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Transsexuals and other Gender-Variant People in Hong Kong: An Exploration of the Spectrum of their Gender Identity Formation and Transformation

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Abstract:

Through a grounded theory approach, the present paper examines the lived experience of transsexuals and other Gender-Variant people (such as Cross-dressers and TBs – a local expression for Tomboys) in Hong Kong. The aim of this study is to gain a deeper understanding of the process of the informants' gender identity formation and transformation within the cultural context of Hong Kong, and how they manage their gender dysphoria and body image issues. By comparing the similarities and differences between the lived experience of transsexuals and other Gender-Variant people, this study aspires to build a model of gender identity spectrum that can help explain gender diversity.

Keywords: gender variance; transsexual; transgender; gender identity formation; gender management; TB (tomboy); cross-dresser; Hong Kong; grounded theory.



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The Medical approach

There has been a very long history recorded in many countries of some men having desired to become women and of some women having wished to become men.¹ However, it is only since the last century when this phenomenon has started entering the psychiatric-psychological-medical arena. The term “transvestite” was first coined by Hirschfeld, at the turn of the twentieth century, for cross-dressers and to distinguish them from homosexuals (Hirschfeld, 1991). Around the 1960s, Benjamin further distinguished sex-changers from cross-dressers by popularising the term “transsexual” for the former (Benjamin, 1966). The first reported sex-change operation took place in Germany in 1931 (Pauly, 1968). But the procedure was not well known until the 1950s when the case of someone with a male birth-gender who underwent surgical gender reassignment in Denmark was published (Hamburger et al., 1953). Meanwhile, the notion of gender identity, which had been split off from the concept of gender role (Money, 1995), had also started to surface at around the 1960s. In the glossary for the book, *Man and Woman, Boy and Girl: The Differentiation and Dimorphism of Gender Identity from Conception to Maturity* (Money and Ehrhardt, 1972), Money defines the notion of gender identity as:

the sameness, unity and persistence of one’s individuality as male or female or ambivalent in greater or lesser degree, especially as it is experienced in self-awareness and behavior. Gender identity is the private experience of gender role, and gender role is the public expression of gender identity.

Not before long, the phenomenon of cross-dressing and sex-changing has become a medical problem to be understood, managed, and treated. For instance, the diagnosis of transsexualism was first introduced in the DSM-III in 1980 for gender dysphoric individuals who demonstrated at least two years of continuous interest in removing their sexual anatomy and transforming their bodies and social roles. In 1994, the DSM-IV committee replaced the diagnosis of transsexualism with Gender Identity Disorder (hereafter GID). The diagnostic criteria for GID in the DSM-IV-TR includes:

- A strong and persistent cross-gender identification (not merely a desire for any perceived cultural

¹ Cf. a brief chronicle in the website of sexuality.org:
<http://www.sexuality.org/l/incoming/trbasic.html>

advantages of being the other sex).

- Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
- The disturbance is not concurrent with a physical intersex condition.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

In Hong Kong, the first documented case of Sex Reassignment Surgery (also known as Gender Reassignment Surgery) was performed in 1981 in Princess Margaret Hospital (Ng et al., 1989). In 1986, a Gender Identity Team (hereafter GIT) was established as part of the sex clinic of the University Psychiatric Unit of Queen Mary Hospital to address the growing number of transsexual patients seeking Sex Reassignment Surgery. The treatment provided by GIT was quite consistent with the Harry Benjamin's Standards of Care which is used by many psychiatrists in many countries as a guideline to treat transsexual patients.

GIT was an organised multi-disciplinary team consisting of psychiatrist, clinical psychologist, gynaecologist, endocrinologist, urologist, medical social worker, lawyer, geneticist, and reconstructive surgeon (Ko, 2003, Ma, 1999). Its aims and functions were clinical services for transsexual patients, education for professionals in the allied mental health fields, and research (Ng et al., 1989). Between 1991 and 2001, 34 cases were referred for assessment relating to Sex Reassignment Surgery, and 28 of them were found to fulfil the DSM-IV diagnostic criteria for transsexual (Ko, 2003). Thus, on average, there were about 2 to 3 patients being referred to the GIT per year, and all patients must be referred by a practising physician or a paramedical professional such as a social worker, clinical psychologist or mental health worker.

According to Ng et al (1989), assessments by the GIT included asking the patients to write about their life story, interviews with various professionals in the GIT, patients undergoing a battery of standardised psychological test and laboratory tests. After the diagnosis of transsexualism and a decision to sex reassignment is made, the patients would then be expected to establish their cross-gender identity and live and function in society in their chosen gender. The patients would then be re-evaluated after about one year of establishing their cross-gender

identity, and if they had shown sufficient emotional stability, they would be placed on hormone therapy. After a further 12 months period, the patients would be re-evaluated with a view to possible Sex Reassignment Surgery. Patients also received psychological treatment which served both exploratory and supportive functions; for example, to determine whether the wish for reassignment is mutable and to help patients cope with negative feelings, such as alienation and social rejection, that were associated with cross-gender identity.

Despite of the achievement made by GIT, in Spring 2005, the Hospital Authority announced, to the disappointment of many transsexual service users, the closure of GIT, and the health service for transsexuals is being regionalised, viz. transsexual patients have to seek the health service in their own regions which often has no or very little experience in treating transsexual patients. It is believed that the decision was made because the public health service is facing a huge deficit.

The Critical approach

Although the Medical model, which often assumes an essentialist stance, has been the dominant approach that deals with the phenomenon of cross-dressing and sex-changing, this is not the only approach. The major critics of the Medical essentialists are the Critical theorists in sociology, Billings and Urban, for example, think that “transsexualism is a socially constructed reality which only exists in and through medical practice” (Billings and Urban, 1982, p. 266). Meanwhile, some feminist writers of the Critical tradition see the Medical approach as a way to perpetuate sex-role oppression. Raymond, for example, thinks that “a patriarchal society and its social currents of masculinity and femininity is the First Cause of transsexualism” (Raymond, 1994). At first sight, Raymond’s claim seems rather naïve, it has, nevertheless, brought out an important point that many advocates of the Medical model have overlooked, namely, the systematic consideration of their own presuppositions of sex and gender role stereotyping, and their preclusion of serious attention to social constructionist formulations of the phenomenon.

Even though the Medical approach and the Critical approach adopt different epistemic perspectives, which are a manifestation of the nature/nature debate in the sex and gender role context, to explain the cross-dressing and sex-changing phenomenon, many advocates of either

camps are contributing to the wellbeing of the cross-dressers and sex-changers through very different routes. The former often work on the individuals' level, and support the idea of easing an individual's intense gender dysphoria by modifying one's body through hormonal therapy and Sex Reassignment Surgery, so that one's body is aligned with one's gender identity.² The latter tend to work on the societal level through public education to raise the social awareness of sex and gender role stereotyping which helps improve the public acceptance of those who transgress the traditional sexual and gender norms.

The Limitations of Medical and Critical approaches

Apart from the criticism social constructionists made, there are other limitations with the Medical essentialist approach. Most notably, as a result of the focus on doctor-patient encounters, the systematic exploration of the social worlds of cross-dressers and sex-changers outside the clinic and consulting room is being precluded, the gaps include the way they make sense of their situations in work, family, medical and member settings (Ekins, 1997).

The other limitation with the medical approach stems from the way categories are being made. For instance, the diagnostic criteria for GID seems to weed out those who can "survive" without sex changing, for example, those who meet all the other criteria except not exhibiting clinically significant distress or impairment in social, occupational, or other important areas of functioning. Whilst this kind of diagnostic criteria can be justified insofar as it helps the clinician to decide whether or not Sex Reassignment Surgery should be conducted, it may also have inadvertently categorised gender non-conforming individuals into transsexuals and non-transsexuals based on some criterion (e.g. level of distress or impairment) that may or may not be relevant in describing and explaining this kind of phenomenon. I would therefore use the term "gender-variance" instead of the diagnostic categories to refer to the people that I am

² There is evidence, however, of more clinicians taking the sex and gender role stereotyping on board. Bockting and Coleman, for example, argue that their treatment model "allows for individuals to identify as neither man nor woman, but as someone whose identity transcends the culturally sanctioned dichotomy" BOCKTING, W. O. & COLEMAN, E. (1992) A comprehensive approach to the treatment of gender dysphoria. *Journal of Psychology & Human Sexuality Special Issue: Gender dysphoria: Interdisciplinary approaches in clinical management*, 5, 131-155.

researching in this study, as I want to avoid the clinical connotation that is attached to transsexuals.

I am using the term “gender-variance” as a working definition to refer to those who do not identify themselves fully with their assigned gender, whether currently or sometime in the past. This non-identification may vary in degrees among different individuals or with the same individual at different times. And it will cover a range of people that are not covered by the medical criteria of transsexuals. For example, ranging from some butch lesbians (also known as TB, which stands for tomboy, in Hong Kong) to some male to female cross-dressers to some gay men. What they have in common is that they are currently experiencing, or sometime in the past have experienced strong gender dysphoria or strong cross-gender identification, but they might or might not have sought medical help.

Although the Critical approach fairs better insofar as it takes a step back and examines the ideological basis and presuppositions of both scientific and common-sense thought (Billings and Urban, 1982), due to it being a form of grand theory through the method of ideology-critique, it does not, to use the terminology of Glaser and Strauss (1967), “fit and work” adequately. Raymond’s discussion on transsexuals is one example of how this kind of grand theory fails to be readily modifiable to account for all phenomena involved. In order to maintain her argument that transsexuals are the creation of the “transsexers” – the empire of male medics and paramedics – who reinforce the patriarchally defined stereotypes because transsexual women are trained to be models of the kind of women that men would like to see, Raymond has to bite the bullet and explains the existence of transsexual men as tokens that save face for the male “transsexual empire”.

Research Questions

The limitations of both the Medical and Critical approaches indicate the research gaps in this field. The medical diagnostic categories may be greatly limited or may even have distorted our understanding and explanation of the phenomenon. They also miss out a population of gender-variant people. As mentioned before, for example, some gays, lesbians and cross-dressers are

gender-variant in some ways but do not fit into the diagnostic criteria of gender identity disorder. Moreover, the way individuals identify themselves as a member of a particular community is insufficient to indicate whether they are gender variant or not, nor does it indicate any further description of the kind of gender variance. For example, while many cross-dressers are happy being a man, I have met at least two cross-dressers who wish to be women but due to various personal reasons, they hang out in the cross-dressing community instead. Thus, while existing categories such as TB or cross-dresser or transsexual can give us some hint on the spectrum of gender variance, they are not the precise categories that describe the phenomenon of gender variance, but rather, communities of people that have various things in common, such as sexual orientation or cross dressing behaviour.

As discussed already, the medical approach is confined to the doctor-patient encounters and precludes the systematic explorations of the social worlds of gender-variant people outside the clinical setting. Meanwhile, the Critical Approach, being a grand theory which is a top down approach, fails to fit and work adequately. Both approaches take us too far away from the empirical social worlds and the lived experience of gender-variant people themselves. So there is a need to build the theory from the data, that is to say, a bottom up approach such that categories and theories are generated directly from the data in order to build theories to explain the gender-variant phenomenon.

I have already immersed myself in the fields of gender-variant people, as a participant, in Hong Kong for about nine months. I got in touch with my informants through my personal networks, such as through some friends in the lesbian community in Hong Kong and through a transgender advocacy group, called TEAM (which stands for Transgender Equality and Acceptance Movement).

The following are my main research questions (RQs) which have been shaped by my observations, in some social gatherings, and informal discussions with my potential informants:

RQ1 – How do Gender-Variant people manage issues related to their gender identification, such as a sense of gender dysphoria and body image?

The reason why there is a management issue is that there is quite a lot of “gender policing” in Hong Kong, especially towards children. So if one does not behave in a gender

conforming way, one would often get “punished” by parents, peers, teachers etc., and there seems to be more gender policing on boys than on girls.

Different gender-variant individuals have different ways to manage their inner sense of gender identity and different ways to respond to pressures from the environment. Thus I am looking at, for example, what they do to ease their feeling of gender dysphoria. For instance, many of my informants who were assigned as male at birth tend to lead a double life especially before they make public about their gender identity issue, such that they appear male in public (including with their family), but dress as female in their own personal space. Often there were some traumatic experiences or punishment in relation to expressing their female self in public before they learnt to live a double life.

Those who were assigned as female tend to manage their gender dysphoria quite differently. There is usually less or even no punishment towards girls dressing or behaving like boys in Hong Kong, so they are usually okay to express their gender identity more freely. Thus, there is no need to live a double life as those who were assigned as male at birth.

RQ2 – What are the processes of the gender identity formation in gender-variant people in the cultural context of Hong Kong?

Although many gender-variant people seem to have started off with similar gender dysphoria, their gender identity formation may differ as they grow older. Thus, I have been looking at the recollection of their gender identification since early childhood, their concepts about gender, and other related questions. I have noticed that there is a link between one’s gender identification and one’s idea about gender. For example, some of the transsexual informants I have met tend to have very rigid notion about male and female, and they do not feel comfortable with the idea that the notion of gender can be fluid. Whereas some butch looking lesbians, especially those who are exposed to some feminist ideas, seem to have more fluid notion of gender, and some show more tolerance of the ambiguity of being neither male or female, and some are quite comfortable to identify themselves as TB.

RQ3 – What are the categories, in terms of gender identities, that will emerge from this study?

By categories, I do not mean the existing categories such as TB, cross-dressers, Transsexuals etc, which at the early stage of research are very helpful in giving me guidance to

which communities I can find my potential informants, rather I would like to generate categories to describe different types of gender-variant people from the data. It is similar to categorising different colours within the visible light spectrum, and this can be done by comparing and contrasting the lived experience of gender-variant people from different groups and communities. This study endeavours to explore and build a theory (or theories) to explain these diverse and yet very similar phenomena.

Methodology

I am using the grounded theory approach, which is a qualitative method, to generate categories and to build theories. One of the prominent features of grounded theory is its use of theoretical sampling (Strauss and Corbin, 1998). It is to sample purposively (as opposed to random sampling), and to find those people and other materials that are representative of theoretically relevant concepts. Thus one needs to have flexibility and openness.

Since the beginning of my research, I have added more groups into my samples. At the beginning, I intend to focus on post-operative and pre-operative transsexuals. However, the more I learnt about the way they manage issues related to their gender identity, the more I realise the need to study on those who also have experience of cross-gender identification but are not transsexuals, and hence my decision to recruit TB and perhaps cross-dressers as well.

Ideally, sample size will be determined by redundancy (i.e. theoretical saturation), viz. when no new information is forthcoming from new sampled units. In practice, I may be constrained by resources, such as time and number of informants available, and may have to terminate the data collection even before the point of redundancy.

In order to aid the recruitment of my informants, I am using several different sampling strategies, such as criterion sampling, maximum variation sampling, homogeneous group sampling (for focus group), snowball sampling, and volunteer sampling.

I am following the ethical guidelines for research. All participations are voluntary with informed consent. All data are handled confidentially and kept in a secure place, and every precaution measure is taken to protect my informants. With the consent from my informants,

interviews are recorded and the recordings transcribed. I plan to interview my key informants several times over my data collection period. I also plan to interview their family members, partners, or friends for data triangulation. When circumstances allow, I would like to organise some focus groups with gender-variant people of similar background, especially in terms of their gender identification and level of gender dysphoria.

As already mentioned, I have immersed myself in some of the gender-variant communities, namely, the transsexual and lesbian communities. I am open about my role as a researcher in this field, and fortunately I am quite well accepted within those communities somewhat as an insider (as opposed to an outsider) because of my own personal background. I have been participating in social gatherings, such as parties for the New Year or some people's birthdays, or at one time even a memorial gathering for someone who had passed away. I build very good rapport with the people in the communities, and do my best to make unobtrusive observation when participating the activities.

Some gender-variant people like to use a certain message boards on the internet to talk about their gender identity issues, some even build their own personal homepages. I have read those websites in order to gain a background understanding on the gender-variant subculture in Hong Kong.

Preliminary Findings

Since I am still in the process of data collection, I have not started the formal data analysis yet. However, based on the data I have collected so far, I have noticed some patterns and recurring themes. For instance, the pattern of the attempt to destroy one's genital at some point in life have been reported by some of my informants, and often they are those who would have gone or plan to go for a sex reassignment surgery. Whereas those who have a more fluid view about gender, for example, those who have bought into the post-modern feminist ideas, may be able to tolerate the ambiguity of not being a man or a woman as traditionally classified.

Other patterns include the belief of metaphysical or religious beliefs that help ease one's gender dysphoria. For example, the belief of reincarnation leads some informants to think that the reason they feel they should have been a certain gender is that they were born that gender in

their previous lives. Some other gender-variant people seem to come to terms with their gender dysphoria as God's will or a result of some previous karma.

My data have indicated that gender-variant people from different groups/communities share some similarities in terms of their gender identity formation, especially during the earlier stages of their lives. So far, nearly all gender-variant informants I have spoken to claim to have cross-gender identification since early childhood. However, not all of them maintain the same gender identification as they grow older. These changes may be related to the way they conceptualise gender, differences in the way they were socialised, and different ways to manage their gender dysphoria.

For example, the level of gender dysphoria and gender nonconforming behaviours among TBs and male-to-female transsexuals are quite similar. Nevertheless, the way they conceptualise their gender identities and manage the issues regarding their gender identity may be quite different. While many TBs are happy or accept their daily nonconforming gender performance, for example, they tend to maintain masculine attires, some bind their breasts, and some are into hobbies that are popular among men; many of these TBs, however, feel uncomfortable to continue their cross-gender identification even if they used to identify themselves as boys when they were children because they no longer buy into the rigid binary gender system. And some take on the identity of a TB as their gender identity instead of the gender identity of a man.

Many male-to-female transsexuals, on the other hand, hold the binary gender system and feel uncomfortable to be somewhere in between on the gender spectrum. This is usually one of the main reasons why they would seek surgery in order to allow them to be a complete woman without any ambiguity.

Many male-to-female transsexuals have cross-gender identification since an early age, but many dare not perform their gender as women in public before they started their transition to become a woman. Many male-to-female transsexuals seem to have very little avenue to ease their gender dysphoria before their transition because there is greater "gender policing" in the Chinese community, in terms of social disapproval, against men behaving in a feminine way rather than vice versa, i.e. for female to behave in a masculine way.

Many natal females, on the other hand, find less pressure from family or society to conform to the gender norms. TBs are tolerated or even welcomed by their peers at many primary and secondary schools, some single sex schools have a very prominent TB culture in Hong Kong. Thus, natal females have a lot more avenue to ease their gender dysphoria.

My Tentative Model

My initial findings seem to support my hunches that gender-variant people belong to the same axis, or gender spectrum, insofar as they have cross-gender identification and dysphoria with their birth gender. However, different gender-variant people occupy different positions on the gender-variant spectrum, and the positions are related to how individuals conceptualise gender, and both their concepts of gender and how they manage their gender dysphoria affect their own gender identification and gender performance. Thus, for instance, many transsexuals may be on one end of the gender-variant spectrum, whereas many TBs and some cross-dressers may be on the other end of the spectrum. With these hunches in mind, I will continue my data collection to see whether it supports my initial model.

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