Queer in the clinic – practitioner and patient issues and challenges

LGBTQ (lesbian, gay, bi-, transgender, queer/questioning) is a growing group within the community at large and thereby also as potential patients. This group is growing in visibility, not because there are more people who are becoming or recognising that they are LGBTQ, but because it is less stigmatised (this though is of course relative. It is less stigmatised than only 10-15 years ago, but that is like saying it hurts less to be beaten 7 times a day with a bamboo rod, than to be beaten 15 times a day with a baseball bat).

The latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) has changed the term Gender Identity Disorder to Gender Dysphoria. While this is without doubt a step in the right direction, as it now implies a temporary mental state of distress, primarily caused by not being able to fit into society, as opposed to an all encompassing and perhaps permanent mental disorder. It is still defining alternative gender identities as a disorder, many transgendered and queer individuals are perfectly happy and feel that, if there is a problem, then it is to be found in society's attitude, rather than in the individual themselves.

How do we define being transgender in a CM perspective

There is a paucity of information about LGBTQ in CM literature. CM and Chinese society in general, like most societies, was and is both heteronormative, as well as traditionally being patriarchal. Furthermore, the Confucian ideal of *li* or appropriate behaviour, creates an emphasis on conforming and fitting in to commonly defined norms.

Even though transitioning from one physical gender to another is legal in China. It can only be carried out, however, under stringent guidelines published in 2009, such as registering with the police and being unmarried. The list is long and tortuous, and many believe it is unfair.[1]

A further discriminating aspect of the transitioning process is that it effectively annuls the educational qualifications of the person in question. Past qualifications no longer match the person’s present gender and become defunct, with local governments not willing to change the

1 http://www.theworldofchinese.com/article/crossing-the-gender-lines. Accessed 22/01/16

educational databases in question. Getting a job is difficult for a transgender person anywhere in the world, but in China if you have transitioned and apply for a job, your qualifications cannot be verified.[2]

Pan Suiming, Director of the Institute of Sexuality and Gender at Renmin University, says there is a shift in the attitudes towards LGBT people, claiming that 90% of university students accept LGBT people. The Chinese Academy of Social Sciences point to a 2008 study which showed that 6-10% of Chinese are LGBT, while only 20% of society accepts them.[3]

My CM angle on queerness

My own understanding of queerness seen from a CM perspective is unashamedly based on my own subjective experiences and how I have related them to CM conceptions.

In my opinion, my own gender identity and presentation, and transgenderism in general, relates to *de* – how *dao* is manifesting. I am manifesting my true self. My *dao* is that there is a discrepancy between my physical gender and my gender identity. A female heart in a male body. My *dao* is to be different from other people, but this is in reality exactly the same for each and everyone one of us. None of us are normal. Normality is a common prison, that we are each of us both prisoners and prison guards in. If we step outside of the prison bars and manifest our true selves, then we follow the *dao* in its manifesting. This is *de.*

When I define here, what transgenderism is for me, it is vital that this is interpreted as exactly this - my own subjective interpretation. Other transgendered person's *dao* can be very different. I for example no longer feel that I was born in the wrong body, though this is the reality for many transgendered persons. I certainly did as a child, and when I was younger. Now I still have a fundamental desire and preference to be female, but I also accept the reality of my physical body. Possibly, this is also because I do not know whether surgery and hormones would 1) fulfil my dream – maybe I would still feel like a man, but now in an operated male body and 2) I have a body that functions reasonably well after half a century on misuse. Surgery and hormones could definitely mess that up!!

2 Ibid
3 http://www.voicesonthesquare.com/essays/2012/07/06/china-and-transgender-people . Accessed 22/01/16

I do not know whether my change in perception is due to my general philosophical approach to life – the acceptance of circumstances that cannot be changed, even if I wished they were different, and then working with the possibilities that then do exist in these circumstances or whether it is due to pragmatism – would surgery and hormones, with all the side-effects that they bring with them, actually make me a woman? My gender identity discordance and my accept of reality as it is, means that even though I have a fundamental yearning to be something, I recognise and accept it as this – a yearning, a desire. Human suffering lies not in having or not having something, but in the desire to have or not have something.

Fortunately I do not have physical self-loathing, as many transgendered individuals do. For them their physical body is not just a prison, but an instrument of torture. For many the choice is not between acceptance and non-acceptance of the physical body, it is between surgery and suicide. Something that is very relevant though, not just for individuals who are transgendered, but also for a great many people, is a fundamental condition of non-contentment. This dissatisfaction is sometimes projected onto the physical body and manifests with a Sisyphean struggle of trying to achieve the perfect body. The problem often being though, that when they get the larger breasts, fuller lips or whatever, they still have the same feeling of dissatisfaction inside. This is probably the main reason that I do not practise cosmetic acupuncture. There is a different dynamic in treating cosmetic dissatisfaction to treating patients suffering from a physical or emotional disorder. Patients with physical and emotional disorders are grateful for their release from suffering, but a fundamental dissatisfaction with the physical appearance or a Canutean struggle against the tides of time will mean, that there is a greater risk of having to relate to patients who are constantly dissatisfied with the results of their treatment.

By presenting as female, I feel a harmony that is difficult to verbalise. It is not so much a sense of me now being who I want to be or who I think I am, more a falling away of something. When I am a “man” I constantly think about my gender or the discrepancy between what I wish I was and what I am. When I am a transwoman, I do no think about my gender, apart from in relation to my surroundings and their possible negative reactions. When I present as female, I can just “be”. This is probably how most cisgender[4] people experience reality.

4 Cisgender - a person whose gender that they were assigned at birth matches their perceived or expressed gender

We are each of us individual compositions of yin and yang. As we know nothing is ever yin or yang, but contains aspects of both in varying proportions. Furthermore yin and yang are three dimensional i.e. it is too simplistic to just define something from one binary relationship. Is chilli ice cream yin or yang? Is hot mint tea yin or yang? Is Damp-Heat yin or yang? We are each of us mixtures of male and female in varying proportions, but also importantly we draw on and manifest various aspects of our masculinity and femininity in various situations. Nothing is static or determined. So far, so good. This is relevant for everyone, whether they are cisgender or transgender. Being transgender has the further challenge, in that the concept and predetermined definitions of gender identity itself is something that can be discussed.

An idealised conception of being transgender is that we present a third gender. We unite yin and yang in the same individual. This is something that is revered in some cultures, with many shamans being transgendered or being considered to have two souls in one body. Guanyin is also portrayed as being male and female at different times in Chinese culture and sometimes as both.

The only classical references that I have seen that relate to transgenderism, are references to eunuchs. There is reference to both congenital eunuchs and castrated eunuchs.

Hun and Shen

A perspective on transgenderism seen from a CM perspective could be to view it as a Shen/Hun imbalance. Hun creating a vision of how or what you should be and deciding to follow and fulfil this vision. This vision is fine as long as it does not conflict with what is normal or acceptable. Shen is that which ensures that we conform to what is normal. Normal is not a predefined condition. It is socially constructed. What is normal in one society is abnormal in another or at another point in time. In a transgendered individual in many societies, the Shen is not powerful enough to restrain the Hun from manifesting its vision.

Heart/Kidney

The American acupuncturist Cody Dodd has a different angle. Cody views transgenderism, in relation to CM, as a conflict between the physical manifestation of the body – jing and the consciousness – shen.

"*This means that the daily experience of one's life does not match one's anatomy. There is a conflict between above and below. It's possible for a person to have the Shen of a male and the Jing of a female and vice versa. Transgender and gender queer people indeed experience the world through the gender they identify with. Since Jing and Shen are intertwined so early in life, children with conflicting Jing and Shen can easily express their Shen, that which is in their heart. A child will act as the gender, which is in their Shen, without any influence from other people. They just know…..........................*

From a Chinese medicine point of view, it is important to understand that the pathology of HT and KI not communicating is not a result of the conflicting Jing and Shen. Even with conflict, when a person expresses what's in their heart, there is Harmony. The Jing communicates with the Shen, even though seemingly they don't match each other. It is when a person feels as if this conflict is wrong or abnormal when pathology begins.

When a gender-variant person lives according to their Shen, free to express their true self, and supported by the society around them, there is no pathology related to their conflicting Jing and Shen.

That feeling of shame and the pathology is a result of a rigid society."

Practitioner/patient relationships

The therapeutic space and how much we should be ourselves

It can always be discussed, how much of our selves we should bring into the treatment room. Psychotherapy certainly operates with the concept of therapist neutrality, but I am not sure that this is always relevant or whether it is even counterproductive as an acupuncturist. By allowing ourselves into the treatment space, we can also empower and liberate the patient. We can create a space where they can be themselves as well. Queer can be liberating - if I can do this, be this, be something that is so much at odds with what is “normal”, even though most agree that it is completely harmless for others, then other people can also be themselves. Their inhibitions or divergences from the golden norm pale into insignificance compared with me. If I can have the courage to show the world my vulnerability and supposed weakness, then they can as well. It is almost my duty to be queer. By presenting my queerness, I help to break down the prison walls of normality that is incarcerating each and everyone of us.

The question therefore for all of us, even though we are not all transgendered is do we open up or close the therapeutic space by bringing our own personality and identity into the room. This is not just our attire and physical appearance, but also our life experiences, our political, religious or philosophical views etc. The answer to this question is of course not simple and singular. It is something that is different each time. Sometimes, we can inspire and empower by bringing our selves and our experiences into the room, but at other times we inhibit and close the space down.

Our contact with the patient is also a part of our treatment. Through our persona and through our language, we will always have a therapeutic or pathological effect on a client. This can of course be very minute and subtle, but it can also be more substantial.

The major difference for me and most of you, is that I no longer have the choice, unless I crawl back into the closet. Even gay and lesbian therapists have the choice of whether they are out and open in various situations. This reminds me of years ago when I group of my friends, who were active anti-fascists found they had strayed into the wrong part of Hamburg. All the white antifascists started to turn their t-shirts inside out, hide their emblems etc. to temporarily conceal their anti-fa identity. This was not an option for their dark skinned comrades. When I walk down

the street, I cannot suddenly not be transgendered, I cannot hide my queerness. Each time I step into a shop, meet new people etc. I have to come out of the closet, whether I want to or not. The same is true in the clinic.

This then can collide with my prospective clients expectations of me as a practitioner. It also raises the practical difficulty of informing clients ahead of their appointment, that I am transgendered ahead of their appointment, so that they do not get a shock and importantly, so that they have the opportunity to not come, if it is something that is too weird for them. This does happen, if only extremely rarely. But then again there are undoubtedly potential clients who actively choose not to contact me, because they know I am queer. This is not a problem for me, because I have an established practice with a waiting list for new patients. It would though be a problem if I was newly started and did not have my professional reputation.

Things to consider when treating queer and transgender patients

When treating transgendered (TG) and queer patients there are several factors that need to be taken into consideration. I have tried to summarise below some issues that it are useful to be aware of, both with regards to potential aetiology as well as understanding a patients background and situation.

Language and alphabet jungles (and how you can seriously piss someone off, by inadvertently using the wrong term!!)

Before delving into the issues, it is also important to learn the lingo!! Something that makes matters even more complicated, is that these terms can mean something different from person to person. I have not defined my own interpretations of these terms here. A definition of some of these terms can be found at: http://www.reneereyes.com/Meeting%20a%20Transgender%20TS/Transsexual%20Women%20101/Community%20Terms/

Androgynous	Dragking	Gender fluid
Cisgender	Dragqueen	Gender neutral
Crossdresser	FTM	Gender queer

Heteronormative	Queer	Transsexual
Intersex	Shemale	Transvestite
Ladyboy	TG	Transwoman
LGBT	T-Girl	Trans*
MTF	Trannie	TS
Post-op	Transgender	TV
Pre-op	Transman	

Gender and sexuality are not related

It is important to be conscious and aware of the difference between gender identity and sexuality. In the same way that you cannot make assumptions about cisgender patient's sexuality, the same is true of queer and transgender patients.

Pronouns

This is a minefield. You cannot be certain how to address a person who is queer or TG and many individuals can be offended or feel hurt, if you use he, she, him, her, his, hers etc., if it is not the gender that they identify with. Furthermore, there are also some who do not identify with either of the binary genders or identify with both of them.

Some are easy going, around this issue, but for many transgender and queer persons this is a sensitive issue. The best policy is always to politely ask what they prefer, rather than just assume. If you have an intake form that either you or the patient should fill out, there should be an option to write male, female, neither, both or not applicable.

Be frank and honest

You may well have doubts, questions and difficulty navigating in how to deal with someone whose gender identity or expression is not congruent with how you perceive them. It is always a better strategy to be frank and honest, but importantly, respectful. Admit to the patient that you are having difficulty navigating and ask the patient for guidance.

Relevant issues when diagnosing a TG or queer patient

Many of the issues below are not just relevant for TG patients, but also for many other patient groups, who have undergone cosmetic surgery or who are in some form of hormone therapy. Other issues are very specific and unique for queer and TG patients.

Cosmetic surgery

Ask about whether they have undertaken cosmetic surgery and explain the relevance of your question. Surgery will always result in some degree of Blood stagnation and this is relevant for our diagnosis.

The issue of cosmetic surgery is far from limited to TG patients and not all cisgender patients elicit that they have undergone cosmetic surgery. With all patients who have had cosmetic surgery, it is important to to gauge the sense of satisfaction and the subjective sense of success. This can often be difficult without being blunt and insensitive. Many patients, not just transgendered, invest their sense of happiness in an idealised physical body and hope they will feel harmonious, content and free when they have achieved this. Unfortunately this contentment does not always arise post-operation.

Hormonal treatment

Lets not beat around the bush. Artificial hormones are bad full stop, but so is the emotional pain and suffering of male and female secondary sexual characteristics, if you do identify with this gender.

There is no ideal solution apart from magic wands and Glaxo-Klein are sitting on the patent for those anyway. The reality for many transgender individuals, is living the rest of their life on a regime of hormone therapy. They will have to both take hormones to repress their natural production of certain hormones, as well artificial supplementation with other hormones. This is necessary, otherwise the physical body starts reverting to its original gender characteristics. This artificial disruption of the natural balance and flow of the endocrinal yin and yang is also seen in IVF patients, when they are being down-regulated. For pre- and post-operative TG patients, as well as some other TG and queer patients, this though is a lifelong reality.

We regularly see many patients, especially female patients, who are on various forms of hormonal treatment p-pills, HRT, IVF etc., as well as patients of both genders whose metabolism is regulated through various forms of hormone therapy e.g. in the treatment of hyperthyroidism, diabetes etc. Different bodies though react differently to different hormones. The original patterns of imbalance will always play a role. TG patient are no different to say IVF patients.

Clients transitioning from male-to-female (MTF) typically may be prescribed oestrogen or antiandrogens. Oestrogen (Premarin) side-effects may include thrombosis; hypertension; thyroid dysfunction; folate vitamin deficiencies; nausea and vomiting; weight gain; depression; hepatic impairment including tumours; breast cancer; impaired glucose tolerance; migraine and other headaches; oedema; emotional lability; and gallbladder tumours. Anti-androgen (Aldactone) side-effects may include diuresis; nausea and vomiting; acidosis; rash; gastritis; hypotension; breastcancer; cramping; diarrhoea; headache; and confusion[5].

Clients transitioning from female-to-male (FTM) often take testosterone and may experience side-effects that include hypertension; weight gain; liver function abnormalities; lipid abnormalities; fluid retention; loss of menses; polycystic ovarian disease; change in blood pressure; emotional lability; acne; and liver tumours.[6]

What we have to do here is no different from what we always have to do. We have to try and interpret the affects and reactions from a CM perspective. Is this Heat? Is it Cold? Is it Dampness and Phlegm? Is it affecting the Liver? The Heart? stagnating qi? etc. The big difference here though, is that the client does not usually want to be drawn back to the original harmony of the body i.e. the pre-hormonal situation, but wants amelioration for some of the side effects of the hormones.

Do they still have ovaries and menstruation, even though they present as a male?

Again beware of assumptions. It requires tact and tone, but it is relevant to gather this information, to be able to make a complete diagnosis.

5 http://www.acupuncturetoday.com/mpacms/at/article.php?id=28252 accessed 23/01/16
6 Ibid

Chest binding and taping of genitals

Many pre-operative FTM (female to male) or TG individuals bind their breasts, so that they are less conspicuous, making the appearance more male. Tight binding of the breasts can create a stagnation of qi and Blood in the breasts.

Some pre-operative MTF (male to female) or TG individuals, as well as some transvestites tape their genitals, so that they are less conspicuous, making the appearance more female. Tight binding can create a stagnation of qi and Blood in the genitals.

Emotional stress

Emotional stress can often be an aetiological factor. The emotional stress can both be in the past and the present. It is very common for people who are TG or queer to experience ridicule, verbal abuse, sexual abuse, as well as job discrimination and social alienation. This is compounded for some, by having or having had difficulty accepting themselves for being who they are. From a CM perspective growing up feeling different and alone, not being able to communicate about how you identify for fear of rejection will definitely affect the Heart qi, but also the Liver (due to frustration) and Kidney (due to fear) can also be affected.

TG also have a much higher incidence of being physically assaulted. In a survey, 78 percent of respondents reported having suffered physical or sexual violence at school, 65 percent of respondents had experienced violence at work. Over half had experienced harassment or bullying in schools[7]. This can both give emotional trauma, as well as qi and Blood stagnation in the body.

A large proportion of TG have been alienated from their family, both alienation from parents/siblings, but also their own children, resulting in severe emotional stress. 57% of TG in the USA experience rejection and being ostracised by their family[8].

There is also the emotional stress described above, when the physical results of surgery, do not match the hopes and expectations that the person had.

All of these factors lead to TG having a significantly higher risk of suicide than the general population - 41%, which vastly exceeds the 4.6 percent of the overall U.S. population.[9]

7 The National Coalition of Anti-Violence Programs report 2014 accessed at: http://www.avp.org/storage/documents/Reports/2014_HV_Report-Final.pdf 23/01/16
8 Ibid
9 Ibid

Addendum

Discussion of gender identity in patients – e.g. breast cancer patients who have undergone mastectomy and then chemotherapy, which has caused baldness. This loss of their breasts and their hair can be deeply traumatic for many women's feminine identity.

Heteronormality in WM

One of my queer patient’s (who was born female) experience of the hospital being willing to provide him with breast reconstruction after his mastectomy for breast cancer, but not being willing to remove the other breast, because it was healthy. As well as being constantly confronted with nurses and doctors sympathy for his breast loss and not understanding his sense of relief at losing one of his female appendages.