dressing people since the 16th century, since the time of the Spanish Conquest. He gives a profound and differentiated insight into the social embedding of these 'third and fourth' genders, and highlights the accepting and respectful social interactions within their societies:

> The original peoples of North America, whose principles are just as ancient as those of Judeo-Christian culture, saw no threat in homosexuality or gender variance. Indeed, they believed individuals with these traits made unique contributions to their communities. As a Crow tribal elder said in 1982, 'We don't waste people the way white society does. Every person has their gift'. In this land, the original America, men who wore women's clothes and did women's work became artists, innovators, ambassadors, and religious leaders, and women sometimes became warriors, hunters, and chiefs. Same-sex marriages flourished and no tribe was the worse for it – until the Europeans arrived. [...] people who were different in terms of gender identity or sexuality were respected, integrated, and sometimes revered. (Roscoe 1998: 4)

The legitimacy (and sometimes maybe even obligation) not to live the assigned sex was often ascribed to a dream revelation. A supernatural force orders the concerned person to live from now on as the other sex. Turner writes:

> Omaha boys, like other North American Indians, go alone into the wilderness to fast and pray. This solitude is liminal between boyhood and manhood. If they dream that they receive a woman's burden strap, they feel compelled to dress and

> live henceforth in every way as women. Such men are known as mixuga. The authority of such a dream in such a situation is absolute. (1964: 10)

Nowadays, the term *berdache* has been replaced by *two-spirit*. Murray (1997) criticises this renaming and considers it an effort to downplay sexuality and to emphasise spirituality (for a more differentiated discussion and a critical analysis of the term, *two-spirit,* see Roscoe 1998).

A further example of anthropological research on gender non-conforming people are the *xanīth* in coastal Oman described by Wikan (1977). According to Wikan, the *xanīth* occupy an institutionalised transsexual role in Oman society. They are men who are socially classified as women, and practise homosexual prostitution. They occupy an intermediate gender position in a society where there are strict rules of sexual segregation. Thus, they retain male names, and can move about freely, a privilege reserved for men (in contrast to women, who must have the husband's permission to go visiting family and friends). However, in the evening the *xanīth* must stay at home like the women (whereas men can spend their time in public spaces). Wikan explains the socially and legally tolerated sex-working practice of the *xanīth* by the essentialist view of the Omani, who consider the sexual drive to be a component of men's nature and, thus, difficult to control. In this sense, the "[*xanīth*] act as a safety valve on the sexual activity of men, and thus as a protection for the virtue of women" (Wikan 1977: 314). Taking into consideration the insights stemming from sexuality studies that understand sexuality to be less driven by biological needs, but rather scripted within a social and psychological framework (cf. Gagnon and Simon 2005), comparing the male sexual drive with a pressure cooker that needs to be relieved from time to time, must definitely be questioned (cf. Lautmann 2002).

Another often referenced anthropological contribution to the sex/gender diversity is Nanda's (1996) work on the *hijras* in India. She comments on their cultural meaning (particularly in relation to religion), and discusses their gender roles and identities. As neither male nor female, living an alternative form of gender role, and despite sometimes being a target for stigmatisation, Nanda conceives the *hijras* as an integral part of society, although they live in a culture "[…] in which male and female sex and gender roles are viewed as essential, sharply differentiated and hierarchical" (Nanda 1996: 417). She considers the example of the *hijras* to be evidence that Western sex and gender dichotomies are not universal. About twenty years later, Nanda's analysis of Indian society and culture (that it acknowledges multiple sexes and genders) has been legally confirmed. In 2014, the Supreme Court of India recognised trans people as a third gender (different from female and from male), an acknowledgment that is attributed to the cultural tradition of the *hijras* (Rojas 2014).

Clinical research and further cross-cultural studies

Together with a growing interest in clinical research on transsexuality and intersexuality in the Western world in the 1960s, there was also a growing interest in cross-cultural studies concerning these phenomena. Edgerton rediscovered the work of W.W. Hill from 1935, whose description of the attitude towards intersexual people by the Navaho (called *nadle*) offered an alternative view to the Western (US-American) response to intersexuality. Edgerton states: "American response to intersexuality combines psychological horror with social incompatibility" (Edgerton 1964: 1289). And he continues: "Our society's solution – aside from threatening such persons with the status of sideshow freaks – is to encourage the assumption of either a male or a female role" (Edgerton 1964: 1290). In this sense, the Western response was deficit-oriented and asked mainly how these persons could be fitted into the binary gender system. In contrast, the Navaho offered intersexed people a favoured position in life. Credited with special supernatural significance, they were respected, and families with an intersexed child believed to have their future wealth and success assured (Edgerton 1964). However, globally, not all indigenous societies respected intersexual people like the Navaho. During his fieldwork with the Pokot of East Africa, Edgerton found a cruel and discriminating attitude against intersexual people. Because the desire for wealth, especially measured in cattle, dominated the life of the Pokot, only 'useful' people deserved respect. Intersexed people were not allowed to marry or to have progeny, and were, thus, perceived as worthless. Nevertheless, some intersexed people managed to receive a kind of acceptance due to their hard work for the family (Edgerton 1964).

The cases of the *guevedoche* ('penis at twelve') in the Dominican Republic and the *kwolu-aatmwol* of the Sambia in New Guinea were further examples of cross-cultural studies. Herdt (1996a) was convinced that these societies had a concept of three sexes. His analysis was a criticism of the publication by a group of American medical investigators in the beginnings of the 1970s, who described the *guevedoche* as a "mistaken sex". They stated that because these people were genetically male, they were mistaken as females at birth, raised as normal girls, but changed their sex and gender at puberty to male. In Western medical terminology, they were labeled male pseudohermaphrodites due to a 5-alpha reductase deficiency. Furthermore, according to this group of medical investigators, this switch of identity and desire, from then on to act and identify as men, happened without any social or psychological influence from the social environment. Thus, they concluded that the impact of hormones (androgens) – which equals nature – has more impact in determining the (male) gender identity than (female) socialisation. Herdt unveils the sex-binary bias of these investigators and holds "[…] that these peoples in the Dominican Republic and New Guinea […] have evolved a three-category sex code in living with male pseudohermaphrodites in their midst over generations" (Herdt

1996a: 441). He concludes: "[…] these persons are not 'mistaken females' but, rather, *guevedoche* and *kwolu-aatmwol*; that is, third genders" (Herdt 1996a: 442).

The *Waria* (male transvestites) in Indonesia (Boellstorff 2004), transgendered prostitutes in Brazil (Kulick 1998), the *māhū* of Tahiti and the *fa'afafine* of Samoa (Besnier 1996; Mageo 1992) or the sworn virgins of Albania (women who live as men) (Grémaux 1996) – to name just a few – are other examples of cross-cultural studies to question the 'natural' order that fixes sex, gender and desire in a sex/gender-binary and heteronormative framework, thus broadening and questioning Western conceptions about masculinity and femininity.

Besides these anthropological observations that hinted at a variation of gender interpretations (inside certain borders), sociological studies about transsexuality (Garfinkel 1967; Hirschauer 1993; Lindemann 2011) and the beginning of the Queer Studies in the 1990s (cf. Jagose 1996; Krass 2003) also helped to question the concept of a sex-dualism as natural and given. Furthermore, there were historical studies that tried to show that the biological bias of the everyday Western understanding of the sex/gender difference is itself a product of history, shaped not least through the emergence of a 'modern' science of men in the 18th and 19th century (Laqueur 2001). Biological research itself helped to put into perspective the strict dual gender classification as everyday understanding has it. Male and female are no longer understood to be contrary, mutually exclusive categories, but as a continuum consisting of a genetic sex (chromosomes), sex of the gonads, and hormonal sex. The criteria that serve to determine sex must neither necessarily just depend on the 'little difference' (penis or vagina), nor can sex be viewed as independent from the environment (cf. Becker-Schmidt and Knapp 2011; Fausto-Sterling 2012; Roughgarden 2004).

1.2 From sexual deviance to gender fluidity

In Europe and North America, at least since the second half of the nineteenth century, medical, legal, and other scientific institutions occupied themselves with individuals deviating from a clear binary sex/gender norm (Ekins and King 2005; Stryker and Currah 2014).

> Although it is possible to cite examples of the phenomenon of transgender throughout human history, the roots of our modern conception of transgenderism are to be found in the latter half of the 19th century. This period saw the beginning of what Foucault terms the 'medicalisation of the sexually peculiar'. (Ekins and King 2005: 381)

Using a historical and chronological approach, Ekins and King (2005) work out that the first influential perspective on the topic was the role of medicine, which

was first to emerge and is in many ways still dominant today. However, the phenomenon was initially judged as a kind of homosexuality, which was understood as lacking masculinity and possessing a female soul. In the beginning of the 20th century, Hirschfeld disagreed with this concept, and argued that not all effeminate men are homosexuals (just as not all homosexuals are effeminate), and introduced the term *transvestite* for these people, who were later categorised as transsexual or transgender. When hormonal and surgical interventions for 'sex change' became a practical possibility (from the 1950s onward), and a concept of the separation of sex from gender was developing, the medical focus shifted from the body as an apparent reality that can hardly be altered (the morphological sex) to a conceptualisation of a gender identity (a kind of psychological sex), as the 'real' reality. Ekins and King note:

> The 'real reality' of what now came to be conceptualized as psychological sex – 'gender identity' – was privileged over the 'apparent reality' of the body – morphological sex. The modern 'transsexual' was 'invented'. (2005: 381)

In the 1960s, Harry Benjamin introduced his influential book *The Transsexual Phenomena* with the words: "There is a challenge as well as a handicap in writing a book on a subject that is not yet covered in the medical literature. Transsexualism is such a subject" (Benjamin 1966: vii). Benjamin counts as a pioneer in addressing the need for medical treatment for transsexual people, and was in favour of the new emerging surgical possibilities to alter the body to the conviction of the concerned individuals (in contrast to those who tried to alter the conviction to fit the morphological sex). When writing the book, he was aware that he would encounter opposition: "Even at present, any attempts to treat these patients with some permissiveness in the direction of their wishes – that is to say, 'change of sex' – is often met with raised medical eyebrows, and sometimes even with arrogant rejection and/or condemnation" (Benjamin 1966: viii). Benjamin's work was to greatly influence how medicine and society approached the phenomenon of transsexuality in the coming decades. I even came across a Spanish translation of "The transsexual phenomena" in the hands of one of my research partners during the field research in 2003. She expected this book to hold the answers to her questions (see 3.2). Benjamin's legacy is manifested by the *World Professional Association for Transgender Health (WPATH)*, formerly called the Harry Benjamin International Gender Dysphoria Association. Today, one of the main goals of the WPATH – through its publication of *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* – is to "[…] promote the highest standards of health care " […] (World Professional Association for Transgender Health 2012: 1) for these individuals. This means: «[…] to provide clinical guidance for health professionals to assist transsexual, transgender, and gender-nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in

order to maximize their overall health, psychological well-being, and self-fulfillment" (World Professional Association for Transgender Health 2012: 1).

Reisner et al. (2016) observe that interest in transgender health-related research has increased significantly in the most recent years. Their analysis is based on a literature review, which included only peer-reviewed quantitative studies that were published between 2008 and 2014 in either English, French, or Spanish. They found 116 studies in 30 countries. However, most of the studies were conducted in the USA. There was no data available for the majority of the countries and for many of these 30 countries they found only one study. Spain was one of those countries represented with one study only.

At the same time, Stryker and Currah draw attention to the high degree of institutionalisation that was happening in the meantime, which they call "[t]he longterm biopolitical project of cultivating 'gender congruence' while eliminating incongruity […]" (2014: 4). Thus, the medical approach still

> […] retains a view of sex, sexuality, and gender as binary and has, on the whole, accepted existing stereotypes of what constitutes masculinity and femininity and their linkages to male and female bodies. Thus […] suitability for hormone and (especially) surgical 'sex change' is determined by the extent to which the candidate 'passes' or demonstrates sufficient masculinity or femininity. (Ekins and King 2005: 283-284)

This kind of medical (or institutional) practice has been reflected in detail by Hirschauer (1993), who unmasked the transsexual phenomenon as being constructed by medicine and an intrinsic part of the construction of the binary sex/gender-system.

Towards a transgender turn

From the beginnings of the 1960s, questioning this developing medical discourse, voices of transgendered people, who sought to avoid medicalization, started to be heard. They "[…] sought to develop their own perspective and accompanying concepts of what it meant to be male/masculine and female/feminine" (Ekins and King 2005: 384).

The political significance of trans gendering arose with the emergence of the gay and women's movement in the late 1960s. On the one hand, transsexual and transgender people were perceived as politically conservative, because they reinforced gender stereotypes (e.g. performing a hyperfemininity). On the other hand, because they somehow broke the congruity between sex and gender, they were also perceived as radical. Among feminist positions on transsexualism (strongly embedded in a gender-binary way of thinking), male-to-female transsexuals were not accepted as women, but regarded as deviant males. In searching and accepting

medicalisation and sex surgery, and, thus, submitting to a medical system that was perceived as patriarchal, trans women were accused of not using their subversive potential. Even worse, they reinforced the patriarchal structures. This kind of argumentation holds that "[…] transsexualism is not merely another example of the pervasive effects of patriarchal attitudes; it actually constitutes an attack on women" (Ekins and King 2005: 387).

In the early 1990s, alongside the consolidation of the term transgender as an umbrella term (see Introduction), and embedded in a postmodern approach, an interdisciplinary field of transgender studies began to emerge. According to Stryker and Currah, the difference between these transgender studies and the so far 'biopolitical project' lies therein that:

> Transgender studies does not […] merely extend previously existing research agendas that facilitate the framing of transgender phenomena as appropriate targets of medical, legal, and psychotherapeutic intervention; rather, it draws upon the powerful contestations of normative knowledge that emerged over the course of the twentieth century from critical theory, poststructuralist and postmodernist epistemologies, postcolonial studies, cultural studies of science, and identity-based critiques of dominant cultural practices emanating from feminism, communities of color, diasporic and displaced communities, disability studies, AIDS activism, and queer subcultures and from the lives of people interpellated as being transgender. (Stryker and Currah 2014: 4)

The emphasis started to focus on transgender diversity and gender fluidity with the goal to overcome the strict binary gender divide. "Within this approach, the idea of permanent core identities and the idea of gender itself disappear" (Ekins and King 2005: 389).

This increasing demand for a free expression of a self-defined gender identity, together with more advanced surgical techniques, is also said to have an impact on the way individuals conceive the right to own their body, "[…] and [to] make whatever temporary or permanent changes to that body the individual pleases …. A new sort of transgendered person has emerged, one who approaches sex reassignment with the same mindset that they would obtaining a piercing or a tattoo" (Califia 1997 as cited in Ekins and King 2005: 389).

At transgender conferences and conferences touching the issues of health, HIV-prevention, sexuality and gender, increased interest in the 'transsexual phenomenon' (within both the concept of gender diversity as well as on more sophisticated techniques to achieve sex/gender congruence within a binary sex/gender concept) can be observed. Around 1'000 people attended the World Professional Association of Transgender Health (WPATH) Symposium in Amsterdam in 2016. Declared as the biggest global transgender conference that had ever taken place (personal note from the morning session on Saturday, June 18th,

2016), this was almost twice the number of participants than at their previous conference two years earlier. Additionally, next to input on medical and surgical treatment, or social science studies focussing on social problems, contributions and testimonies from trans individuals increasingly emphasised their 'Pride', thus addressing issues of self-esteem and claiming one's place in society no matter what medicine, law and the social environment are up to. This growing 'pride' and 'claiming one's place in society' also became obvious in the confrontation initiated by trans individuals during the WPATH. The conference provoked local trans activists (in Amsterdam) to raise their voice and criticise the high fees for attending the conference, which would make it impossible for trans people with low economic resources to participate. They complained that discussions at the WPATH-Symposium would once again be *about* transgender people, instead of *with* transgender people, and (by distributing flyers) they drew attention to an alternative event for the opening day of the conference, called FREE PATHH (Free Event on Practicing Actual Trans* Health and Human Rights).

A further sign of a commitment to increased research on transgender issues is the foundation of the European Professional Association for Transgender Health (EPATH) – a European branch of the WPATH – in December 2013, whose focus is on the situation in Europe (www.epath.eu).

In addition, conferences that hitherto addressed trans topics under the all-embracing term LGBT (lesbian, gay, bisexual, transgender), started to offer specific time slots for trans issues. For example, on the 21st International Aids Conference 2016 in Durban, South Africa, trans issues were a thematic focus at this biennial and world-renowned conference on HIV/Aids for the first time. Under the slogan "No More Lip Service: Trans Access, Equity and Rights, Now!" (cf. IRGT A Global Network of Transgender Women and HIV 2016), transgender people had their own stage at the all-day pre-conference. A transgender speaker from India cherished this by declaring: "It's our day! This is a historical moment!" (Personal note from the pre-conference on Sunday, July 17th, 2016).

The annual HIV/STI-Forum, organised by the Federal Office of Public Health in Switzerland, might serve as another example (on a national level). In 2013, they dedicated the forum to the sexual health of trans people for the first time (Bundesamt für Gesundheit 2016).

It is not least due to the more insistent voices of academically trained transgender persons themselves that the above-mentioned conferences started to offer a specific platform for trans topics *and* trans people. Neither the Federal Office of Public Health (BAG) nor the International Aids Society (IAS) would have organised such a platform, if not for the insistence and collaboration of the people concerned. In this sense, contemporary transgender activism is encountering fertile ground. However, Reisner et al. conclude that despite a growing interest in research, "[t]he global disease and health burden of transgender people remain understudied, par-

ticularly in relation to the effects of stigma, discrimination, social, and structural factors that affect the health of this underserved population" (2016: 431). Being to a large extent still invisible and marginalised, trans people are a vulnerable group. A US-Study found "[…] that the transgender older adult participants had significantly poorer health in terms of physical health, disability, depressive symptomatology, and perceived stress than the nontransgender LGB older adult participants […]" (Fredriksen-Goldsen et al. 2014: 496).

Besides this contemporary increase in involvement of trans issues in both a part of the scientific community and the health sector, addressing or dealing with gender non-conformity is a recurring theme in popular media, in film, on television, in the Internet, and in the press. Fausto-Sterling remarks: "Confusion about gender categories (Male? Female? Neither? Both?) seems to be perennially newsworthy" (Fausto-Sterling 2012: 1). Ekins and King summarise this as follows:

> There are transgender plays and novels, there is transgender photography, and there is transgender art and transgender pornography. Trans people themselves have written their autobiographies, formed organizations, and produced magazines, bulletins, and guides to and celebrations of the topic. During the 1990s, in particular, a number of openly trans people made significant contributions to the academic literature. (2005: 380)

Due to this development and the current interest (and epistemological potential) in trans issues of a broad variety of critical thinking (and not only from institutions representing medicine and law), and due to the raised voices of the individuals concerned, Stryker and Currah speak of a "transgender turn" (2014: 3).

This growing focus on transgender issues is occurring in an international and global context. It can increasingly be noted that native terms describing gender non-normative people are being overlaid by the Western term *transgender*. This 'colonising' effect of the term is taking place despite the fact that transgender theory used to rely on anthropological findings, "[…] which has often focused on the idea of an institutionalized 'third' gender or liminal gender space, anticipating in many ways some of the concepts common in contemporary transgender theory" (Ekins and King 2005: 381). Without wanting to dismiss the term, Stryker and Currah feel this topic must be critically addressed within the trans studies themselves:

> Understanding the dissemination of *transgender* as a term that originated among white people within Eurocentric modernity necessarily involves an engagement with the political conditions within and through which that term circulates. Because transgender can be imagined to include all possible variations from an often unstated norm, it risks becoming yet another project of colonization – a kind of Cartesian grid imposed on the globe – for making sense of human diversity by

measuring it within a Eurocentric frame of reference, against a Eurocentric standard. (Stryker and Currah 2014: 8)

1.3 The situation in Spain and Andalusia: From criminalisation to inclusion in the Public Health System

Manolito Chen, among my interlocutors a well-respected and well-known trans woman in Andalusia, tells in a newspaper interview that she was put in prison ahead of a festive day to prevent tourists from seeing her. She refers to the beginnings of the 1960s when a new and reactionary mayor in town exercised the repression he inherited as representative of the Franco regime (Pérez 2013). Homosexual and trans persons (at this time no distinction was made between homosexuals and transgenders) were persecuted based on the law for "loafers and vagabonds" *(Ley de vagos y maleantes)*. The *ley de vagos y maleantes* had already been written in 1933 during the Second Spanish Republic. Yet during the Franco dictatorship, it was changed in 1954 to include homosexuals as well. The law allowed homosexual and trans persons to be taken to jail or concentration camps (Boletín Oficial del Estado 1954). Theology (the church), the legal system, psychiatry and civil authorities formed a dispositive, which condemned and persecuted these individuals (Ugarte Pérez 2008). The documentary film *Witnesses of a damned time (Testigos de un tiempo maldito)* from the year 2012 by the Spanish film maker Javi Larrauri reflects upon these times by portraying contemporary witnesses. There existed about 180 camps all over Spain, including the islands, e.g. one notorious one in Fuertaventura (Larrauri 2012). At a presentation of his film in Berne, Switzerland, Laurrari mentioned his difficulties finding contemporary witnesses willing to speak about this time. He connected this restraint not least to still existing tabus in Spain concerning the time of the dictatorship. People would not talk about those times, and there would be no political reappraisal (personal note at the film screening, November 8th, 2013). Among some of my interlocutors, who happened to come of age during Franco's regime, the oppression experienced at this time led to a political consciousness that keenly appreciates the achievements of democracy, but is also aware of its fragility (see Chapter 4.5).

Homosexuality was illegal in Spain until the end of 1978, and regarding transsexuality, gender reassignment surgery (then called sex change surgery) was illegal until 1983. Before the latter was legalised, the Spanish Penal Code considered 'sex change surgery' (as was the case in many other countries as well) a crime of injury on a healthy person (mutilation, castration, sterilisation), and the doctors who performed it risked imprisonment (Salván Sáez 2001). After this legislative change, medical treatment for transsexual people was no longer a crime, but an unpublished paper by Colega (an LGBT organisation in Seville) written in 2003, criticised

the lack of efforts on the part of public institutions to improve the situation of transsexual persons. They criticised the public authorities *(los poderes públicos)* for forgetting these people, and for allowing them to become the object of ridicule, persecution and even murder in "our country". Reminding the Spanish government of their duties, they emphasised that it is a constitutional obligation to "remove obstacles to the full development of the personality" (COLEGA 2003).

Gender affirmation procedures as a Public Health Issue

In Spain, the healthcare system is decentralised and organised in each of the 17 autonomous communities. The organising of a national healthcare system was undertaken during Spain's transition to democracy. Significant legal advances were the adoption of the Spanish Constitution of 1978, and the General Law on Public Health of 1986. The first guaranteed all Spaniards access to healthcare; the second delegated the healthcare policy-making to the autonomous communities. This reorganisation of competences for the autonomous communities happened step-by-step and took altogether 21 years. Andalusia was the second autonomous community in Spain (three years after Catalonia) where public health administration was transferred to its community (Aguilar and Bleda 2016).

Gómez-Gil et al. (2011) observe that Public Health attention to people with a gender identity disorder is a recent reality in Spain. In February 1999 the Parliament of the Autonomous Region of Andalusia approved that persons with a gender identity disorder were integrated in the sanitarian services of the Andalusian health system (*sistema público sanitario andaluz, SAS*). In October of the same year, the *Unidad de Trastornos de la Identidad de Género* (Gender Identity Disorder Unit), UTIG for short, was created in the Hospital Carlos Haya in Malaga as a specialised unit for the attendance of transsexual people, and as a national reference centre. Andalusia was the first autonomous region *(Comunidad autónoma)* that established such a unit, offering complete medical care to transsexual people at public expense (Giraldo et al. 2001; Soriguer Escofet 2001). For those individuals who wished to undergo surgical gender affirmation procedures, but did not have the financial resources to have it done in a private clinic, the creation of the UTIG opened new perspectives. For example, Ronaldo would have liked to start transition earlier, but:

> "Lo que pasa que no tenía las facilidades para hacerlo. Costa mucho dinero, no había la Unidad, no estaba la Unidad del Trastorno. Sabía … me informaba y sabía de lo que … de lo que valía y de costo y cual. Y era como una … utopía, no … no voy a pasar allí nunca, aunque por mucho que trabaje y tampoco, por mucho que … grite … estoy muy mal y no quiero ser así, tampoco, por mucho que me vuelva loco y me intente quitar la vida, tampoco, y por … yo que sé … con mucha que diga, yo no quiero ser así, tampoco. Entonces pues … hasta que llegó esto de las subvencio-

nes de la operación y la Unidad del Trastorno. Entonces ya sí … vi un poco más …" (Ronaldo, 2003)[1]

The UTIG in Malaga claims to adhere to the Standards of Care of the World Professional Association for Transgender Health (former Harry Benjamin International Gender Dysphoria Association) (Giraldo et al. 2001). (For a discussion that questions the usefulness of a standardised medical accompaniment for gender affirmation procedures due to the heterogeneity of the concerns of trans people, see Hirschauer 1997). The Unit comprises a multidisciplinary group of professionals, and coordinates plastic surgery, psychiatry and endocrinology (Soriguer Escofet 2001). The Andalusian Health Service (SAS) provided for the following procedure: 1) referral to the UTIG through the primary care network (mostly the health centres of the place of residence of the person concerned); 2) support by the psychologist of the UTIG, who conducts interviews with the person concerned and family members; 3) a real-life test for one year, whereby the 'patient' proves that he/she dresses and moves around publicly in the desired gender/sex; and 4) hormonal treatment (Tena 2010). The hospital Carlos Haya in Malaga was chosen to form the UTIG not least because there already existed a group of professionals who were experienced in attending to people with gender identity problems before the Andalusian government decided to integrate their treatment into the services of Public Health. One of the plastic surgeons had even introduced a new technique in the professional literature, called the "Malaga Flap" (Soriguer Escofet 2001).

I wondered why Andalusia was the first autonomous community that integrated attending to transsexual people in its public health system. I wondered even more when I realised that this was not especially a question my interlocutors confronted themselves with. I had the impression that simply seeing themselves as Andalusian seemed to explain it (a mixture of Andalusian national identity with some distinctive features that distinguish them from other communities). When I asked Magdalena, why Andalusia was the first one, and not another community, she states:

Magdalena: "Porque fueron los únicos, se luchó. El único lugar de la … el único lugar de España donde se ha luchado para que exista esa unidad era en Andalucía. Fuimos muy Andaluza."

1 "I didn't have the possibility to do it. It costs a lot of money, there was no unit, no disorder unit. I knew … I informed myself and I knew about the costs and everything. And it was like a utopia that I will never reach, no matter how hard I work, and or how much I cry, how very bad I feel and I don't want to be like that, or how much I go crazy and intend to commit suicide, or … I don't know … how much I say I don't want to be like this. So, well … until this subsidy for the operation and the disorder unit came along. Then yes … I saw a bit more …" (Ronaldo, 2003)

> Christoph: "¿Cómo se ha luchado?"
> Magdalena: "Pues presentando proyectos … y, en el parlamento andaluz …"
> (She interrupts the conversation to get her tapas at the counter)
> Christoph: "Lo que no entiendo es cómo es posible que en Andalucía se ha luchado más que por ejemplo en Cataluña, porque Barcelona me parece bastante …"
> Magdalena: "… pero para … avanzada, ¿no? Cataluña ha luchado por el derecho de gays y lesbianas, no por el derecho de los transexuales. Ha sido aquí, pues fueron transexuales que se han unido para algo muy complejo. Porque normalmente en el resto de las comunidades, ellos … son grupos sociales juntos. Consiguen cosas generales. Ya que aquí los transexuales han reclamado algo necesario para ellos. Por eso solo en Andalucía, porque ha sido el único colectivo, el único grupo social de personas transexuales el que se ha movido. Y la persona que lo consiguió fue Kim Pérez. Es la presidente de la Asociación de Identidad de Género de Granada. Que es profesora du un colegio, de un instituto en Granada." (Magdalena, 2003)[2]

The pioneering and influential role of Kim Pérez as an activist and "líder histórica del movimiento asociativo transexual andaluz" (historical leader of the Andalusian transsexual movement) (Tena 2013: 51) is generally acknowledged. According to a newspaper article in El País (and confirming Magdalena's statement) it was due to the Association of Gender Identity of Andalusia *(Asociación de Identitad de Género de Andalucía)*, which Kim Pérez presided, that Andalusia was the first autonomous community in Spain to include the complete treatment process and genital sex reassignment surgery in its sanitary service catalogue *(catálogo de prestaciones sanitarias)* (El País 2007).

Besides the outstanding role of Kim Pérez, another interlocutor proposed that Andalusia implemented this service to distinguish itself as a socialist autonomous community from the conservative rightwing-governed national government.

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2 Magdalena: "Because they were the only ones that fought. The only place in Spain, where people were fighting for such a unit, was in Andalusia. We were very Andalusian."
Christoph: "How did they fight?"
Magdalena: "Well, presenting projects … and, in the Andalusian parliament …"
Christoph: "I don't understand why it was in Andalusia that people fought harder than for example in Catalonia, because it seems to me that Barcelona is quite …"
Magdalena: "… but for … developed. No? Catalonia has fought for the rights of gays and lesbians, and not for the rights of transsexuals. It was here where transsexuals united for something very complex. Because normally, in the rest of the communities, they … the social groups are together. They achieve general things. Here, the transsexuals have claimed something necessary for themselves. That's why only in Andalusia, because it was the only collective, the only social group of transsexual persons that has moved. And the person who achieved it was Kim Pérez. She is the president of the Association of Gender Identity from Granada. She teaches in a college, in an institute in Granada." (Magdalena, 2003)

Another reason (but never mentioned to me) might also be of a symbolic nature because it concerns the reputation a healthcare system has among its citizens. According to Aguilar and Bleda: „[A] national healthcare system is generally considered one of the cornerstones of a country's well-being since a healthy population is an indication of a nation's social progress and economic prosperity" (Aguilar and Bleda 2016: 307). Thus, the inclusion of transsexuals in the public health care system might be regarded as a sign of social progress and well-being. However, one could also argue that this assistance helped to maintain the 'traditional' binary sex order. Since 2007, due to the state's economic problems and conservative political forces, the Spanish Health Care system risks a backlash and the beginning of privatisation (Aguilar and Bleda 2016).

Meanwhile, the UTIG changed its name to *Unidad de Transexualidad e Identidad de Género* (Transsexuality and Gender Identity Unit), which avoids the mention of the gender identity disorder. As Tena (2013) suggests, the change in the name was motivated through an agreement in the European Parliament in September 2012 to abandon the pathologisation of transsexuality. This led the UTIG to change the T for *trastorno* (disorder) to a T for transsexuality.

Between my two field research periods, two laws were introduced to facilitate the legal situation for trans people in Spain. In 2005, Spain legally recognised same sex marriage (Jefatura del Estado 2005). This implies that those individuals who transition their sex/gender within a married partnership, no longer have to divorce. Additionally, since 2007, a Gender Identity law has enabled trans individuals to change their name *and* sex on their legal documents without having to undergo any more sex reassignment surgery (Jefatura del Estado 2007) (this topic will be addressed in detail in Chapter 6). Thus, it is no longer a matter of simply choosing an ambiguous name. However, one of my interlocutors still perceives a lack of progress for the *"personas transexuales"* (transsexual persons) since the implementation of the Spanish Constitution after Franco's death. There was the legalisation of gender surgery in the 1980s. There was the first judgment in the 1990s that allowed trans persons to change their identity documents after surgery. And in 1996 there was the first case of a marriage of an operated trans person (after a judgement as well). (Prior to this, even trans persons who had undergone surgery and changed their identity documents were not allowed to marry.) Additionally, there was the law of 2007 that facilitated the process of changing identity documents. However, the fact of being diagnosed, judged by the medical system, and treated differently than *"cualquier ciudadano"* ("any citizen") still exists, thus:

> "Bueno mira, las personas transexuales en treinta y seis años de … o treinta y siete años que lleva la constitución española aprobada, hemos avanzado poquito (em-

> phasised), poquito, poquito y lo poquito parece que son como limosnas." (Mar, president of the ATA, 2013)[3]

1.4 Some numbers

There are different numbers of population estimates circulating. A first estimate of the number of transgender people globally was published in the Lancet in June 2016. It suggests that 0.3% to 0.5% of the global population identify as transgender (Reisner et al. 2016). However, there is also an unknown number of transgender adults that blend into mainstream society and no longer identify as transgender (Fredriksen-Goldsen et al. 2014).

A Swedish study analysed the prevalence of transsexualism out of studies from different regions (Western European countries, Poland, USA, Canada, Australia, New Zealand, Singapore, and Japan). For male-to-females, the figures range from 1:2'900-1:100'000; and for female-to-males from 1:8'300-1:400'000. The authors also mention that their numbers do not represent all persons with transsexualism or gender dysphoria, be it for not needing or wanting medical transition, or for it having been denied by health care professionals. They conclude that some of their analysed studies

> [...] suggest that some degree of gender dysphoria is more common than the number of persons who actually decide to proceed with a gender reassignment. If societal changes result in increased awareness and acceptance of gender change, a further increase in incidence cannot be excluded. (Dhejne et al. 2014: 1043)

In Spain, there was hardly any information about the prevalence of transgender persons, that is to say, persons with a gender identity disorder (to use the medical term) before the approval of integral treatment in Andalusia in 1999. The estimated numbers were obtained from studies that were conducted in Sweden, Great Britain, the Netherlands, Germany and Singapore between 1968 and 1996. However, as Esteva et al. (2006) observe, it is a difficult task to estimate the frequency of gender identity disorders in the general population, not least due to different methodologies in these studies, especially where the definition of the cases is concerned. Some studies included only patients that had already undergone sex reassignment in their statistics. Others estimated the number based on the initial cases that consulted the specialised clinics, independent of their clinical presentation or therapeutic stage. Nevertheless, emanating from these studies, the *Agencia*

3 "Look, the transsexual persons, in these thirty-six ... or thirty-seven years since the approval of the Spanish Constitution, we have made little progress, only little, little, and the little things seem like alms." (Mar, president of the ATA, 2013)

de Evaluación de Tecnologías Sanitarias (AETS) from the *Ministerio de Sanidad y Consumo* guessed that there could be between 387 and 2,187 man-to-woman transsexuals, and 167 to 571 woman-to-man transsexuals all over Spain. The *Consejería de Salud de Andalucía* expected that 100 to 300 persons would request this integral medical service in Andalusia. Five years of work in the UTIG in Malaga showed that 2-3 patients per week had been registered. They concluded that the prevalence of transsexuality in Andalusia was higher than expected, and higher than what had been published in studies from other western countries (Esteva et al. 2006).

In a descriptive and comparative study, Gómez-Gil et al. (2011) evaluated the demand for public health services during the period of 2000 to 2009 in this Andalusian unit, and compared the data with the unit in Barcelona, Catalonia. The latter was approved in 2006 as the second unit in Spain to attend to trans people. For the unit in Malaga (Andalusia) they counted 828 subjects having requested clinical assistance, of whom 88% fulfilled the criteria for gender dysphoria. The male/female ratio was 1,6:1, with a predominance of man-to-woman trans people. Over the last years, the demand of woman-to-man trans persons has risen. Therefore, the authors guess that the prevalence of woman-to-man cases could have been underestimated historically. The mean age was 28 years. This average was quite stable during this study period, but the range has widened, and is now between 11 and 64 years. In the study period, 284 sex-reassignment surgeries were performed, which included 115 vaginoplasties (a plastic surgery and cosmetic procedure to construct a vagina) in male-to-female trans persons, 100 mastectomies (the surgical removal of the breast), 45 hystero-oophorectomies (the surgical removal of the uterus and ovaries), and 24 metoidioplasties or phalloplasties (two different kinds of techniques to construct a penis) in female-to-male trans persons. Furthermore, the authors observe that more individuals from other regions of Spain requested assistance in Andalusia (15.2%), compared to Catalonia with 4.7%. They explain this by the fact that the unit in Malaga was the first and the better known, because it functions as a reference unit on the national level. In contrast, the unit in Catalonia is just a reference centre in its own autonomous region. However, the latter has attended to more patients born outside of Spain; one quarter of the man-to-female trans persons were born in Central- or South-America. The number of new cases each year has been quite stable, with around one hundred in the last few years. This number has been compared with studies in Germany, Sweden, the Netherlands and Belgium, with the resulting conclusion that this number in Spain can be considered high (Gómez-Gil et al. 2011).

In the UTIG in Malaga, the waiting list for any surgical procedure was initially 2-3 years (Gómez-Gil et al. 2011). The authors claim that this waiting list has actually shortened, which they attribute to several factors: the handling of a large number of cases in previous years (they refer to it as 'a bag of history' due to the fact that for many years they have been the only reference centre in Spain to of-

fer sex reassignment surgery), the substantial endowment of the operating room, and a more selective choice of surgery procedures for some of the patients. Of particular note is the reduction in demand for masculinising genitoplasty techniques because of the elevated risk of complications and insufficient functionality. However, my interlocutors who underwent genital surgery had to wait longer than 2-3 years. Anabel had to wait five years for the operation, and all of them experienced this long waiting period as highly arduous. Regarding the decreasing demand for masculinising genital-plastic surgery by FtMs, these were no longer offered by the UTIG in Malaga during my second field research stay (see the case of Bittor in Chapter 5, who regretted this fact). Ronaldo experienced the long waiting periods and then finally being invited for surgery as a kind of "being left in the middle":

> "Y nos quedamos a media. Pero son ellos los que nos quedan a media. Son ellos los que nos quedan a personas que tienen … ya no tienen ambigüedad, y nos quedamos durante mucho más tiempo sin operar y no nos sentimos bien. El fin … la causa final se trata de conseguir porque somos muchos operados a media." (Ronaldo, 2003)[4]

In summary, the demand for clinical assistance for people with a gender dysphoria in these first two units in Spain was initially higher than expected, based on prevalence assumptions from European studies. However, in the meantime, there are no significant differences in relation to the percentage that fulfils the criteria of gender dysphoria, the sex ratio, and the median age, neither between the unit in Andalusia and in Catalonia nor with Western European countries (Gómez-Gil et al. 2011).

The intention of this chapter was to approach the state of the art of the topic, as well as to break it down to the situation in Andalusia. Having outlined this background information, I will now turn to the memories and experiences of my interlocutors on their journey towards a new awareness of their sex/gender.

4 "And we're halfway between. But they are the ones who leave us in between. They are the ones who leave us as persons who show … no longer ambiguity, but we stay for much more time without surgery and we don't feel good. The purpose … the root cause, what we aim for … because we're a lot of half operated." (Ronaldo, 2003)