

The Invisibility of Gender Diversity: Understanding Transgender and Transsexuality in Nursing Literature

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PURPOSE. Increasingly, people are living their lives without strict attachment to one gender. In this paper, we discuss key discourses identified in a literature review of transgender and transsexual issues in nursing. Our aim is to highlight the power of dominant discourse and lack of adequate understanding of gender diversity on the part of nurses. We use stories of trans people to illustrate these discourses. An increased awareness may support respectful care of those who do not fit comfortably within culturally defined parameters of male and female.

CONCLUSION. The invisibility of gender diversity in health care remains a threat to ethical nursing care. The effects of invisibility of transgender people in health care result in a cycle of repetition where those who have been denied recognition in turn avoid disclosure. Key discourses addressing trans people in nursing literature include invisibility, advocacy, cultural competence, and emancipation.

PRACTICE IMPLICATIONS. There is a need for further education about gender diversity in order to dispel and counter misunderstandings, stigma, and invisibility. This can be achieved through sustained efforts in nursing research and educational curricula to include gender diversity and trans people. Policies for the protection of those who change their sex or identify outside the dominant gender schema are urgently needed.

It is taken for granted in our Western society that there are only two genders, and the preference is that these be clearly presented (Lorber, 2008). At birth, if a child presents ambiguously, the decision is made to call the child either male or female and, if necessary, provide the surgery to complete this decision (Lorber, 2008). Increasingly, however, people are living their lives without strict attachment to one gender or are transitioning from one gender to another (Monro, 2005). As with other healthcare providers, nurses are gaining knowledge of the physiological and psychological implications of these changes, but have limited understanding of the scope of gender diversity, including what vocabulary to use (Alegria, 2011;

Bradley-Springer, 2009; Eliason, Dibble, & DeJoseph, 2010; Fish, 2010) to ensure respect, recognition, and inclusion of transgender and transsexual (trans) people.

The aim of this paper is to highlight dominant discourses including the invisibility of transgender and transsexuality issues in nursing literature and to foster a better understanding and ability to talk with patients and families about gender diversity. To this end, the paper is organized as follows. First, we provide a background clarifying: key terms, the importance of understanding gender diversity, the size of trans populations, and the common vocabulary nurses may encounter when working with people who do not fit

into culturally defined gender categories. Second, we present an overview of discourse, a description of the dominant gender schema adopted in Western culture (Devor, 1997), and four key discourses generated from a review of nursing literature addressing transgender and transsexuality. Third, we present stories of trans people's experiences to illustrate these discourses. And finally, we conclude with recommendations for nursing practice and education.

Background

Clarifying Key Terms: Trans and Gender Identity Disorder

For the purposes of this paper, we use the term *trans* to include both transgender and transsexual. In this context, a *transgender person* is understood as one who presents their gender in a manner that is different from the socially expected man or woman. This term can embrace a multitude of gender expressions, including transsexual, intersex, drag queens, masculine women, effeminate men, as well as a host of people who might fit anywhere in between (Stryker, 2006a). While these terms have some overlap, a *transsexual person*, on the other hand, is someone who believes that their body does not match their true sex. For this reason, many desire surgical and hormonal intervention. Even so, some transsexual people choose not to have any alterations to their physical bodies and live in a way that reflects what they believe their sex to be (Lev, 2004).

Another term nurses encounter that is related but not synonymous is the medical term *gender identity disorder*. This is a psychiatric diagnosis presently under revision in the American Psychiatric Association's (APA, 2010) *Diagnostic and Statistical Manual of Mental Disorders*. The diagnosis includes the wearing of sex-specific clothing and engaging in sex-specific activities that are not consistent with natal sex. Some activists have called the definition of this diagnosis "a fiction of natural gender" (Spade, 2006, p. 320) because it reinforces the dominant narrative that all girl children play with dolls and wear dresses and all boys prefer pants and rough play. While critics have spoken out against pathologizing that which they understand to be a natural and normal variation on sex and gender (Cermele, Daniels, & Anderson, 2001; Chase, 2006; Feinberg, 2006; Singer, 2006; Whittle, 2006), the diagnosis is considered necessary by many clinicians in

order to prescribe hormones and carry out surgical alterations of the body for those who do not identify with their natal sex and the expected gender presentation. Removing gender identity disorder as a mental health diagnosis also risks removing the funding available for sex reassignment surgery (SRS).

Why Is This Important for Nurses?

Without adequate understanding and experience, nurses may cause unnecessary and unintended harm when providing care for people who do not fit within culturally defined parameters of male and female. Nursing is a profession highly regarded among the general public and governed by ethical guidelines and standards of practice. In the Canadian Nurses Association (2008) *Code of Ethics*, values such as "providing safe, compassionate, competent and ethical care; promoting health and well-being; preserving dignity; and promoting justice" (p. i) are clearly outlined. Similarly, the College of Registered Nurses of British Columbia (CRNBC) requires that a nurse "Advocate and participate in changes to improve client care and nursing practice" (CRNBC, 2011) and that "Nurses have an obligation to provide safe, competent and ethical care to their clients" (CRNBC, 2010, p. 2). We contend that if nurses are not educated to critically question discourses of sex and gender, including the diagnostic category of "gender identity disorder" introduced above, they will be unable to provide competent, compassionate, and ethical care to people who either change their sex or express their gender differently from the culturally determined gender categories.

How Large Is the Trans Population?

It is very difficult to estimate the numbers of people who identify as transgender and transsexual. According to Burrows (2011), 10,000 people have undergone SRS in the United Kingdom by 2009, and another 46,000 were waiting for treatment. Blunden and Dale (2009) state that the number of people in 2009 in the United Kingdom who were being treated for gender dysphoria was estimated to be 1 in 4,000. Lombardi and van Servellen (2000) put the numbers of trans-identified people in the Netherlands around 1 in 20,000–50,000 in 2000. A recent research report by Gates (2011) estimates the transgender population in the United States to be .3% or around 697,529 people

(p. 6). The lack of accurate numbers for transgender and transsexual people is complicated because neither the United States (Cobos & Jones, 2009) nor Statistics Canada (2011) include a category of transgender in the census forms. Furthermore, people whose transition is accomplished to their satisfaction may no longer identify as trans but prefer to present and identify as men or women (Stone, 2006).

Common Vocabulary

There is a wide range of terms used in the literature that reflect the heterogeneity and complexity of gender diversity. In Table 1, we present an introduction to common vocabulary that nurses may encounter in healthcare contexts with patients and families and that are used in this paper. We acknowledge that this glossary is both preliminary and may be incorrect in some situations. Terminology is considered correct if the people named have chosen the name or at least are in agreement with its use. It is important to use correct terminology and therefore to inquire directly with the people involved. Calling someone by a term they do not recognize such as trans when the person identifies as a man or woman risks disrespect, invisibility, and exclusion.

Discourses, Dominant Gender Schemas, and Nursing

A general discussion of the nature of discourse and the dominant gender scheme within Western cultures is presented. Within this broader context, a literature review of nursing scholarship addressing transgender and transsexual issues from 1985 to 2011 is described. Key findings from this review generated four discourses: invisibility/erasure, nurse as advocate, cultural competence, and emancipatory discourses.

Understanding Discourse

We live in a world of binary opposites: male and female, black and white, right and wrong. Discourse from a critical perspective refers to a manner of thinking that is often taken for granted, unexamined, and operates subliminally (Crossley, 2005; Mills, 2004). Discourses shape our lives and guide us in making meaning of our perceptions and experiences (Purvis & Hunt, 1993). A dominant discourse is made so by support from institutions and society generally (Mills,

2004). Discourses of gender are generated and reinforced in society through the power of institutions and social conventions that determine and support a particular manner of thinking.

For example, dominant discourse of sex and gender tells us that a child recognized as female at birth will behave as a girl and grow into a woman. Dominant discourse also tells us what behaving as a girl entails and what is acceptable as womanly behavior, but within this discourse there is room for a discourse of femininity that allows for such alternate expressions of gender as the tomboy and the farmer woman who dress in clothing and behave in ways usually reserved for men. Therefore, the threads of one discourse can be woven alternatively, and the same discourse can be dominant or alternative depending on the situation. Foucault (1978) describes “a multiplicity of discursive elements that can come into play in various strategies” (p. 100) that are at once “an instrument and an effect of power, but also a hindrance, a stumbling block, a point of resistance and a starting point for an opposing strategy” (p. 101).

Dominant discourse defines the margins of acceptability as well as who falls outside those margins. When someone exceeds that margin, it is as if they are invisible but at the same time they threaten the margin. As a result of this threat, exceeding the boundaries of dominant discourses of sex and gender can mean verbal or physical attack and, in some cases, death. In order to make room for alternatives, dominant discourse first must be exposed. Moussa and Scapp (1996) argue that it is the work of the members of a dominant culture (such as nurses) who see and abhor the discrimination and prejudice perpetuated through a dominant discourse to clear a “discursive space in which those who were previously silenced might speak up” (p. 90).

Dominant Gender Schema

The invisibility or erasure of trans people in nursing is a reflection of the adherence, in Western culture, to a rigid gender schema. Devor (1997) outlined the gender schema that is dominant in the West and that is still very much in evidence today. In this schema, sex is understood as “biologically deterministic” (Devor, 1989, p. 46) and is established at birth by inspection of the genitals. There are only two sexes, no one can be both or neither, and changing from one to another requires surgery. Within this schema, gender follows from sex. That is, males will be boys and men,

Table 1. Glossary of Gender Diversity Terms

Sex	Sex is thought by many to be based on the biological chromosomal composition of the body, with the visible manifestations shown in the genitalia and secondary sex characteristics. Sex is a fixed organizing basis for Western society so people are forced into one of only two choices, even if it is by surgical means. Sex is both a bodily reality and a social construction (Dozier, 2005), in that male or female can be constructed culturally by gender roles.
Gender	Gender is often differentiated from the biology of sex and understood as the socially constructed attitudes and behaviors used to differentiate males and females. There is no universal definition, but many scholars believe the expression and characteristics of gender are fluid and a process of becoming (Bornstein, 1994; Kaufmann, 2010; Linstead & Pullen, 2006; Monro, 2005). It is assumed, in Western culture, that a person who is pronounced male will become a boy, a man, and take on masculine roles and characteristics, and a female-bodied person will be a girl, woman, and behave in feminine ways (Butler, 1999; Devor, 1989).
Intersex	This term has largely replaced the previous medical term <i>hermaphrodite</i> and is used both by the healthcare community as well as those who claim this identity for themselves to mean someone who has primary sex characteristics of both male and female to varying degrees. It can also be used to refer to someone whose genitalia do not measure up, quite literally, to medical standards, or are ambiguous in some way. Chase (2006), an intersex-identified woman and advocate, describes the condition as “individuals who arrive in the world with sexual anatomy that fails to be easily distinguished as male or female” (p. 300).
Transgender	A person may use this term to convey that they do not identify with their natal sex or they do not wish to be confined to just that sex. It may also mean that they identify with the gender usually associated with the “opposite” sex, or they may feel their gender expression is such that it does not fit the currently available categories.
Trans	This shortened version of transgender is an attempt to circumvent the struggles that some have experienced with the word <i>transgender</i> . Shelley (2008) considers transgender an unsatisfactory umbrella for the many identities that must constantly be explained. As a result, many prefer the term trans. Shelley uses the term “trans-people” (p. 16). Others use “trans-man” or “trans-woman”.
Transsexual	This term has been the subject of controversy. Combining “trans” with “sexual” seems to conflate transitioning with sexuality (Devor, 1997; Whittle, 1999). It often describes someone who uses varying means of altering natal sex, such as taking hormones, dressing as the preferred sex, or undergoing surgery and other body modifications to bring their body into alignment with their gender (Crossman, 2011). Some people struggle with the term because of the medical connotations associated with its use as category of diagnosis (Lev, 2004).
Gender identity disorder	This is a diagnosis in the American Psychiatric Association’s (APA, 2010) <i>Diagnostic and Statistical Manual of Mental Disorders</i> (DSM-IV). The diagnosis includes the wearing of sex-specific clothing and engaging in sex-specific activities that are not consistent with natal sex. Some activists have called the definition of this diagnosis “a fiction of natural gender” (Spade, 2006, p. 320) because it assumes that all girl children play with dolls and wear dresses, and all boys prefer pants and rough play. The diagnosis is presently under revision. While critics have spoken out against pathologizing that which they understand to be a natural and normal variation on sex and gender (Cermele, Daniels, & Anderson, 2001; Chase, 2006; Feinberg, 2006; Singer, 2006; Whittle, 2006), the diagnosis is considered necessary by many clinicians in order to prescribe hormones and carry out surgical alterations of the body for those who do not identify with their natal sex and the expected gender presentation. Removing gender identity disorder as a mental health diagnosis also risks removing the funding available for sex reassignment surgery.
Sex reassignment surgery (SRS)	This term is used for any surgical revisions made to the body in order to bring relief from the disjuncture of living in a body that does not match an individual’s gender identity. This can include chest reconstruction, hysterectomy, oophorectomy, removal of the vagina, phalloplasty, breast augmentation, orchidectomy, the creation of a neo-vagina, and face and voice surgeries. All of these surgeries are expensive, and some are partially covered by the various provincially funded plans in Canada as well as health insurance plans in the United States.
FTM and MTF	These acronyms are in common use, both by the person so described as well as healthcare professionals, and refer to people who were born female but identify as male (female to male, FTM) or born male and identify as female (male to female, MTF).
LGBT	This is a common acronym that stands for lesbian, gay, bisexual, and trans. The initials are often separated depending upon who or what is being discussed. For example, when indicating sexual orientation, LGB is used.

and females, girls and women, and this cannot be changed unless the sex is changed. And, like sex, no one can be both or neither gender. Devor also describes *gender styles* (p. 72), meaning each gender is expected to conform to socially sanctioned ways of being their gender, such as behaving in what is considered a masculine or feminine way, according to whether they are males or females. If people do not perform in the gender style considered appropriate, it is held to be an indication that they are sick in some way or that errors in socialization occurred during their formative years (Roughgarden, 2004).

Stryker (2006b), a male-to-female (MTF) transsexual person, writes of the birth of her partner's child and how the unquestioned proclamation of "it's a girl" reinforced the "hegemonic oppression" (p. 251) that results from the assumptions of all those around the infant about the naturalness of sex. Because of being trans, Stryker never had the experience of being recognized at birth for who she was, and further, this new child had a gender thrust upon her that may not accurately express who she will become. Stryker reminds us that "bodies are rendered meaningful only through some culturally and historically specific mode of grasping their physicality that transforms the flesh into a useful artifact" (p. 253).

Trans and intersex people, more than any others, challenge or trouble (Butler, 1999) the dominant discourse of sex and gender. They may change their sex, present a gender different from their anatomical sex, claim a gender that is not within the binary of masculine or feminine, live in the space in between or outside the binary, or they may act in a way not authorized by dominant discourse, such as behaving as feminine men or masculine women. Some trans activists call upon one another to "speak from outside the boundaries of gender" (Stone, 2006, p. 230) rather than disappear into the dominant culture. Whittle (2006), a trans man, declares that "trans'ing . . . fully queers the pitch by highlighting, clarifying, deconstructing and then blowing apart . . . all the things we know about sex, genders and sexualities" (p. 202).

Sociologist Aaron Devor (1997) wrote *FTM: Female-to-male transsexuals in society* wherein he elaborates this dominant gender schema in seven descriptive points. They are as follows in an abridged format:

1. Sex is intrinsic, biological, there are two only, male or female, determined by visually inspecting genitalia or by genetic testing.
2. All people must be one sex or the other. No one can be neither or both. No one can change sex without surgery.
3. Gender is the social outcome of sex, there are only two genders that follow from sex, boys and men and girls and women. All males must be boys and men, and all females must be girls and women.
4. All people must be one gender or the other. No one can be neither or both. No one can change gender without also changing sex.
5. Gender styles are culturally determined expressions of sex and gender. There are two, masculine and feminine. Males are naturally masculine, and females are naturally feminine.
6. Many do not live up to their expected gender styles because of poor socialization or because they suffer from some pathology.
7. Males, boys, men, and masculine people are naturally entitled to greater power and status than females, girls, women, and feminine people (p. 587).

More than a dozen years later, these gender and sex schemas are still pervasive in North American culture (Bauer et al., 2009; Dewey, 2008). Until recently, we have not questioned the socially constructed understandings of sex, gender, and sexuality: the doctors who try to find a diagnostic rubric for those who vary from the schema (Spade, 2006), the transsexual people who gladly take on the culturally inscribed attributes of femininity or masculinity (Hausman, 2006), and writers who attempt to make sense of something outside of their experience (MacDonnell, 2007). Through analysis of nursing literature, we identify four additional discourses that follow: invisibility/erasure, advocacy, cultural competence, and emancipation.

Review of Nursing Literature

Data Sources

A review of articles published between 1985 and 2011 addressing transgender and transsexual issues in nursing was conducted. Published articles and textbooks were identified from electronic databases: The Cumulative Index to Nursing and Allied Health Literature, and Summon (which includes PubMed, Medline, Web of Science Direct [Elsevier], Sociology Abstracts, Academic Search Elite, Health Sciences SAGE, Healthsource [nursing/academic], Academic Search

Premier, and PSYCinfo). Search words included combinations of nursing, transgender, and transsexual. Inclusion criteria included research, discussion, editorials, magazine articles, and theoretical articles where the central topic was transgender. Articles with a strict focus on pharmaceuticals, surgical intervention techniques, research tools, and methods were excluded. Only articles written in English were considered. A total of 77 articles were included in the review.

Key Findings

Invisibility/erasure. In nursing, Devor's (1997) dominant gender schema is prevalent and often unquestioned as demonstrated by the few nursing schools or textbooks that teach about sex, gender, or gender diversity (Bauer et al., 2009; Fish, 2010; Hanssmann, Morrison, Russian, Shiu-Thornton, & Bowen, 2010; Lim & Levitt, 2011; MacDonnell & Andrews, 2006; Merryfeather, 2011; Morgan & Stevens, 2008; Polly & Nicole, 2011; Richards, 2004; Sperber, Landers, & Lawrence, 2005; Vanderleest & Galper, 2009; Weber, 2009; Williamson, 2010). Nursing, as a profession, has been slow to enact policies regarding trans patients or nurses (Eliason et al., 2010; MacDonnell & Andrews, 2006; Polly & Nicole, 2011; Shaffer, 2005; Sperber et al., 2005; Weber, 2009). There is a scarcity of nursing literature or research into the lives of trans people (Addis, Davies, Greene, MacBride-Stewart, & Shepherd, 2009; Alegria, 2010; Bauer et al., 2009; Hanssmann et al., 2010; Lombardi & van Servellen, 2000; Sevelius, 2009; Sevelius, Carrico, & Johnson, 2010; Singh & McKleroy, 2011; Sobralske, 2005; Stieglitz, 2010; Thompson, 2008; Thornhill & Klein, 2010; Vanderleest & Glaper, 2009; Weber, 2009).

Based on the literature reviewed, nurses and other healthcare providers lack familiarity with the vocabulary with which to engage trans individuals (Burrows, 2011; Hanssmann et al., 2010; MacDonnell & Andrews, 2006; Merryfeather, 2011; Pimenoff, 2006). Unfortunately, there are still examples of nurses refusing to care for gender-divergent people with respect and courtesy, failing to use the appropriate name or pronoun, or in some reported cases even abusing their clients emotionally or verbally (Adams, 2010; Fish, 2010; Lombardi & van Servellen, 2000; Phillips & Patsdaughter, 2009; Polly & Nicole, 2011; Smith, 2007; Sperber et al., 2005; Thornhill & Klein, 2010).

This invisibility is further demonstrated by research reports and articles in and about nursing purporting to

include lesbian, gay, bisexual, and trans (LGBT) people (or that mention transgender and/or transsexual people) when they fail to direct any remarks toward the specific needs of trans clients. Almack (2010) wrote a review of a paper that discussed social exclusion of LGBT people but focused more on LGBs without apparent awareness of the omission of trans people. There is an assumption, based on a dominant gender schema discussed above, that trans people do not exist or that their needs are the same as the LGB population, even though LGB people's needs are not homogeneous either. In a comprehensive paper addressing the needs of the older "GLBT" person, Blank, Asencio, Descartes, and Griggs (2009) spend less than half a page discussing the "more extreme" (p. 17) issues faced by transgender people. Seven papers included in this literature review indicated either LGBT or trans people in the title or abstract, yet the authors omitted any discussion of transgender and instead focused on sexual orientation and homophobia and heteronormativity (Blackwell, 2008; Gabrielson, 2011; Heath, 2002; Keepnews, 2011; Irwin, 2007; McGuinness, 2008; Rondahl, 2009). Chesla (2005) directly groups "GLBT" under "sexual orientation" (p. 340), which entirely excludes the trans component. For Guberman et al. (2004, p. 15), *gender-based diversity* means diversity between men and women only. Even though the authors of this paper mention a focus group from a drop-in center for "lesbian/bisexual/transgendered young women" (p. 17), they confine their discussion to the sexuality of women. Similarly, Owen and Khalil (2007), in their analysis of diversity, speak only of men and women in the category of gender but list "transsexuals and transvestites" (p. 471) under diversity of sexuality, by which they indicated they meant sexual orientation. Diversity does not include trans people for Yearwood, Hines-Martin, Dato, and Malone (2006), and even though Weber (2009) speaks of transgender parents in the abstract of his paper about sexual minority parents, he restricts his discussion to same-sex parents.

Nurse as advocate. It seems ironic that the discourse of *nurse as advocate* would follow closely on the heels of the discourse of invisibility for trans people because they seem in direct opposition to one another. However, the nurse as advocate has been central to the profession from the time of the earliest nurse theorist, Florence Nightingale, who advocated better living conditions for the poor in order for them to experience better health and saw nurses as instrumental in

achieving this (Pfettscher, 2002). Likewise, with this emerging community, nurses have an opportunity to be leaders in advocating for gender diversity.

Several papers directly address the mandate for nurses to advocate for their trans patients (Adams, 2010; Cobos & Jones, 2009; Dysart-Gale, 2010; Fish, 2010; Jenner, 2010; Keiswetter & Brotemarkle, 2010; Morgan & Stevens, 2008; Polly & Nicole, 2011; Shaffer, 2005; Thornhill & Klein, 2010; Vanderleest & Galper, 2009), while others hold advocacy to be an important nursing function for all those marginalized and underserved without specific mention of trans people (Axtell, Avery, & Westra, 2010; Blackwell, 2008; Irwin, 2007; Lim & Levitt, 2011; McGuinness, 2008; Owen & Khalil, 2007; Weber, 2009, 2010; Yearwood et al., 2006). Some authors see the difficulty of advocacy in our current Western culture because research into trans issues is not considered as important as other areas (MacDonnell, 2007; MacDonnell & Andrews, 2006). Eliason et al. (2010) identify barriers to advocacy as including the labeling of such attempts as "having an agenda," "strident," or "unsubstantiated," and because of unwarranted scrutiny not leveled at advocacy for other groups (p. 214).

Cultural competence. Cultural competence, according to Papps (2005), is an idea within the concepts of transcultural nursing, first proposed by Leininger in the 1950s. It begins with an awareness of differences among various cultures, which then develops into personal sensitivity and culminates with the nurse becoming culturally safe to provide care defined by those who receive it (Papps, 2005). As will be seen in the following discussion, cultural competence in regard to people who identify as trans is still an ideal waiting to be realized.

Cultural competence is a goal frequently mentioned in the literature reviewed. Wepa (2005) broadly defines culture as "our activities, ideas, our belongings, relationships, what we do, say, think, are" (p. 30–38), and this is the definition that informs our understanding. Although it has similarities with advocacy, cultural competency is seen as something to be approached from which appropriate advocacy can be launched. In order to become culturally competent, one needs to identify the culture in question. Bith-Melander et al. (2010) report findings from a study among transgender people of color in which the researchers identified many intersecting axes of discrimination and marginalization, but they did not recognize transgender as a culture in itself. Similarly,

Melendez and Pinto (2009) view culturally competent care for transgender women as being aware of racial and ethnic concerns. Yearwood et al. (2006) also view culture in a racial/ethnic light. In contrast, Gibson and Catlin (2011b), in the third paper of a series of three dealing with the clinical nursing care of transitioning children and adolescents, implicitly recognized a culture of transgender by calling upon nurses to be culturally competent by behaving with compassion and integrity in a nonjudgemental fashion toward those who undergo sex change procedures. Lombardi and van Servellen (2000) recognize transgender culture as a diverse but nonetheless unique culture requiring nurses to be culturally sensitive, as do a number of other authors (Sevelius, 2009; Shaffer, 2005). Several scholars name the difficulty for nursing to provide culturally competent care to the restricted understanding of culture as only race or ethnicity (MacDonnell & Andrews, 2006; Polly & Nicole, 2011; Vanderleest & Galper, 2009).

Emancipatory discourses. The final discourse identified is emancipatory discourses. Daley and MacDonnell (2011) directly identify emancipatory discourses as social determinates of health, anti-oppression, and citizen/social rights (p. 5). These three categories, the authors demonstrate, expand the discourses of diversity and multiculturalism, which tend to exclude/erase transgender people. De Santis, Martin, and Lester (2010) reported on a program for human immunodeficiency virus prevention among trans women that used trans women to facilitate sessions. In another paper that reviewed research literature into human sexuality, De Santis and Vasquez (2010) named "respondent-driven" (p. 180) sampling wherein the researcher first identifies willing participants and asks them to recruit others. Dewey (2008) identifies resisting established medical decisions as a counter discourse for trans people. MacDonnell and Andrews (2006) and MacDonnell (2007) advocate research that focuses on sexual minorities as emancipatory discourse. Singh and McKleroy (2011) identify "just getting out of bed" (p. 34) or mere survival of traumatic events as counter discourse for transgender people. Stieglitz (2010) names this discourse "resilience" (p. 192). Phillips and Patsdaughter (2009), in their editorial to the special edition of the *Journal of the Association of Nurses in AIDS Care* that features transgender people, identify the special edition as an opportunity to engage in alternate discourse of trans. And finally, Cook-Daniels (1998)

identifies ways of being such as identifying, recognizing relationships, careful listening, and respect that compose a discourse that counters invisibility.

Illustrating Discourses with Stories

Nursing is a relational practice (Doane & Varcoe, 2005), and stories are a good way to demonstrate the relationality of a life lived. The brief stories we present here will, we hope, bring some trans people's experiences to life and illustrate the discourses described above. Some of the stories come from personal communication, and others are from the first author's (L. M.) nursing experience. Names and locations are changed or disguised for reasons of confidentiality. These stories are recounted with the understanding that memory is created in the present (Muncey, 2010). The stories are presented chronologically, with the oldest first. Arranging them in this way helps to illustrate how discourses have and have not changed over time.

Sheila (Circa 1999–2000)

Sheila was over 6 feet tall, weighed about 200 pounds, and was male bodied. As a man, she had been a marine and was the proud bearer of several navy tattoos. Later in life, Sheila identified as a woman, but because of her medical status as a brittle diabetic and her lack of funds, she was unable to take any steps toward achieving her dream other than dressing as a woman, growing her hair, and using a feminine name and pronoun. Sheila came to live in a residential facility where I worked. She would come to the dining room dressed in a frilly housecoat that did little to hide her chest hair or her private parts and wore high-heeled mules lined with pink faux fur, and the other residents reacted with shock and disapproval. She seemed to be somewhat unaware of the effect she was having and treated everyone with friendliness in spite of their reactions to her. Sheila's physician was not supportive of her and refused to call her by her name or use the correct pronoun. Some of the staff seemed to comply with Sheila's wishes but were then overheard speaking disrespectfully about her behind her back. I organized a workshop for staff and volunteers that was very successful and helped them to understand their own fears and embrace Sheila as a member of the community. Unfortunately, Sheila's sister, who was

her only next of kin, did not support Sheila's choice of name or pronoun, and when Sheila died, she was buried under her birth name.

This story illustrates the interconnectedness of various discourses. By their reaction to Sheila, the staff and residents demonstrated their adherence to the dominant discourse of sex and gender. They were often shocked and offended by her demeanor and clothing choices because these did not match the dominant schema of sex and gender. Her doctor adhered to a discourse of invisibility, as did her sister. The discourses of advocacy and cultural competency are shown in the attempts, supported by the organization, to organize education for the staff. By her exuberant existence, Sheila was the creator of the most powerful counter discourse. She wore what she wanted, and the more flamboyantly feminine she could present, the better she liked it. It is my observation that the education provided was very helpful, but it was Sheila's unwavering belief in her own worth as a person and her right to be who she wished to be that had the biggest impact on staff attitudes.

Gerald (Circa 2005)

Gerald, a trans-man, lived full time as a man, used masculinizing hormones and had had chest reconstruction surgery, but had not had genital surgery. He required surgery that had nothing to do with his gender status. During the preliminary examination of the surgical site, the surgeon asked to see Gerald's genitals, using the excuse that he had never before dealt with a transsexual person. Gerald refused his request but was troubled by it and so contacted the head nurse of the operating room where his surgery was to take place. He explained his concern to the nurse, that his genitals might be unnecessarily exposed or that his trans status would be discussed disrespectfully. The nurse reassured him in a respectful and professional manner. Subsequently, Gerald suffered complications from this surgery and visited his medical doctor. During the examination, the nurse who was present purposely looked at his genitals, and Gerald saw shock on her face when she realized that he did not possess a penis. Following this visit, Gerald's doctor ordered home-care nurses to visit every other day to dress the wound. Gerald was able to conceal his genitals from them by positioning himself before the nurses arrived. He did not discuss his gender status with them because he felt too

vulnerable due to the previous experiences surrounding this surgery (C. Moore, personal communication, December 10, 2011).

In this story, the discourse of invisibility is both dominant and counter, “a multiplicity of discursive elements” (Foucault, 1978, p. 100). Gerald did not want to be seen as trans, but only as a man in this case, as it was irrelevant to his need for surgery, but his surgeon erased Gerald’s identity by posing his inappropriate request. Gerald created counter discourse to his invisibility by asking the operating room nurse to advocate on his behalf, invoking what Daley and MacDonnell (2011) refer to as citizen/social rights. Because of his feelings of vulnerability, Gerald used the discourse of invisibility for his own ends in preventing the home-care nurses from seeing his genitals, creating the impression that he was not trans, but a biological male. In doing so, he may have prevented the nurses from practicing advocacy and developing cultural competency.

Charlene (Circa 2010)

Charlene, who had completed MTF SRS and had changed her name legally as well as her designated sex on her driver’s license, was admitted to a small town hospital for a procedure that had nothing to do with her sex or gender. The hospital staff, taking their cues from her previous records, insisted on calling her by her previous name and used the corresponding pronouns. Charlene was devastated. A peer support organization helped her file a complaint with the hospital, and subsequently they changed their policy to one that recognized and respected the current name, pronoun, and sex of someone who changed sex (C. Moore, personal communication, December 10, 2011).

This story begins with the discourse of invisibility and the resultant emotional distress but ends powerfully and well because of advocacy provided by peer support. The staff were obliged to obey hospital directives, which further emphasizes that advocacy cannot flourish without institutional support. The power of the individual to create effective counter discourse is shown in that it was not a large and influential group that lobbied on her behalf, but the woman affected and other trans people, which resulted in a policy change that itself both demonstrates counter discourse of sex and gender but also encourages counter discourse by its existence.

Revisiting Dominant Discourses in Nursing

These stories and the research reviewed illustrate how the dominant discourse of invisibility has changed very little since Sheila’s story in 1999. What has changed is that trans people are becoming more empowered to speak on their own behalf, and institutions are beginning to enact policies for the protection of those who change their sex or identify outside the dominant gender schema.

In order for the other discourses in nursing under discussion (advocacy, cultural competency, and emancipation) to be properly rendered, the discourse of invisibility must first be revisited. The most frequently illustrated and most powerful discourse identified in nursing literature is that of invisibility/erasure. Namaste (2000) and Shelley (2008) have written evocatively about the invisibility of transgender and transsexual people. Shelley uses the word *repudiation* to mean something similar to invisibility/erasure and claims that trans people are “the most subjugated and marginalized of social groups” (p. 3). Namaste argues that trans people are “continually and perpetually *erased* in the cultural and institutional world” (p. 2, italics in original). Why is this so and why would a profession such as nursing, dedicated as it is to health and wholeness, be a complicit partner in this erasure?

One answer could be that transphobia is embedded in all social institutions (Daley & MacDonnell, 2011) and that includes nursing. Another is that nursing has subscribed to multiculturalism and diversity, but trans people are often not considered as having their own culture and are frequently subsumed into the LGB community when it comes to diversity (Daley & MacDonnell, 2011). Differences have been blurred rather than celebrated as a result, in spite of good intentions, of multiculturalism (Ramsden, 2005). De Santis and Vasquez (2010) suggest that nursing did not consistently include human sexuality in its educational curricula until around 1980, and there may be a lingering discomfort among nursing instructors regarding the place of sexuality in nursing education or practice. It is also becoming more frequent that institutions where nursing is practiced do not employ nurses at the level of policy making (Canadian Nurses Association, 2009; Lowe, 2002) so the ethical and practice guidelines that direct nurses to empower their clients/patients are not present in decision making, as illustrated in the stories of Gerald and Charlene. Those entrusted with the task of educating nurses are often unaware of either the existence or the unique needs of

trans people so these are omitted when planning nursing curricula (Eliason et al., 2010; Irwin, 2007).

Advocacy has been an important aspect of nursing since nursing's inception, as previously discussed. The various authors of the 25 papers reviewed in regard to advocacy have singled out issues faced by trans people, but only 16 have considered invisibility as the overarching problem. In the remaining papers, it has been assumed that the presence of trans people is "sensational" (Adams, 2010), "unusual" (Shaffer, 2005, p. 407), engenders discrimination (Owen & Khalil, 2007; Polly & Nicole, 2011), shows a need for change (Yearwood et al., 2006), and is an occasion for "tolerance" (Irwin, 2007, p. 72), "acceptance" (Jenner, 2010, p. 408), and intervention (McGuinness, 2008). In order for advocacy to be an alternate discourse for trans people, their voices need to be heard, as in the MTF and FTM stories. Thornhill and Klein (2010) told stories of individual trans people; Shaffer identified herself as the mother of a trans person but only Morgan and Stevens (2008) used the actual words of trans people. Research that foregrounds the experiences of trans people and tells their stories using their words would be an example of advocacy as counter discourse in regard to invisibility. If those authors who are trans or trans allies identified themselves as such in their work, it would further enhance visibility.

Cultural competency has been a relatively new concept in nursing, beginning around the early 1990s (Papps, 2005), so to find it as a dominant discourse in nursing is encouraging. However, it, too, must be examined in the light of trans invisibility or it can become little more than pleasant rhetoric. Of the papers cited in regard to discourses of cultural competency, only two did not include the problem of invisibility for transgender or transsexual people (Gibson & Catlin, 2011a; Yearwood et al., 2006). Of the remaining papers, six included either the actual voices of trans people or their stories.

All of the literature reviewed containing emancipatory discourses address the problem of invisibility. Emancipation is created by seeing and recognizing trans people as valued human beings. Cook-Daniels (1998) identifies herself as a member of the LGBT community and says, "If they (lesbians and gay men) are invisible, then transgendered elders have been inconceivable" (p. 36). Daley and MacDonnell (2011) noted that "the very few references to LGBT populations are often bracketed as afterthoughts" (p. 4) in the literature they reviewed. De Santis and Vasquez (2010) suggest that people who represent

sexual minorities may be unwilling to participate in research unless one of the team is also identified as belonging to a sexual minority. MacDonnell (2007) implies her membership in a sexual minority category and discusses the need for nurses to examine the often "invisible dynamics of power" in regards to sexual diversity (p. 81). One of the hurdles that transsexuals face in their contact with the medical profession, according to Dewey (2008), is to be seen as "real" or authentic (p. 1345).

Recommendations and Conclusion

As previously discussed, it is within the mandate of nursing to provide care that is safe, ethical, compassionate, and competent. In order to do this, it is important for nurses to become aware of issues faced by people who are transgender and transsexual. We offer some concluding thoughts and recommendations as to how this important task can be accomplished.

To be rendered invisible is one of the most emotionally painful experiences possible. It happens to many people at different times of their lives: childhood (adults are in control), illness (a person becomes a patient), disability (the tendency to address the one pushing the wheelchair rather than the person in it), women (if there is a man present, she is often relegated to inferior status), and aging (white hair can render one unimportant). In fact, invisibility is something that all minority groups must face. For trans people, it occurs in a much more systemic way: women's shelters (many won't help MTFs), surgery (many American states won't fund SRS), prisons and hospitals (some will only recognize birth sex), media (many are focused on SRS rather than issues of justice), academia (research in the trans arena is often underfunded and less respected), and government policies (trans people are often not consulted) (Namaste, 2005).

Findings from this literature review suggest there is a pressing need for nurses to understand gender diversity and transgender people in particular. Through educational processes and researching the lives and stories of transgender people, understanding and awareness may help to dispel and counter the discourse of invisibility. Developing curricula to educate about trans people should be in direct consultation with trans people and their allies, and/or by consulting research conducted by people who identify as either transgender or allies. Nursing research is urgently

needed to counter the discourse of invisibility of trans-identified people.

Nurses can advocate for transgender and transsexual people when we understand the issues and the barriers trans people face every day when we see people living their lives. If nurses approached everyone as if they could be trans, as indeed they could be, then we would be able to stay aware of our part in erecting barriers or fulfilling our advocacy mandate.

Nurse leaders, educators, and academics need to develop cultural competence as it relates to trans people and sex change by first recognizing that this population has a unique culture. Those belonging to trans culture have different views and needs than other sexual minority groups, although there are many areas of overlap. For example, gays and lesbians face discrimination as a result of heterosexism, which could also apply to trans people if their sexual relationships are seen as same sex. However, trans people also often face discrimination from the LGB community (Raymond, 2006; Rubin, 2006; Stryker, 2006a). It is also important to realize that trans culture represents a wide diversity. For example, it could be said that FTMs and MTFs, while sharing some cultural uniqueness such as the obvious need to find practitioners to aid in their transition and find funds to pay for such assistance, have divergent challenges and goals. There are quite separate issues in regard to availability and cost of surgical procedures between FTMs and MTFs, and mainstream cultural gender values come to bear if one's goal is to pass as a natal male or female.

We cannot escape the "vectors of power" (Butler, 1993, p. 187) created by discourse, but we can examine them and bring them to conscious understanding. Nurses can be challenged, transformed, and enriched by learning about and caring for people who identify outside of cultural parameters of sex and gender. Phillips and Patsdaughter (2009) see this opportunity as a gift that makes us capable of "professional transformation" (p. 335) and remind us of every patient's right to self-determination and a nurse's ethical responsibility to uphold this right.

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