

The (Im)patients

An Analysis of How Stigma Leaks Through
the Layers of Trans Specific Health Care

IF YOU LIVE in Sweden and are in need of gender corrective care you have a long road ahead of you before you may be allowed that care. Some of the aspects that make the road so long are due to general regulations of the health care system, and some are due to factors that regulate this specific and specialized form of care.

The Swedish health care system is tax funded. Those funds run both public and private hospitals and clinics. The country is divided into 20 counties, which are responsible for their practitioners' provision of equal health care to their inhabitants. As long as they follow the national directives of equality, the counties are autonomous to a large extent to set up their own regulations on which kind of care they provide and finance. Primary health care is generally made available throughout the country, not to be confused with easily accessible, though. To reach a specialist you generally need a referral. If you need care that is not offered in the county in which you are registered, you need to get a referral to another county. Also, if you experience that your needs of care go beyond what is offered in your county, in some cases you have the right to a second opinion in another county. These two options are afforded by the home county. You can also seek health care in another country within the EU, the eligibility is decided, and if approved, financed by the Swedish Social Insurance Agency (Försäkringskassan). A third option is to try to

seek and pay for your care outside of the tax funded system in a private clinic within Sweden or abroad.

All of these aspects of Swedish health care in general affect the trans specific health care, as they limit the options and make the starting-points unequal for people who seek this specialized form of care, depending on at a minimum the vectors of regionality and financial status. The National Board of Health and Welfare (Socialstyrelsen), the governmental regulator that supervises the health care in Sweden on the county level as well as individual clinics, recently produced an overview of trans specific care (Socialstyrelsen 2010) that includes recommendations for the future. Similar reports regarding gender corrective care have also been produced on a EU-level (Whittle et. al 2008). To reach a gender evaluation team in Sweden you need a referral from your primary health care physician either first to a specialist in psychiatry who can refer you to a gender evaluation team, or directly to the specialist team. Getting a referral can be a high hurdle to overcome, and if or when you pass that step there are often long waiting lists before you get your first appointment at the gender evaluation clinic (Socialstyrelsen 2010). If you are over 18 years of age, there are six counties in Sweden where assessments regarding whether or not you meet the diagnostic criteria, are made. If you are under 18 years of age there are specialized clinics in two counties. If you live in a county where there is no specialized clinic, you need to get a referral to another county. The theoretical possibility to seek care in another EU-country exists, but we do not know of anyone who has used it for accessing trans specific health care. That does not mean that there has been no need, but may imply that this alternative requires the capability to combat the red tape of an unknown system.

If you reach the specialized clinic, you have to be registered there for at least a year before you get the diagnosis – if you are found to meet the criteria. During this year you have to go through various physical, social and psychological tests, and evaluations. These have been criticized for being unethical and intrusive, and also for not being evidence-based (Socialstyrelsen 2010). Your county has, or as in most cases has not,

budgeted for this kind of care and thereby gives different conditions of accessibility for users in different counties (Socialstyrelsen 2010). Eventually you may be given a psychiatric diagnosis and after that follows somatic treatment which can consist of hormones, voice training and/or surgery. The care provided differs between clinics in many ways: how long the waiting time is, if you get support during the evaluation period or not, if you can switch provider if you do not feel comfortable with the one you got or not, if you see an endocrinologist who prescribe your hormones or not, if you get to see a speech therapist or not, if you get follow-up or not, and which kind of surgery you can get (Socialstyrelsen 2010).

In recent years trans specific health care and trans identified people's health have been discussed and analysed in Sweden within activist communities (Darj and Nathorst-Böös 2008; Berg and Summanen 2011), in governmental institutions (Ungdomsstyrelsen 2010), and in some parts of the academia (Engdahl 2010; Bremer 2011). We have been told and have read many testimonials of a dysfunctional trans health care service, a topic that has also been part of the larger debate on the criteria for legal gender recognition. Trans specific health care has been described as normative, lacking transparency, being prescriptive, inaccessible, not being evidence-based, as increasing stigmatization of its users,¹ and not being centered on the users' self-defined needs. Facing these systems, or having been excluded from them, many trans people start to self-medicate with hormones.²

Who We Are and How We Have Worked

We, the authors, hold our respective academic degrees in medicine, and in leadership and organisation, but this paper was written from our perspectives as activists. We work together with users of trans specific health care, and fellow activists and researchers who work on trans/gender projects within the academia in Sweden and the US. Between us, we have had contact with hundreds of trans people with experience of trans specific health care. These contacts have been spread out over a time period of a decade and have taken place in online communities,

high-profile conferences, social meeting points, professionalized non-governmental organisations, autonomous networks, and personal relationships. It is in these collective experiences that our problem analysis, argumentation and recommendations for principal and practical change are rooted.

This text is developed from a presentation that we held at a conference at Linköping University, organised by the Unit of Gender Studies in the Department for Thematic Studies and the Unit of Gender and Medicine, titled *Trans Rights as Human Rights – The Implications for Trans Health (Care)*, 8–10th of May 2012.

We find that much of the critique towards trans specific health care we hear as friends and activists never finds its way to the official reports. It is important to keep in mind that even if the judgements made of trans specific health care are harsh, the stories being told in public are still only the most privileged ones. We think that this is due to the internalised cisnormativity and psychiatric stigma of the health care system (Corrigan 2005), the unbalanced power dynamics between doctor and patient, and also to that people who have been users of trans specific health care just want to leave behind the trauma both of the (more) gender dysphoric states, and of the increased stress and stigma caused by trans specific health care. We know that users of trans specific health care feel they are dependent upon the good will of the personnel in the gender evaluation teams. Direct dialogue about improvements is therefore not possible if one is not to jeopardise the care one needs, a care that can be hard, expensive, risky, and sometimes impossible, to acquire outside of the medical and legal systems.

In March 2012 we listened to a radio program on Swedish public service radio (P1 Morgon 2012) on self-medication with hormones among trans persons. In the program two persons who had been self-medicating were interviewed in a report. This was followed by a studio interview with the head psychiatrist at the department of gender corrective care in Stockholm. We talked about the program, listened to it again several times, transcribed it and found that many things being said in the interview could be used as examples of how trans specific health care

works today more generally. Therefore, we do not wish to single out this one physician but rather to use this as a tangible example, which reveals the fundamental conditions of trans specific health care. It can also illustrate how trans people are generally positioned within the medical, institutional and legal systems in Sweden today.

The critique of the systems we have mentioned is absent from the program. Instead those affected by the systems are unfairly blamed for the consequences of them. Those who self-medicate are talked about as ignorant ("How can they think that they know what they are doing?") and impatient ("If they only wait, the health care system will help."). As activists, listening to the program we found three assumed conditions on which this view is based: 1) that everyone who needs it has access to gender corrective care, 2) the existence of a fair health care system and 3) an objective neutral diagnosis. We also found mistrust of users' self-knowledge that we understand to be a consequence of the psychiatric diagnose. In the program, the voices of trans people were given space only in the reports. The space for analysis of and discussion about what was said was saved for the physician. This division into object/subject roles is another example of how the interpretation of one's trans experience is not something one is given the right to, but is something over which the medical community has expertise. We argue that what is described as the problem – trans people self-medicating – is rather a symptom of, and a reaction to, those problems that should really receive attention. The legal and medical systems, that are supposed to support trans people who are affected by society's ideas and organisation of gender, fail to do so and instead increase victimisation by enhancing the stigma, blame and harm on those who seek that support.

So we argue for a trans specific health care that is centered around and developed together with its users in which the person seeking help can take an active part in the decisions. We also argue for a depsychiatrization of trans experience and identities, and point to the necessity for a reduction in general psychiatric stigma and a less cisnormative society where there is space to live outside the binary gender system. We think that it is the responsibility of professionals within trans specific

health care to be knowledgeable about how normativity, stigma, and power asymmetries influence their perceptions of service users, and to do whatever they can to counteract it, and thus empower those affected.

The Big Picture

Trans people become stigmatized by a society that only recognises two genders, man or woman. This way of organising gender makes trans identities and experiences invisible (Darj and Nathorst-Böös 2008; Ungdomsstyrelsen 2010; Berg and Summanen 2011; WPATH 2011). We will refer to this system as the gender binary. Within the idea of two genders, there is also an idea that those two genders and related expressions are more desirable and legitimate than all others, and that there is a huge difference between the cisgendered and the transgendered person. This adds a fundamental aspect of power to the understanding of gender. Kate Bornstein maps this out in *My Gender Workbook* as the Gender/Identity/Power System where one can either *be* some perfect gender, *be like* that gender or *be liked* by that perfect gender (Bornstein 1998, 45). We will refer to this system as cishnormativity. It credits non-trans identities and bodies as better and more authentic than others (Bornstein 1998). A cisgendered person is a person without friction between body, gender identity, legally registered gender, gender expression, and perceived gender, and is in a state where all these categories follow the same line. Transphobia and stigmatization of trans people comes from cishnormativity. Health care that is not aware of cishnormativity will encourage and expect trans people within it to be as much men or women as they can (be that perfect gender), to try to pass as these men or women, who are perceived as more authentic than the transman or -woman (be like that gender), or to at least be pleasant and apologetic to people in a cisgendered position and not make claims of one's own definitions (be liked by that perfect gender).

The Role of Health Care

Gender dysphoria is discomfort or distress that a person experiences that is linked to a mismatch between gender identity, body and the ex-

pectations that follow (WPATH 2011, 168). Dysphoria is commonly attributed to the sufferer, that something is "wrong" with the person. The World Professional Association for Transgender Health (WPATH), which is a global member organisation for professionals working for trans people's health, explicitly identifies society as the source of harm. It therefore becomes the role of health care professionals to alleviate the dysphoric state. The following are guiding principles stated in Standards of care version 7 (WPATH 2011) regarding what can alleviate to gender dysphoria:

Exhibit respect for patients with nonconforming gender identities (do not pathologize differences in gender identity or expression); provide care (or refer to knowledgeable colleagues) that affirms patients' gender identities and reduces the distress of gender dysphoria, when present; become knowledgeable about the health care needs of transsexual, transgender, and gendernonconforming people, including the benefits and risks of treatment options for gender dysphoria; match the treatment approach to the specific needs of patients, particularly their goals for gender expression and need for relief from gender dysphoria; facilitate access to appropriate care; seek patients' informed consent before providing treatment; offer continuity of care; and be prepared to support and advocate for patients within their families and communities (schools, workplaces, and other settings). (WPATH 2011, 167)

Psychiatric stigma can be said to function in a similar way to the organisation and valuing of gender in that people are organised into two groups (healthy/ill, cis/trans), and it is perceived to be a major dividing line between the two groups. Lack of mental illness (i.e. good mental health) is a founding assumption of society and considered the normal, neutral and desired state. We are expected to embody the desired level of sanity, try to be like those who pass as sane and be perceived as mentally healthy, or at least be liked by those who fulfil the expectations. The ideas and ideals surrounding psychiatric diagnoses result in injustices in the contact with all kinds of health care (Corrigan 2005).

A trans person within today's health care system will *as a minimum* face three hurdles of inequality. 1. The power imbalance for anyone who seeks health care in a doctor-patient relationship. 2. The power imbalance between a transgendered person and a cisgendered person/the cishnormative system, which is perceived as natural and neutral. 3. The power imbalance between a person with at least one psychiatric diagnosis and a system/professional perceived as mentally sane, and therefore objective. These three layers of power imbalances strengthen one another and work together. The psychopathologization of trans experience and identities is dependent upon, and builds on the idea that trans is something unnatural and unwanted, but without transphobia there would not be a need to create such a diagnosis in the first place. When trans is a psychiatric diagnosis it is harder for trans people to claim one's right to one's body in contact with a cishnormative health care provider, who has support in cishnormative diagnostic criteria. A health care system that is not aware of the normativity and power imbalances that it builds upon will reinforce them. This will be at the expense of those who seek and need what the system can offer.

Depathologization

Internationally there exists a large movement campaigning for the de-pathologization of trans experience called STP2012 (Stop Trans Pathologization). In the campaign's manifesto the political processes, including causes and effects, are described:

With "psychiatrization" we name the practice of defining and treating transexuality under a mentally disordered label. We are also speaking about the mistaking of non normative bodies and identities (those out of the cultural dominant order) for pathological bodies and identities. Psychiatrization gives the medical-psychiatric institutions the control over gender identities. The official practice of these institutions, motivated through state, religious, economical and political interests, reflects and reproduces the male/female binomial on people's bodies. Making believe this exclusive position is a "true" and natural one. [---] The legitimiza-

tion of social norms that are part of our life experience and our feelings, implies the invisibilization and pathologization of all the other existing options, setting one single path that doesn't question the political dogma around which our society is built: the solely and exclusive existence of only two ways of being and feeling. [---] Nowadays transexuality is considered a "Gender Identity Disorder" [...]. In them [the diagnostic manuals], we find a less than casual error: the mistaking of the transphobia effects for those of transexuality. Social violence against those that don't follow the gender standards is invisibilized. This way, it is actively ignored that the problem is not gender identity but transphobia. [---] Transexuality's pathologization under the "Gender Identity Disorder" is an extreme exercise of control and normalization. (International Network for Trans Depathologization 2013)³

The campaign is supported by the following Nordic organisations (among others): LLH (Landsforeningen for lesbiske, homofile, bifile og transpersoner) in Norway, RFSL (Riksförbundet för homosexuella, bisexuella och transpersoners rättigheter) in Sweden, Trasek in Finland, TransDanmark, LGBT Danmark (Landsforeningen for bøsser, lesbiske, biseksuelle og transpersoner), and BLUS (Copenhagen LGBTQ Students) in Denmark. The World Professional Association for Transgender Health (WPATH) has released a statement for de-psychopathologization of gender variance (WPATH 2010). The international trans activist network Global Action for Trans Equality (GATE), which includes some professionals working with trans people, has also taken a stand for depathologization (GATE 2011). Apart from an occupation of the National Board of Health and Welfare's lobby made by the network Anarcho Pride in April 2012, the issue of depathologization has, however, not been made widely visible in Sweden.



STP Anrcho pride.

In the following sections we present extracts from the radio interview about self-medication and analyse what is said in relation to cisnormativity, psychiatric stigma and reports about the current state of Swedish trans specific health care. The material has been organised around the three assumptions listed earlier: 1) that everyone who needs has access to gender corrective care, 2) that the health care system is fair, and 3) an objective neutral diagnosis.

The Idea That Everyone In Need Has Access

Interviewer (I): How often do you meet patients who self-medicate?

Physician (P): It is quite common that we see patients who either during the assessment have started medication or in some cases even before they have come to us. The greatest risk is with patients who do not seek medical care at all, who...

I: Do it on their own?

P: Yes.

(P1 Morgon 2012)⁴

Firstly, we interpret this statement to mean that there would be no rational reason for trans people to avoid health care services. However, being aware of the deficiencies in the systems that have been listed in the critical reports, it is understandable that people avoid seeking medical care despite their needs. Secondly, there is of course a risk with treating oneself with hormones, without support from a medical system. However, put this way the implication is that everyone who seeks care will get the help needed. Unfortunately this is not the picture of reality that has been shared with us by those affected.

I: We heard in the program that people who have self-medicated, say that doctors they have met have not really cared. What do you say about that?

P: It kind of depends on what you mean by not caring, it is really hard to take responsibility for a medication you have not prescribed. [...] But we usually control with a blood sample.

I: Is it not a doctor's role to try to take as much responsibility as you can

for your patient?

P: Yes, of course.

Over the last decade we have heard many testimonials from friends and activists who self-medicate. When they have tried to get their blood samples checked, they have been denied this service, despite the physician in the radio program suggesting that this testing is common practice. Those who have actively sought care are viewed as having put themselves in the situation, and therefore the approached health care services have no responsibility to help (Berg and Summanen 2011). Compare this kind of reasoning to when someone is seeking care for a sexually transmitted infection, abortion, alcoholism, or even a bone fracture after a sports trip. Should these people also have only themselves to blame, and therefore not get any help? To us, this is a moralizing way of seeing the problems at hand. It is like the care provider is saying: "Oh, you should have thought about that you will need to get your blood checked earlier, it is not my problem that you have put yourself in this situation." This kind of reasoning places the whole responsibility for one's health on the individual, and does not recognise that one's health is affected by a lot of factors which one does not have the power to control, such as the gender binary system and cisnormativity. Also, we all have different abilities to make decisions about our health depending on access to information, earlier experiences, economic factors, and more. To refuse or blame those who ask for help is neither the way of to get people not to self-medicate, nor the way to empower people or assist them in taking better care of their bodies.

I: You have started a project at Huddinge [a hospital in Stockholm, authors' note] [...]. What is that about?

P: [T]here are people who may not suffer from transsexualism, but have other kinds of gender identity problems. In those cases we try to evaluate individually what kind of suffering the person has and what that person's needs are. How can we understand it and treat it in the best possible way? In some cases we prescribe hormones, in other cases something else.

The physician refers here to a brand new project that has started in Stockholm where some trans people who are found not to meet the criteria for transsexualism, are enabled to access some kind of care. This is in line with what the National Board of Health and Welfare proposed in their report and with international development in the area (Socialstyrelsen 2010). While we welcome this initiative in Stockholm, it is important to remember that up until now, in Stockholm and still in most parts of Sweden, this category of trans people has been denied treatment. If you are found not to meet the criteria for the diagnosis, your case is simply closed at the clinic and you are left on your own, without follow-up or support. This rejection can lead to increased gender dysphoria and stress for the individual left without treatment. Therefore it is important that those in the need are granted continuous support, care and treatment (Socialstyrelsen 2010). In this process we believe that it is crucial that the running project in Stockholm is evaluated together with its users to see if it fulfils the needs of its users.

Furthermore, the phrasing "suffer from transsexualism" and "gender identity problems" again places the responsibility for the problems faced, with the individual and pathologizes the experience, instead of talking about the cisnormative society that creates gender dysphoria among trans identified persons. We argue that this attitude increases stigmatization and reduces trans people's chances for autonomy. It is our experience that the psychiatric language has the effect that those transsexuals, who accept and work within the frames of the psychiatric diagnosis, are seen as the serious ones. They can take on the role of being spokespersons for all people who are in need of any kind of trans specific health care. This creates internal hierarchies in the community where only those, who are perceived as being trans enough can take part in the discussions and organisations.

The Idea of a Fair Health Care

I: Because that is the problem, we hear in these testimonials that they [the patients] do not trust the medical care.

P: No, and I think that it is sad to hear that.

This answer by the physician surprised us and we understand it as an expression that because health care is seen as fair, the criticism is either not addressed, or is attributed to individual problems of mistrust. It sounds to us as if a professional that has both the possibility and the responsibility to initiate the changes needed, has not acknowledged the vast criticism of trans specific health care.

I: What do you do when you find out that a patient is taking hormones?

P: We usually try to speed up their assessment when possible, point out that there is a risk with this, that they take their own responsibility, and talk about if it is possible to wait a little longer.

The message given between the lines here is that people who self-medicate are impatient ("If they only could wait, we could help."), and ignorant ("They do not know what they are doing, and that there is a risk associated with it."). This view can only be understood if health care is seen as a sphere where everyone is treated equally and respectfully. The implication is that care is given to those in need, if you just wait for your turn. People who need treatment with hormones seem to be choosing between two, equally viable options; either get medical care free of charge, legally, safely, and comfortably, or self-medicate in an illegal, expensive way with accompanying health risks. These statements show no understanding of the inaccessible health care system and the gender binary society that pushes people to take these actions. We understand this as a patronizing, hierarchical system where the physician dictates the terms that the patient ought to follow. Consequently, attempts to take one's own initiative with regards to improving one's health are disqualified.

The Idea of an Objective Diagnosis

The fundamental power imbalance between the user and the physician is also illustrated in the following statement:

I: What do you think about this attitude that we hear in this piece: "I want to take control over myself, I'm not going to let anyone else do it."?

P: It is understandable, that is what we all want. It is a human aspect that one wants to do it that way. But it is hard to take charge fully of one's body if you do not have a medical training.

The diagnosis of transsexualism should, in essence, be a self-defined diagnosis. By that we mean that people know their own identity, and no one else can make that decision. The diagnostic criteria are built from user's feelings and emotions, which cannot be confirmed with blood samples or X-rays. When a person seeks care with a desire to have gender altering hormone treatment or surgery, the physician's role should be to check that the person knows what the treatment can and cannot do, and knows about long-term effects. It should also be to diagnose and treat possible depression or mental health problems, and to provide support along the way. As trans specific health care works today, we do not see this happen. In current practice the diagnosis is unfortunately not an objective one, about which the user and the physician can have a relaxed conversation. The physician has all the power to decide whether or not, and if, when the patient will get treatment. This is often referred to as gatekeeping (Lev 2004; Socialstyrelsen 2010), where the physician has the key to open the gate to treatment. We understand the statement above as coming from this system, as if it is saying: "If you do not have medical training you should not try to take charge of your body, but rather leave all the decisions to someone who does." In fact, Swedish law states that the health care provider must respect the patient's self-determination and as far as possible make decisions regarding treatment in consultation with the patient (Hälsö- och sjukvårdslag 1982:763). In our view, this intention in the law is not reflected in trans specific health care today.

The Need for a System Change

We see this radio program as one example of how the development of trans specific health care is held back by these ideas of supposed objectivity and fairness. Regardless of the knowledge that is produced, criticism will always be brushed off due to psychiatrization, a doctor/patient power imbalance, cisnormativity, and the support of the trans people

who work and identify within the current pathologizing framework. Knowledge of the current circumstances will not be taken into account so long as layers of stigma continue to dehumanise those affected.

A further example of this can be seen in the report from the National Board of Health and Welfare in 2010. It contains proposals and recommendations for how to improve health care for trans identified persons. The report is critical of the ways in which the system works today, and has been welcomed by many in the trans community for its progressiveness. However, the report still talks about trans experience as a mental disorder. This strengthens the idea of the objective psychiatric diagnosis and neutral gender binary social system, while also hindering the development and empowerment for which this governmental institution strives. Unknowingly, the institution reinforces the systems that cause the harm it wants to alleviate.

We believe that as long as transsexualism continues to be defined through a psychiatric diagnosis, those in need of care will continue to experience imbalances in power, and also stigmatization from the physicians. The idea of the disordered, irrational, selfish, and desperate trans person who self-medicates without knowing about the risks, is supported by the diagnostic procedure and by a lack of a critical perspective on the system: "The patients are mentally ill and therefore make these irrational choices." Or: "The patients do not know what they are doing." Seen through the lens of this superior health care service, the fact that a patient self-medicates without medical training, or questions the diagnosis, can be taken as proof of how out of touch with reality the person is. The diagnosis is imagined to be objective, established by mentally sane people, and therefore trustworthy. If the patient complains, the problem hence must be with the patient. This can be compared with popular culture portrayals of institutionalized psychiatric patients who claim they are not mentally ill, in this case, their lack of insight functions as strong evidence that they are ill.

If we, instead, understand the trans person as one who constantly meets friction and is harmed in a gender binary and cisnormative society, the action of taking hormones to get some respite and feel better in your

body is rational and understandable. Of course it would be better if that person could take part in the treatment prescribed in a legal, cheaper, safer way, and get their blood samples checked too. However, with the deficiencies in contemporary Swedish trans specific health care, this is not an option for many. If we abolish the frameworks of psychiatric diagnosis regarding trans experience and the gatekeeping function, and instead establish a health care system, which starts from the needs of the user, we are confident that the amount of people who self-medicate will decrease, and that health in the community will improve. We believe that the greatest large-scale possibilities to improve trans people's health lies in the hands of the legal and medical systems, which could generate non-pathologizing, anti-oppressive and participatory, user-centered practices.

Recommendations and Conclusions

Based on this analysis, we suggest that future presentations of problems and solutions are addressed on structural levels and met with adequate counter-measures:

1. Harm reduction

We want to see a change in approach towards harm reducing strategies within health care. When a person seeks care and it becomes clear that they are self-medicating, the physician should check for complications from the medication by checking blood samples, or by taking other relevant actions, and as soon as possible take over and prescribe the medication to reduce the risks associated with self-medication. This way of dealing with the situation is already outlined in the Standards of Care (WPATH 2011), and can easily be done even without any other system changes.

2. The user's influence

We want users of trans specific health care to have influence over their bodies, lives, and processes. We want to see a move towards health care developed by professionals and users together, in which the views, ex-

periences, and expertise of those who are currently treated as objects are, instead, recognised and listened to as subjects. Health care users should be involved in both their own processes *and* in the long-term strategies and priorities of the gender clinics. This is a matter of quality of service, since health care is known to have the best effects when actively working together with its users (Ottosson 1999; Socialstyrelsen 2009).

3. A responsible user perspective

Health care should be designed to meet the users' need for the kind of help and support necessary for them in dealing with society. We recommend that it should be seen as the responsibility of trans specific health care professionals to be knowledgeable about how the gender binary, cis-normativity and stigmatization affect their users. They should be aware of how these factors and the power imbalance between practitioner and user shape their perceptions, and do whatever they can to counteract it, and thus empower those affected.

4. Depsychiatrization of trans experience

The diagnosis surrounding trans experience should be removed from the mental disorders manuals in coming versions of DSM (*Diagnostic and Statistical Manual of Mental Disorders* from the American Psychiatric Association) and ICD-11 (*International Classification of Diseases* from the World Health Organization). This is in line with what WPATH, GATE, STP2012 and even the European parliament (European parliament 2011), among others propose. Sweden should have an active role in these liberating processes. The psychiatric label on trans experience strengthens the idea of the neutral and natural cisgendered person.

5. Increasing – not decreasing access

The available logopedic, surgical and endocrinological treatments are still lifesaving, and therefore it is crucial that they are state funded. There is a common fear among some of the local trans communities that changing the diagnosis would lower the priority of this health care, and make it even less accessible than it is today. The amount of suffering on

a group-scale amongst the ones seeking care will persist. We cannot see why accessibility would need to be tampered with due to depsy-chiatrization, simply by shifting the focus of the problem from the one experiencing the symptoms to society. The trans psychiatric diagnoses are simply not clinically relevant (Whittle 2008; GATE 2011). A useful analogy can be to think of how pregnancy related health care is administered and guaranteed without the need of a psychiatric label (Stryker 2012). Instead there is a possibility in this for increasing accessibility when the layers of dehumanization caused by stigmatization are partly lifted and those in the need can get more space for self-definition.

6. Breaking up general psychiatric stigma

Shifting the trans diagnosis from a psychiatric to somatic levels must not be at the expense of reinforced psychiatric stigma. When working for the depsyiatrization of trans experience we need to do it for the right reasons. For users of trans specific health care the psychiatric label functions as nothing more than additional stigmatization and external control. Other symptoms and conditions may actually find adequate support within the psychiatric framework. The depsyiatrization of trans experience cannot normalize oppressive practices in psychiatry. Lack of transparency and agency are problems that need to be worked upon within health care as a whole, including psychiatry (Corrigan 2005).

A user of trans specific health care is far from autonomous. This can be explained by at least two kinds of stigmatization that are fundamental part of trans specific health care services. By acknowledging the deep roots of psychopathologism and its effects surrounding the current work of the gender teams, changes for improving health can be made. The teams can start advocating for global depathologization of trans experience. By involving those most affected by the work of the gender clinics, that is to say the users, there is a chance to turn around the practices from cisnormativity, moralism and stigmatization towards non-harming, user-centered and dysphoria-alleviating practices, which can work with users instead of against them.

Summary

We live in a context where only two genders are accepted, a gender binary society. Together with cisnormativity, a power structure that values cisgendered people and devalues transgender people, this creates stigma towards trans people.

Trans specific health care is organised around transsexualism as a psychiatric diagnosis. In recent years the system has received critique both on national and international level, with regards to dubious content and inaccessibility that reinforce stigmatization of its users. Faced with this system, some people start to self-medicate with hormones in order to reduce the gender dysphoria that comes from interactions with a cisnormative society and to create a body in which they feel more comfortable.

This article is based on a radio program about self-medication with hormones, broadcasted on Swedish radio in March 2012. In this program critiques of the health care were not raised at all, instead the problem was placed on the individuals who self-medicated. Only the physician who participated in the programme was given space to offer an analysis and give answers. The ones who were self-medicating were positioned as impatient and ignorant. We found three assumptions upon which the programme based this view; an objective diagnosis, fair health care and the idea that everyone who needs has access to gender corrective care.

If we instead understand self-medication as an active way of trying to take control over one's body and life, to achieve better health, then the conclusions will change. We argue that health care professionals and the medical system, as a whole must be aware of cisnormativity in society in order to be able to alleviate its symptoms and not to put extra pressure on the people seeking support. We believe that trans specific health care must be centered around and developed together with its users, and not only because user participation in medical treatment processes in general are required by Swedish law. We also argue for a depsychiatrization of trans experiences and identities, and request that effort is put into combating general psychiatric stigmatization and working towards a less cisnormative society where there is space to live on one's own terms outside of the binary gender system.

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NOTES

1. We have chosen to exchange the word "patient" for "user" or "the person who needs trans specific health care." This is not a neo-liberal attempt to transform health care services into a commodity bought and sold on a free market, but rather a way to transform the idea of a person seeking health care from being perceived as a passive receiver of care, to being perceived and appreciated as an active, capable party together with whom the service can work.
2. Self-medication means that people get hormones from somewhere else than having them prescribed to them personally by a physician, for example by sharing doses

with someone, buying from abroad, or on the internet. Injections might require assistance from someone who can perform the treatment, and have access to sterile equipment. It may also include a wish to have one's blood values checked, so that one can manage the risks that come with any kind of hormone treatment, be it within or outside of the medical system. The access to self-medication is thus dependent on one's economic situation and contacts.

3. The text is reproduced here with the original spelling.
4. The citations from the program are transcribed from the radio program and translated to English by the authors.

SAMMANFATTNING

När vi lyssnade på ett radioprogram om självmedicinering med hormoner bland transidentifierade reagerade vi som aktivister på hur problem definierades och presenterades av en representant från det medicinska kollegiet som var inbjuden som ensam expert. Vi reagerade på hur brukare av vården talades om och hur långt ifrån brukarna vården är. Vi började analysera programmet, dess underliggande antaganden och normäterskapande effekter. Denna artikel är ett resultat av våra reflektioner utifrån programmet. Det vi fann var föreställningar om transsexualism som en objektiv diagnos, att vården är ett rättvist område och att alla som är i behov av denna specifika form av vård också får tillgång till den. Vi argumenterar för att psykiatriseringen av transerfarenheter underbygger de här tankarna och att detta leder till en vård som ökar istället för minskar stigmatisering av transidentifierade personers identiteter och liv. Som en effekt av denna analys formulerar vi rekommendationer om hur den transspecifika vården skulle kunna transformeras för att fungera i samspel med dem som berörs av den och därmed öka brukarnas hälsa.

Keywords: self-medication, depathologization, gender binary, transgender health, gender corrective care