

CHALLENGING IDENTITIES



WRONG BODIES AND REAL SELVES:
TRANSSEXUAL PEOPLE IN THE HUNGARIAN
SOCIAL AND HEALTH CARE SYSTEM

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This paper presents the main findings of the first descriptive sociological study of the situation of transsexual people in Hungary.¹ The research project was initiated by the Háttér Support Society for LGBT People in Hungary in 2003 and funded by the Ministry of Health, Social and Family Affairs. The main goal of the research was to explore the official and medical possibilities for gender transition in Hungary by analysing how transsexual people as well as medical experts and other professionals perceived the functioning of “the system,” i.e. the system of gender transition and related services.

Methodologically the project was based on a preliminary self-administered questionnaire survey (N = 39) publicised mainly on the internet,² followed by the collection of semi-structured interviews in the case of transsexual people (N = 17)³ and structured interviews in the case of professionals (N = 10).⁴ Our transsexual interviewees were mostly people who had filled in the questionnaire. Further interviewees were contacted through respondents. In seeking out professionals for interviews, we relied on the list of professionals posted on TransSexual Online. In addition, information obtained by questionnaires and interviews, we also used written accounts from transsexual people.

Considering the transsexual respondents, our target was to reach persons who have entered or intended to enter the health care system, and

¹ The full research results are available in the book *A lélek műtétei* (Surgery of the Soul) in Hungarian—with an English summary (Takács 2006).

² The questionnaire was published on the websites of TranSexual Online <<http://tsonline.uw.hu/>>, pride.hu, hatter.hu. Calls for transgender respondents were also published in the printed press (*Mások, Magyar Narancs*).

³ Age range: 19–77.

⁴ Eight of the professional interviewees take part or have taken part in the health care provision for transsexuals as psychiatrists (4), a clinical psychologist, a surgeon, a urologist and a geneticist. A sociologist and an ethologist were also interviewed: although their activities were not closely related to the health care services available for transgender people we hoped to get additional insight from their fields.

who have considered, started or completed gender transition in their lives. Thus instead of relying on a purely medical definition of transsexualism,⁵ we have focussed on the self-definition of our respondents.

TRANSSEXUAL PEOPLE'S PATHS

Analysis of interviews conducted with transsexual people was inspired by a social constructionist—and especially the ethnomethodological—approach as well as Breakwell's social-psychological theory of identity processes, with special regard to threatened identities.

In modern Western societies people's genders are assigned according to socially approved, acquired rules based on externally visible physical/biological features. A child will get assigned one of the two genders according to its genitals. People's gender identity will in the majority of cases be defined by the group membership acquired at birth. The formation of the gender identity is a process in which a person self-assigns such group membership. In the case of transsexual persons the assigned and self-assigned genders do not coincide.

As practical experience confirms the validity of external (social) assignment of gender, people who grow up in conflict with their assigned genders are left with transitioning into the "opposite" of their birth gender. In this context of real dichotomies, a "real" transsexual will be a person who undoubtedly changes their physical sex by appropriate genital surgery. The ethnomethodological approach, however, reveals that although we live in a fundamentally two-gendered world, this is not the only possible world (Kessler and McKenna 1978, 40).

Inquiring into transsexuality, we need to pay special attention to the processes in which transsexual people build their identities. Uncertainties around gender identity may be linked with problems in socialisation, and may lead to difficulties in adult re-socialisation. A failure in the external gender assignment may result in early feelings of difference, strangeness, "abnormality." The individual in such a situation may be

⁵ An internationally recognised definition of transsexualism is found in the International Classification of Diseases (a publication of the WHO): 1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment. 2. The transsexual identity has been present persistently for at least two years. 3. The disorder is not a symptom of another mental disorder or a chromosomal abnormality. See <http://www.genderpsychology.org/transsexual/icd_10.html> (5 December 2006). Another "tool" for diagnosing transsexualism is found in the publication of the American DSM-IV, under "gender identity disorder." (DSM-IV. 302.85 referring to adolescents and adults. See <http://www.genderpsychology.org/transsexual/dsm_iv.html> (5 December 2006)).

threatened by the normative expectation of their social environment, which would signpost the path to a well-socialised lifestyle.

Identity threats may be experienced by anyone: in a sense, every identity is threatened, as an individual will in all their life face challenges that threaten their identity (Erós 2000, 81). The seriousness of the threats, however, can be largely varied. Breakwell examined factors threatening the principles of the basic processes of identity such as *distinctiveness*, *continuity* of identity, *self-esteem* and the *desire for autonomy* (Breakwell 1986, 23). Breakwell's theory of identity threats is applicable in a practical investigation into problems of identification around transsexuality. Prior to transition, transsexual individuals commonly experience the feeling that the continuity of their identity and their self-esteem are threatened. At the same time, their individuality, distinctiveness may reach such a degree, that they are unable to (re-)integrate into society.

DEVELOPING THE CONCEPT OF TRANSSEXUALITY

The word "transsexualism" was coined by the German sexologist Magnus Hirschfeld,⁶ but the term with its contemporary meaning—referring to a possibility of physical gender transition—first appeared in 1950 in the American surgeon, David O. Cauldwell's "Questions and Answers on the Sex Life and Sexual Problems of Trans-Sexuals": "Trans-sexuals are individuals who are physically of one sex and apparently psychologically of the opposite sex. Trans-sexuals include heterosexuals, homosexuals, bisexuals and others." However, Cauldwell did not believe in treatment offering alterations to the body, which he referred to as "mutilative operations," being a sign of the lack of mental equilibrium (Cauldwell cited by Meyerowitz 2002, 44).

During the first half of the 20th century the work of Harry Benjamin—German endocrinologist who lived and practised in New York—greatly contributed to the growing medical-scientific awareness around transsexuals' specific problems. Benjamin was convinced that psychotherapy could not help transsexuals whose problems could be resolved only through medical intervention: in his view it was evident that if "the psyche cannot be brought into sufficient harmony with the soma, then and only then is it essential to consider the reverse procedure, that is, to

⁶ Hirschfeld applied the umbrella term *transvestite* (referring to a much wider category than it does today) to people who we now call transgender or transsexual (Hirschfeld [1910] 1991). In the 1930s, the British sexual psychologist Havelock Ellis used the term Eonism (after the name of the 18th century French diplomat Chevalier D'Eon) to describe people who did not simply dress as the other gender, but felt that they belonged to that gender (Ellis 1936).

attempt fitting the soma into the realm of the psyche” (Benjamin cited by Meyerowitz 2002, 113).

As gender reassignment processes became more accessible in the second half of the 20th century, there was a change in the definition of transsexualism. People who sought to change their biological sex were considered “patients” rather than “psychopaths,” and the definition of transsexualism started to include the personal need for practical transformation that had previously been dismissed as dreams or fantasies. In 1968 the American psychoanalyst Robert J. Stoller defined transsexualism as “the conviction in a biologically normal person of being a member of the opposite sex. This belief is these days accompanied by requests for surgical and endocrinological procedures that change anatomical appearance to that of the opposite sex” (Stoller 1968, 89–90).

In the 1960s Stoller began to use the expression (social) gender identity in the sense of psychological sex. The new terminology made it possible to separate *sexual identity* (linked to sexual practices and fantasies) on the one hand, and *gender role identity* on the other hand, reflecting the expectations of the society (manifesting themselves in masculine and feminine modes of behavior), and what individuals feel towards their gender identity, related to their being men or women (cf. Stoller 1968).

In 1990 the feminist theorist Judith Butler pointed out that the presumption of the internal coherence of identity, which is manifested in the opposition of asymmetrically divided female and male characteristics in the cultural matrix of gender norms, and in the “heterosexualization of desire,” is illusionary, and more and more untenable: there is no necessary causal link between a person’s sex, culturally constructed gender roles, their sexual desires, and sexual behaviour (Butler 1990, 23). Butler considers the querying of this virtual coherence to be the deconstruction of identity, which may lead to the formation of a new type of (identity) politics.

From the 1990s onwards, the social concept of transsexuality (to be distinguished from the medical concept of *transsexualism*) has been transformed mainly by the emergence of the transgender—or as Sandy Stone puts it *post-transsexual* (Stone 1991)—movements relying on post-modern *queer* theory that institutionalises scepticism towards categories previously thought to be absolute. This has allowed transsexual activists to form coalitions with other sexual- or gender-diverse people. The central element in these movements is the struggle for the freedom of expression, which may focus on several areas from the social constructionist interpretation of biological sex through more abstract questions of social justice to matters of human rights and anti-discrimination.

WRONG BODIES AND REAL SELVES

While in social scientific theoretical discourses it has almost become a commonplace to analytically separate (biological) sex, gender and sexuality, that is, to acknowledge that one's sex does not necessarily define either one's gender or one's sexual identity, everyday life experiences are still dominated by expectations about identity coherence at least sex- and gender-wise.

On the basis of analysing the interviews conducted with self-defined transsexual people one of the most important characteristics of transsexuality seemed to be the lack of harmony between the individual's external, bodily appearance and inner self, self-image. This lack of harmony was expressed as having the "wrong body," which the individual sought to change.

Basically, I am a woman in the wrong body. I think this is what is called transsexualism. And in short it is about this: one has a mind that does not match the body (9).⁷

I turned to him [the GP—general practitioner] with the problem that I felt I was born in a completely wrong body, and that this needs [to be] changed, as someone had to leave this body, it is not enough for two (3).

This is a condition that does need to be changed. This is [as if] . . . I had an extra hand that was a hindrance. Therefore I am simply asking competent people to change this. It is as simple as that (6).

The need to alter the body was connected with the interpretation of transsexuality as illness, congenital condition or condition to be remedied. Most transsexual respondents were aware that to change their bodies they need medical intervention and that in contemporary Hungary transsexuality was classified as an illness called transsexualism. At the same time, they were aware that this is not an "ordinary illness," and several did not think they were ill.

I would not say that I am transsexual therefore I am ill. This is a condition that does need to be changed (6).

I don't see myself as ill, I think this condition is more of a birth defect that current medical science can address in order (8).

The problematic construction of gender categories may have led our transsexual respondents to widen the spectrum of interpretation of their gender (for example: differentiate between bodily, genetic, psychological sex, gender and sexuality), and recognise the existence of degrees and diversities of being transsexual.

⁷ In order to protect the complete anonymity of our respondents we assigned them each a number.

It is important that people become aware of the loads of variations. Some don't mind what their genitals are like, they could be somewhere in-between, but definitely not female. Some are happy with female genitals. Some will need male genitals at all costs. Some can reconcile with their female genitals and would only go for surgery if that could have a very good result. In this respect there are millions of in-between states . . . There are countless individual shades between male and female (8).

Transitionality seemed to be a key concept in defining transsexuality. This can refer to birth sex—as a previous reference point for identification—, the transsexual condition and that these may be “over.”

I, too, was transsexual up to my surgery, that is, . . . well, opinions differ as to who considers what . . . I consider a person transsexual until they exclude this issue. Technically I am an infertile woman. . . . All in all, I think one is transsexual until they have dealt with this issue [the surgery] (2).

Another experience of transitionality was expressed by respondents when other possible categories of identification appeared in previous constructs of identity such as hermaphrodite, transvestite, homosexual.

Well, the first thing was to think of transvestitism. . . . But . . . it became apparent that there is a great difference between transvestites and transsexuals; it wasn't only the question of going out being “full girl” at the weekend—that in fact is less preferable than weekdays when I am not in “full girl mode” . . . lots of people treat me like a girl . . . that means a lot more (1).

After I had achieved some status of being a gay man, I started to realise that that was not it after all. There were complications. . . . I wasn't satisfied being attracted to men, and that everyone respected this, I also had to add that there is something wrong with me: I am not entirely a boy. And bit by bit I started to go around in women's clothes and all. There was a time when I thought I was a transvestite, but I think it was only a phase . . . in the end I managed to clarify it for myself what was really all about: that I am a girl, and I diagnosed myself as transsexual. After that, things had been going pretty smoothly, slowly but surely (12).

Transsexual identity processes appeared to be discontinuous: statements like “I used to be male/female, but I no longer am” or “I used to be transsexual but I no longer am” could be interpreted as attempts at the elimination of a past status that may have been characterised by a disturbing sense of distinctiveness logically resulting in the desire for integration. In these cases self-esteem could be gained by a toning down of distinctiveness, the negation of difference.

In the case of transsexual people their practical life managing strategies can reflect queries concerning the coherence of biological sex, gender roles and sexual practices. Among transsexual people we inter-

viewed there were two different types of resolution to this situation: the first group was most concerned with “putting right” their biological sex. For them shifting—from the inappropriate biological sex to the appropriate one, from the “wrong body” to the right one—within a mutually exclusive two-sex/gender paradigm was seen as desirable.

I think I would be quite self-giving, as far as I can see it. I would try to give everything that a man and a family need, all a woman is expected to do: that she should keep the family together really . . . with her love and her understanding and sympathy. And there are the accidental things like housework and the like besides others (3).

For members of the other group fitting into the social gender system became problematic because they experienced inability and/or unwillingness to integrate into the existing sex/gender paradigm.

I have to a certain extent managed to make my peace with the two halves of the world that there are women and men. And I have managed to shed light on the fact that if so and it is absolutely and inevitably necessary—as this is a whole terrorist system, even if you only go out into the street you face the question whether you are a man or a woman—where I put down the coin. . . . Because I am really so much between the two that if I don't say anything, people start wondering. And then you can have the so-called objective criteria and the like, but I don't even want to apply objective criteria. Applying my subjective criteria I am saying that I am not a woman. I have no choice, I am a boy. I have no other choice. And if I had another choice, I would be neither male nor female (10).

Thus while members of the first group were busy re-arranging their own (sex/gender) coordinates within a system they accepted without criticism, the others were actively criticising the system itself. (As it will be indicated later, in Hungarian medical practice the first group of transsexual people seems to be preferred.)

Homosexuality as a transitory—previous—identity category was part of some transsexuals' understanding of themselves. Some came to define themselves as homosexual because the term and concept of transsexual was unknown to them.⁸

I first heard about transsexuality when I was sixteen or seventeen. Up to that point I had not known that such a thing existed and I thought that I was a lesbian and that was all there was to it (15).

⁸ For our respondents the Internet was the primary source of information on transsexuality, the basis of further enquiries. The importance of the information accessed via the internet cannot be overestimated. State-of-the-art specialist literature or information is almost non-existent in Hungarian, and the field was unexplored in public discourse.

This was an enormous taboo in the family. And I had not known anything, of course. I had not been clear about the basic concepts. . . . I consented to be something. First there was the homosexual, then there was the transvestite (*sighs*), but really the first shock when you realise who you are—[happens] when you go to a place like that. Go clubbing. . . . And that's where I realised the state of things. That's where I realised that a gay guy is really proud of his male body. Probably very masculine, trains and works out. So that's where I realised all these things. And that a lot of them have a thing about showing themselves. I mean the ones that have come out. And they are looking for guys like themselves—with similar masculine bodies. . . . Well, I immediately realised that this is—not (*laughs*)—that this is not what I am (3).

Homosexuality is a phenomenon more widely known than transsexuality, thus occasionally it may have served as a “cognitive introduction” when explaining oneself to others, for example, to parents. In such cases homosexuality might later become a negative point of reference. Despite the unfavourable public opinion of homosexuality, our respondents thought that homosexuals' situation was better than transsexuals'. Homosexuality was “better off” by being more widely known and more “institutionalised” than transsexuality. It was also noted that the “gay infrastructure” may sometimes be more open and inclusive for transsexuals than the “straight world.” In some cases the advantage of being in a gay/lesbian environment was that it gave “shelter” from the ordeals of the “traditional hetero world” and at least temporarily provided manoeuvring ground for transsexuals in search of their identity.

[My mother] still believed that I was a lesbian, and I tried to persuade her to come with me to see the doctor then he would tell her all about it. But she didn't want to come along, because she was stubborn; she did not care, it was my own business, she wasn't interested; so I started to tell her about this thing bit by bit. She still didn't understand. . . . My study group at uni know everything . . . and accept it. They accept this, although nobody knew about it previously. I thought it was strange that someone ages with me should not know about this. . . . They know about transvestites, lesbians, but not about this (15).

Lesbians or gay men are better off in a way, as everyone understands what they are about. And I never stop explaining things to even the most well-informed of people. . . . People talk more and more about gay men and lesbians. They have also heard about transvestites, but they don't know the difference between people who just dress up when they feel like it and people who want to change their gender. But it would be great if they understood this (5).

And today I say that I wish I was gay because I know lots of gay people and their life is extremely easy, lot easier in a way that they go between worlds. . . . It is extremely easy, as they know what they want. It is fascinating that it is me saying all this. I too know what I want, but it is . . . not possible. Biologically my body is unfit, and then

here we are, wondering why not—(*sighs*) because I would not be fit to do a lot of things afterwards either. And I will not transition for the sake of a guy. So I should do it for myself in the first place, but I am fine as I am for now (11).

However, we detected points of conflict between transsexuals, gay men and lesbians. Our interviews showed that in some cases gay men and lesbians did not respect or listen to the self-identification of transsexuals among them, the main factor of classification for them being the gender of the preferred sexual partner.

When there is a gay male company and a gay female company, that is almost nearly the same. Especially now I don't frequent gay female company because they say that whoever thinks I am a man is either stupid or blind. . . . So they classify me as butch and that I can bear for a while. . . . I clearly present a very strong stereotype, that lesbian females are very, very masculine. But this is not the case with me. By the time I explain this, that they should not see lesbian women through me because I am not one, because they are on the wrong track, the sun goes down (10).

In contrast, transsexuals, who have realigned themselves according to the heteronormative gender paradigm, drew on the “normality” they achieved in opposition to aspects of homosexuality they saw as socially transgressive.

I am an average, normal man, who rejects the notion of any sexual deviance. I don't frequent gay company. For example, at the festivals, a muscular man with a well worked-out body puts on feminine make-up. This is part of the gay world, but because the media like to pick this up, transgender people are judged by the same standards and this is obviously harmful for the case [of transsexuals] (8).

I think that instead of difference, it is sameness that needs emphasising in transsexual existence. For example, my problem with gay people too is that they should not shout about how different they are; instead, they should shout about how bloody similar to everyone else they are (2).

Nearly all of our respondents reported to have experienced signs in childhood or adolescence that could strengthen a gender identity different from the average. In this context the two areas most frequently referred to were clothing and the relationships with members of the other gender. Rejection of expectations relating to gender-specific appearance, for example clothing and hairstyles, was interpreted as rejection of the gender assigned at birth. In retrospect, many respondents considered their relationship with members of the opposite gender a sign of their transsexuality.

I put on my mum's clothes, underwear and the like (*giggles*). This is standard, so to speak. And as soon as—when I was alone and all, I put on women's clothes—of course, not in public—as they say in the United States, I was a “closet queen” (16).

According to their current perceptions, they “worked in line with their real gender.” This type of adolescent or young adult experience was characterised by insecurity and confusion as it soon became clear that it did not fit the social expectations. To avoid individual and community sanctions for transgression of norms related to appearance and behaviour towards the opposite gender, on the interpersonal level some chose isolation or “assimilation,” while on the inter-group level they maintained multiple affiliations. For some time some individuals appeared publicly as members of their birth sex and tried to be successful in certain areas of life, such as studies, professional and community life. At the same time, they tried to organise their private sphere according to their “true gender.”

I remember that I started fantasising about being a boy—what I would play, how I would behave—, and then I made myself a whole fantasy world . . . [with] the people in the real world in it, only I was different. I was a boy . . . and I spent a lot of time daydreaming like this (4).

The need to harmonise the two worlds caused our respondents to decide to take steps to eliminate the confusion caused by ambiguity and to actualise themselves.

It culminated in me telling my dad . . . this time last year that I would put an end to this (smiles), as I could not live like this any more. Well, they had known for long—my parents—about me. And then I decided that this year 2003 was going to be a good time for decision-making about what I should do about this. . . . Because it was already obvious that I would have to do something. Because I was going down too deep and—that was not good (3).

School was often the first institutional scene where practical problems arose from non-average or non-conformist self-identification. While gaining acceptance from the family—one or both parents and siblings—may have taken place over a longer period in several steps leaving conflicts latent or unspoken, in the more formal school environment they became more apparent. Primary or secondary school may have been inefficient places of socialisation for our transsexual respondents, as they posed expectations from teachers and peers that these individuals did not want to or could not conform to. Experiences included isolation from peers, not being understood, sanctions for the transgression of formal expectations and exclusion.

They tried to ostracise me or exclude me; I could not play with them for various reasons . . . they told me I was queer and such things . . . well, I did not feel I was one, because—I don't know, it was such a shame for me that I withdrew. I became an introvert. I was a not more of a loner. And of course, I became more aggressive as well, and I tried to retaliate (15).

Gaining acceptance within the family was an ongoing struggle parallel with school conflicts, if the family had any knowledge of such problems. One obstacle to “coming out” in the family may have been lack of knowledge about transsexuality on both sides. Parents did not seem to want to acknowledge their children’s “difference.” Some tried to make them behave “the right way” trusting that the problem would be just a phase. Some respondents reported parents’ fear of the reactions of the wider environment, some experienced total rejection when parents did not want to face possible or realised consequences of gender transition.

I thought that my family would tolerate this and all would be fine. It did not even occur to me that this might not be acceptable . . . so I came out with it to my family and I was kicked out of the family home. And there I was, completely lonely (2).

I told them I had taken steps to officially change my name and gender. And they were completely shocked and said what else could I be but a girl, and then I said I had been to a psychiatrist who then passed me on to a psychologist and that was the point I was at, in the middle, or rather towards the end of that consultation, and soon I would have my first referral. . . . And then my father got very violent and shouted that everyone who assists me in this should be killed (10).

Rejection was the most often mentioned reaction from the family. This could appear in the form of denial or rephrasing the problem. Rejection could in some cases be followed by “reconciliation.” This generally took place in the phase of medical intervention, when the first changes to the body made clear the irreversibility of the situation. After several years of struggle some had experienced practical signs of acceptance. In our interviews, acceptance by the family was mostly discussed in relation to the parents. We only had one respondent who had to communicate the start of gender transition to their biological children. Some respondents had considered that they may in the future talk openly to their own or their partners’ children about their transsexuality. Our respondents understood and to a certain extent empathised with their families’ difficulties in coming to terms with transsexuality. They also knew that their needs were not everyday needs.

I can understand [my mother’s negative reactions]; after all, she was raised in a completely different social atmosphere, she may well experience this as a trauma. . . . She



had not been raised in a discriminative family, or what not, simply at the time when she grew up, there was hardly any awareness that people like me exist (12).

I can hear their fears. That there is a healthy body, and why does a healthy body want to be cut up? Of course, one tried to avoid the doctor as far as surgery is concerned, if we look at it from a healthy perspective (6).

Some even thought that their parents could benefit from psychological help and specialist information they could familiarise themselves with the phenomenon of transsexuality, become more sympathetic, stop blaming themselves, and prepare for their offspring's impending changes.

I thought about the matter and told my mum that we should look for a psychologist for her, . . . whom we would both see, because she must be having a hard time. . . . I simply cannot talk to her about this. She is starting to show more understanding, but . . . this is hard to overcome. To come face to face with the fact that . . . she had raised a girl for eighteen years, and then it turned out that it was not a girl but a boy and wants to have sex reassignment surgery. It is hard (13).

Partnerships provided the main interpersonal space for gaining acceptance. Our respondents thought that well functioning partnerships were based on openness, i.e. giving up within the partnership isolation and assimilation techniques otherwise used in relation to the wider society. Our respondents thought that openness was also important in interpersonal relationships within the family, but as one's family is a given and they cannot be "swapped," in some instances our respondents could not build with them an open relationship based on mutual understanding and acceptance. In a partnership, however, acceptance of the partner was a basic requirement, thus the well working partnership could be interpreted as proof of interpersonal acceptance. Accepting partners usually gave a supportive background to the individuals who were transitioning.

I never felt secure enough to think that I could do it all on my own. I definitely needed someone to stand by me and not to influence my decisions, someone to simply support me. And I am very sure that everybody needs that. It gives you incredible strength and the feeling of security (6).

Gaining acceptance was not an issue for individuals within partnerships, as acceptance was the very basis on which the partnership was built. Some respondents experienced problems in connection with their inability to accept their "wrong bodies," "less than 100%" specific gender status and/or performance, especially in sexual practices.



[The most difficult thing is] sexual life. Definitely. That for example, I don't undress—I would like to, but I never had the inclination to do it like this. Otherwise I would really like it and all, but—not like this (5).

Perhaps [the most difficult thing was when] my partner cheated on me with another man. . . . I knew that he was a hundred percent man and I was not. I knew that I could not give her what he gave her. Never. I would never be able to give her that (15).

Sex—or the lack of it—as a problem led some respondents to report “asexuality” as their main experience, this became part of their understanding of their own identity.

Most respondents envisioned “average, ordinary” lives they wished to achieve in the future. In connection with this, gender transition was thought to be a prerequisite for a “simple, normal” life, ridding the individuals of an overwhelming and disturbing sense of distinctiveness.

I have no great expectations—[just] basic things like I think a normal average person is able to get. And to be recognised—[that] when I introduce myself and say my own name and in the meantime I can see a big question mark on their faces—so I would like this to be average. This is all I would like. I don't think that's much to want to achieve (7).

One of my dreams is to have a family I can be with, meaning a wife, child, and a job, and that's it. I would try to live an ordinary life (15).

The contents of an envisioned normal life, of course, were very varied. Most respondents tried to achieve an “average, ordinary” life by turning to the health care system.

TRANSSEXUALITY AS “ILLNESS”—INTERVIEWS WITH PROFESSIONALS

Almost all of our experts agreed that the main characteristic of transsexuality is the need for the harmonisation of body/soul, outside/inside. While some psychiatrists picture a transgender spectrum allowing for the possibility of successful psychotherapy in some cases, others—the surgeons and one psychiatrist—argued that in transsexual cases the only solution was physical, surgical intervention. One expert contended that prejudices and false views of both medical professionals and lay people—which would also be worth researching—make it difficult to clearly define transsexuality.

“Cure” in the treatment of transsexual patients may involve the alteration of a medically healthy body as a result of which the patient has to

remain in contact with the health care system in the future: they may undergo life-long hormone therapy; their hormone levels would then need regular check-ups; different phases of gender realignment surgery may be followed by revisions, especially in the cases where the original surgery fails.⁹

DIAGNOSTIC CRITERIA OF TRANSEXUALISM

Within the discourse of transsexualism as illness, the international literature uses the term *gatekeeping* to describe the function that the specialist, mainly the psychiatrist or various officials and the surgeon fulfil in the life of the transsexual person who enters the health care system (cf. Raj 2002). Persons wishing to change their gender need to convince the health care professionals of their transsexuality and thus entitlement to gender-realignment treatment. Recognition of this entitlement mainly depends on who the specialist considers to be transsexual.

Some of our professional interviewees highlighted the importance of *differential diagnostics* in diagnosing transsexualism. The diagnosis has to exclude mental illness, transvestitism, homosexuality, intersex conditions, personality disorder and that transsexual identification should be a covering story of another problem. Homosexuality and transvestitism were mentioned the most often in opposition to transsexualism.

Only a few experts described transsexual identification as a stage in the development of the personality asserting that the transsexual condition of the individual has a history, which cannot be regarded independent of the social environment. The transsexual individual's path (as confirmed by our interviews with individual respondents) often leads through membership of categories that medical diagnostics seeks to exclude, for example, homosexuality.

⁹ The WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." See <http://www.who.int/bulletin/bulletin_board/83/ustun11051/en/index.html> (5 December 2006). It is also described as the "ability to lead a socially and economically productive life" (cf. Declaration of Alma-Ata. See <http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf> (5 December 2006)). These definitions of health reach beyond the disease-centred approach used by WHO in ICD-10, where transsexualism is classified specifically as a "mental or behavioural disorder." Our transsexual respondents most often emphasized the lack of harmony of body and soul when describing their past or present condition rather than any mental or physical illness. Throughout our research, we are concerned with issues of health rather than solely issues of medicine. We do not aim to dismiss the value of any medical treatment requested by individuals who wish to transition to improve their own physical, mental and social well-being.

PRACTICAL ASPECTS OF IDENTIFYING TRANSEXUALISM

Theoretically, the patient's transsexualism is diagnosed with the help of a set of criteria and tests. Our interviews revealed that in the absence of official guidelines the professional in question will determine the appropriate procedure to safely diagnose transsexualism based on his/her insight and experience. These psychological, psychiatric practices may be very diverse.

In diagnosing transsexualism, it is essential that the health professional should accept the credibility of the patient's transsexual self-representation. Some professionals for instance accept only total inability of the transsexual patient to socially integrate in the sex they were assigned at birth. Some patients may be labelled "media-transsexuals" or "livelihood transsexuals," because they talk about their lives and transition stories in the media. It is widely presumed that transsexual people will hide their condition from the world. Stronger than average conformity to gender stereotypes, rejection of or alienation from the gay subculture and heterosexual choice of partners are also among the credibility criteria. Some claim that "real transsexual people" will have had no sexual experience in their birth sex. Fulfilling professionals' expectations regarding sexual life may in some cases be a necessary survival technique for gay, lesbian or bisexual transsexuals: having been informed by others, they often conceal their same-gender attractions from their specialists.

The pursuit of all possible kinds of gender realignment surgery seems to be another significant credibility criterion. According to this, the transsexual individual wants to have surgery even if science or the expertise and technology available within the national health care system cannot perform it on the required level. Fulfilling this criterion can be a serious health hazard and may have high costs. Some specialist will doubt the patient's transsexuality if the patients consider their own needs at the beginning of the transition process, and feel that they can wait with certain treatment until it is safe to perform. Patients with this attitude may find it more difficult to obtain a referral for treatment, without which the most basic official changes—change of name and gender on the birth certificate, change of school certificates—essential for everyday life cannot be made.

THE ROLE OF HEALTH PROFESSIONALS IN THE TRANSITION PROCESS

While transitioning, the transsexual patient is in contact with health professionals specialising in different fields of medicine. The longest contact may be established with surgeons and endocrinologists. Specialists in

medical fields relevant to phases of gender transition know each other only indirectly or not at all. Specialists, focusing on their own specialised fields, often do not have a holistic picture of transition and may know little of other procedures relevant to different stages of transition. After the psychiatrist has given referral, the plastic surgeon, the endocrinologist, the gynaecologist or urologist will treat the patient's body without any contact with the professional who gave the referral. Surgeons specializing in different fields perform gender realignment surgery in ad-hoc teams depending on whether or not the hospital in question is willing to accommodate the surgery. The specific experience of surgeons is typically limited to a few Hungarian transsexuals.

Our interviews revealed that there were no official guidelines or protocol for the procedures to be followed in the case of transsexual patients. From psychiatrists to surgeons each health care professional will follow their own considerations. At the time of the research an official at the Ministry of Health, Social and Family Affairs confirmed in writing that there was no legal structure for gender transitioning in Hungary. On one hand, the lack of protocol makes surgeons more careful in performing irreversible surgery—every referral is checked several times. On the other hand, the lack of regulation in performing treatment may involve serious health hazard. The letter obtained by the research team from the relevant official in the Ministry also confirmed the lack of guidelines as to how and within what time the results of surgical malpractice should be revised.

Patients wishing to undergo gender transition must mainly count on themselves to find the way from one health care professional to the other within the health care system. Their main obstacle is the complexity of the system.

SUCCESS AND FAILURE IN THE CLINICAL RELATIONSHIP

The success of the health care professional in the context of transsexualism may best be measured by the happier and more balanced life of the patient, who can feel that their soul and body are in harmony and that they do not have serious conflicts with their environment because of their ambiguously gendered appearance. As psychotherapy cannot “cure” transsexuality, neither can it successfully teach the individual to live with this condition, surgical intervention is often necessary. Transsexual people often hope that such treatment will improve their life.

Some professional respondents highlighted that medical treatment should begin with appropriate referrals, as the success of the treatment

depends on the correct diagnosis by the psychiatrist as much as on the realistic expectations of the patient. According to these views, it seems to be equally important that the transsexual individuals should successfully integrate into society in their self-identified gender, if possible, even prior to treatment. These professionals believed that after a series of successful surgeries the patient would leave the transitory, transsexual condition behind.

The course of treatment that is to bring peace of mind, however, is prone to failure at several stages. Psychotherapy could assist patients in dealing with unsuccessful surgery. Very few, however, turn to psychotherapy. In this case the lack of regulation or official guidelines is unhelpful, as no one offers transsexual patients psychotherapeutic assistance at the post-operative stage and no one encourages them to seek such help.

If surgery does not bring satisfactory results or fails, the transsexual patient—at that point clinically ill—has a lower chance of survival than before they began treatment. The situation may be further aggravated by the knowledge that there is no guarantee of surgical revisions.

DIFFERENCES IN PRIVATE AND STATE HEALTH CARE

In Hungary gender realignment treatment is available both within the state health care system and privately. At the time of the research there was no institution with the obligation to accommodate gender realignment surgery, and there was no nominated specialist in the state health care system whose remit included dealing with transsexual patients. Specialists who might have the expertise did not necessarily empathise with transsexuals' specific problems.

In Hungary, recent official information on gender realignment options can be obtained from the Department of Health Policy in the Ministry of Health in the form of a standardised letter (being the only—and not too convincing—evidence that the ministry tries to fulfil the role of provider of information and guidance). However, the official letter does not specify whether psychiatric or psychological referral can be obtained only from the two specialists mentioned in it, who else might be approached for referral; whether the specialists named will see the patient in the state scheme or privately, or whether there is a consultation fee. Our research findings showed that the specialists named in the standard letter from the ministry would in the majority of cases see the patient in their private practice. This practice may suggest that the ministry directs patients to private health care, or indeed that the state health care system is not aware of specialists who will treat transsexual patients within the

system. Patients might reasonably expect to be informed that they may not access state health care.

Transsexual people informing the research told us that professionals in the system are highly likely to refuse to see transsexual patients. Reasons given include lack of expertise and this attitude may stem from an unwillingness to treat another doctor's patient. Such experiences usually cause the transsexual patient to turn to private health care, where the professional's positive attitude can be "bought." Due to the costs involved, however, this is not a feasible solution for many.

Gender realignment surgery requires special expertise grounded in professional experience. In the last decade—as a professional interviewee put it—"ever-growing focus on professional development has brought more interest" in surgical treatments for transsexualism amongst Hungarian surgeons. Another interviewee pointed to tensions between surgeons working in the state and private health care, which is rooted in the lack of financial rewards on one side and vested financial interests on the other. The low number of patients requiring such treatment in Hungary continues to be a problem: It is a financial risk to establish specialist practice for the treatment of transsexuals both in the state and private health care schemes.

We could not obtain information directly from professionals working exclusively in private health care. Our information about private health care comes from indirect sources, mainly from transsexual respondents. We were informed of cases that suggest unclear boundaries between state and private health care. In one case the surgeon helped his private patient to obtain state support for the next surgery. In another case, the surgeon encouraged a patient who had obtained state funding for surgery to register as his private patient, and was unwilling to perform the surgery within the state scheme. In another example, a surgeon who worked in the state scheme told the patient how much money he expected from the patient on whom he was going to perform surgery within the state system.

Our research findings show that at the time of the research there was no official stance on whose duty it is to provide treatment to transsexual people. State and private health care were not separated in the course of gender realignment surgery, and there were examples of unethical professional attitudes.

SUPPORT

Our professional respondents agreed that the treatment of transsexual patients could be optimised with support on three levels: professional support, administrative/official help and self-help.

Respondents agreed that optimal *professional support* could be ensured for transsexual patients within a professional team. This would benefit the patient as they could obtain reliable information on the overall procedure at the beginning of transition, including the possible risks involved. Professional help from outside the sphere of medicine may also be needed: social workers could guide transsexual persons through official matters. Several professional respondents saw the need for a place or places which would be centres for transsexual care. Such a centre might be incorporated into an institution with a wider remit and could provide transsexual outpatient services.

In the context of professional help for transsexual patients, *transphobic* and *transpositive* clinical practice can be distinguished. *Clinical transphobia* is:

within the context of the professional working relationship between clinician and client, any belief, attitude, act or behavior (whether therapist- and/or client-generated) *which negatively values, denies, undermines, discourages or disempowers* trans-identified or GV clients in terms of their unique identities and subjective realities (including, but not restricted to, physical sex, gender identity, sexual orientation and sexual identity), quality of life, the pursuit of self-determination and human rights, and the right to comprehensive health care. If clinical transphobia is initiated by the therapist, we can call this “therapist transphobia,” and if internalized by the client, “client transphobia (internalized).” By comparison, “clinical transpositivity” can be defined as its diametrical opposite, substituting, where appropriate, the phrase: *positively values, affirms, supports, encourages and empowers* (Raj 2002).

In terms of *transphobic* attitudes, we did not find substantial difference between state and private health care; and our interviews with professionals were not free from transphobia either. Examples of *transphobic* clinical attitudes included: guiding the transsexual patient to one’s private practice (otherwise being too busy) and regarding the request for gender transition a luxury or a matter of ethical choice, by which the transsexual person may endanger others around them. A health care professional who thinks that gender realignment treatment helps people achieve an extreme degree of self-expression will most likely refuse to treat transsexual patients. Some professionals may find it difficult or impossible to treat patients against their own convictions.

Interviews with our professional respondents suggest the existence of *transpositive* clinical practice. A psychiatrist treated the process of

gender transition as an integral part of psychological development in transsexual patients. A surgeon emphasized that the types and sequence of surgery is defined by the patient's needs, therefore it is essential to know the patient as a person. Another surgeon and another psychiatrist agreed that for a successful post-transition social integration it is more beneficial if the transsexual person can finish the legal changes of name and gender before any major surgery. Transpositive clinical attitudes may contribute to a successful working relationship of health care professional and patient and also to the successful post-transition integration into society. This nevertheless requires a greater professional knowledge of transsexuality and better empathy towards transsexual persons.

Transsexual people need administrative/official assistance in gender transition especially in amending official documents and records and in relation to financing treatment. The change of personal documents is an essential part of gender transition. Documents can be changed any time—pre-, mid- or post-surgery or other treatment—after obtaining two psychological assessments/referrals. However, this official procedure lacks any legal basis, it is grounded merely in a currently humane—or *transpositive*—official attitude.

Appropriate official attitudes are essential in order to ensure inclusion of gender realignment surgery in the state health care system. Despite irregularities the current situation marks a step forward in the recognition of transsexual's entitlement to gender realignment treatment within the state system: "mastectomy or castration is a type of surgery that can be obtained at any health care provider. However, hormone therapy and genital surgery are not yet provided with financial support."¹⁰

In an ideal case official help would include reliable and correct information. Real transparency would benefit not only transsexual people but also the state, as current irregularities may lead to unlawful actions as well as unnecessary expenses.

At the time of our research there was no *self-help* group for transsexual people in Hungary, and the persons concerned had mixed views of its necessity. The existence of the internet site TransSexual Online (TSO) suggests a need for reliable and all-encompassing information about transsexualism.¹¹ TSO provides a forum for the exchange of experiences for transsexual people and thus fulfils a certain role in the representation

¹⁰ See Senior Advisor Timár's official reply to the written enquiry of researcher Judit Takács (Takács 2006, 180).

¹¹ See <<http://tsonline.uw.hu/>> (5 December 2006).

of their interests. Despite its limitations, this form of self-help ensures the flow of information about medical aspects of gender transition, and occasionally helps build an informal network of people with similar life experiences.

Improving the representation of transsexual people's interest within the health care system could be a specialised area within the representation of patients' rights. An organisation specialising in the representation of transsexual rights could work for the improvement and standardisation of the current situation and could call the attention of responsible decision-makers to unresolved issues.

TRANSSEXUAL PEOPLE'S RIGHTS

§. 54. (1) of the Constitution of the Republic of Hungary provides that "In the Republic of Hungary everyone has the inherent right to life and to human dignity. No one shall be arbitrarily denied their exercise of these rights."¹² The right to identity, autonomy, freedom of action and the protection of private life are all included in the right to human dignity.

The European Court of Human Rights considers it to be a breach of Article 8 (right to private life) of the European Convention of Human Rights in cases where a state does not recognise the acquired gender of a transsexual person. It considers it to be a breach of Article 12 (right to marry) when a state does not allow a transsexual person whose acquired gender has been officially registered to marry a person of the opposite gender. It is a breach of Article 14 (equal rights of men and women) if a state does not provide the same rights for transsexual persons as it does for non-transsexual persons.¹³

The violation of transsexual men's and women's rights partly originates from the fact that in contemporary Hungary official treatment of gender transition issues are unregulated. Act CXXV of 2003 on equal treatment and the promotion of equal opportunities is the only piece of legislation that provides direct protection from discrimination on the grounds of gender identity.

Legal aspects of gender transition, while officially unregulated, follow a more or less established legal practice. Having obtained the appropriate gender on one's birth certificate, a matching official name and documents, a transsexual person's rights and responsibilities are exactly the

¹² This part of the paper was written with the assistance and advice of József Kárpáti LL.D., a Hungarian legal expert of LGBT human rights.

¹³ See *Goodwin v. UK* (Ref: 28957/95) and *I v. UK* (Ref: 25680/94) at the European Court of Human Rights.

same as persons' of the same gender. They can marry their partner of the opposite gender, form a family, and together they are guaranteed all the rights of a different-sex couple.

The Act of 1982 on birth certificates contains no provision for the change of name in the process of gender transition. According to the information obtained from the Ministry of Health the registration of the "new" gender takes place as a correction of the original entry in the birth register. It is unclear whether the change of name and gender can legally require prior medical intervention, and if so, of what type. The current practice suggests that a change in gender does not require prior surgical intervention.

There are two main areas of law where transsexual people might be discriminated against. Their rights as patients and their right to access to state health care might be denied. Similarly, their rights as married partners and parents may not be respected. Transsexual people may request state support for their gender reassignment surgery on an individual basis. It is unclear, however, in what framework the decisions are being made, what surgery will be supported, or whether there is provision for rehabilitation after unsuccessful surgery. Gender reassignment, revision and rehabilitation in Hungary falls under point 2 d) and k) of paragraph 142 of Act CLIV of 1997 on the provision of state health care services. Regarding the treatment of transsexual patients procedures need to be created that respect individual freedom, autonomy and the preservation of dignity and health as laid down in paragraphs 1, 2 and 10 of the same act.

In the field of marital and parental rights, transsexual people's rights may be affected by current regulation, which effectively annuls a pre-existing marriage if one of the partners transitions into the opposite gender, as after transition the married partners would be of the same sex, and this form of marriage is currently not recognised in Hungarian family law. The situation may be even more difficult in a family where there is at least one child, as the child would legally lose one of the parents. Along with the recognition of the acquired gender of a transsexual person, there is a need to make legal arrangements for the families created by two mothers or two fathers.

LACKS AND CRITICISM

When we tried to map transsexual respondents' paths from the recognition of transsexuality to their experiences in the health care system, our research results suggested that it would be over-confident to describe the

changes in the situation of transsexual respondents with the metaphor of a path. We found persevering transsexuals were people treading on unbroken ground rather than a clear path.

Through our research, we identified the following main *milestones of gender transition*:

1. The individual develops the conviction that they are transsexual.
2. The individual decides to take steps to officially change their gender (and name).
3. The individual gathers information about practical possibilities of gender transition.
4. The individual turns to a health care professional.
5. The individual gets psychiatric referrals.
6. The individual applies for an official change of name.
7. The individual starts medical treatment and undergoes surgery.
8. The individual lives their everyday life as a member of their acquired gender.

The sequence of the milestones may vary. It is important to note that previously surgery had been required before the official change of name was possible, while at the time of our research more and more transsexual individuals changed their name prior to surgery, after psychiatric referral. During the research, it was very difficult to identify these milestones: The changing official procedure, the lack of regulations with regard to the whole process, the unreliable and incomplete information and the diversity of individual needs and possibilities meant that our findings showed a plethora of variations in gender transition paths.

The most common motivation for beginning a transition process was that a person was unhappy with their birth sex and the gendered life it prescribed. They had a conviction that they needed to change their gender status and find their “real self.” Individual stages of the gender transition process could be interpreted as practical expression of this basic motivation, which, however, often came up against practical difficulties.

Transsexual people have to face several practical difficulties during gender transition of which they were critical. We sorted their *criticisms* under two headings: Firstly, we collected criticisms of the contemporary Hungarian system of gender transition. Secondly, we collected their remarks on their dealings with medical professionals and state officials.

The main criticism of the system of gender transition was the lack of regulations, which may have resulted in arbitrary decisions, unexpected situations and a discontinuous flow of information. This may have made the whole process of gender transition too complicated, and caused some individuals to spend years trying to obtain the necessary infor-

mation, referrals, official permissions and treatment. It seems that the process of gender transition had previously been clearer, as treatment could only start after the approval of a National Health Board and official documents could be changed only after irreversible surgery. By the time of our research the approval of the National Health Board was not necessary and official documents could be changed prior to any surgery. Administration remained complex and slow. The psychiatrists' referrals were the major go-ahead, the "green light" to gender transition. The most severe criticism was that there was no clear set of criteria in deciding on the transsexuality of the individual. Many respondents thought that the professionals dealing with them had insufficient expertise and experience. Insufficient expertise, a lack of attention and the shortness of time could mean that professionals did not necessarily give referrals to those "really" in need of them. Criticisms of the system referred to problems around data protection. Transsexuals, too, have a right to the confidential handling of their data, which in practice does not always happen.

The second group of criticisms referred to the experiences of interacting with health care professionals and officials. Many respondents were unhappy with the quality and impersonality of these interactions.

Most respondents were also concerned about the *financial aspect* of their gender transition. Lack of official regulations of gender transition involved a lack of information on what type of health care service is available within the state health care system, and which consultations or types of treatment and surgery had to be paid for individually. The phenomenon that state and private health care are not clearly separated in Hungary also impacts on the treatment of transsexualism. We encountered an example of privately paid surgery performed in a state hospital, where the institution in question did not receive all the money paid by the patient. Our respondents referred to several instances where the separation of private and state health care was unclear. All our respondents thought that having a certain amount of money was a prerequisite of seeking medical help. Although they were mostly aware of their entitlement to state health care, it was unclear what this entitlement included or how to access available support.

Our transsexual respondents listed several arguments for their entitlement to treatment under the state health care system which, in an optimal case, would be characterised by consistency, transparency, reliability, responsibility as well as financial and psychological support. Our research findings indicated that transsexual people in Hungary could be assisted in several ways, of which peer *support* and state support would be the most necessary: several respondents would welcome centralised,

institutionalised state assistance, within which information and treatment would be accessible under the existing entitlement to state health care. The research results also suggested that gender reassignment could create the conditions for successful social integration therefore it might be understood as treatment to prevent problems like unemployment or isolation later in life; and the state could assist transsexual people by providing reliable information and state services being more aware of the human dimension of their problems.

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