FROM THE GUEST EDITOR

Increasing Gender Awareness to Reduce Harm in Health Care

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In this guest editorial, the author first discusses how gender is a historical and biopsychosocial construct. This means that there are many aspects of gender besides identity, such as gender expressions, roles and experiences. They address how this issue highlights some of these aspects but that these are not exhaustive, given the topic. They highlight how being able to consider our own gender identities, roles, expressions and experiences is an essential starting point if we are to be competent health-care providers. Finally, they suggest that stories might be one way to learn about aspects of gender we may not be as familiar with, as they allow us to connect emotionally, not just cognitively, with these aspects.

Keywords: gender; cultural competence; transgender; nonbinary; reflexivity

As you approach this Seeing Beyond Gender issue of *Creative Nursing*, my hope is that you feel half as excited as I did when I was asked to introduce it. Within the pages of this issue you will find a broad range of insights, experiences, evidence from the literature, and clinical wisdom in relation to a topic near and dear to my heart: gender. Gender has always fascinated me because I found it both confusing and beguiling. Here was a category that seemed to dictate much of how people behaved and thought of themselves and one another, and yet was also confining, and often, let's face it, not rooted in people's real experiences. In the end, I would go on to undertake a whole PhD program looking at gender and devote much of my career to the study of gender, sexuality, relationships, and disability. However, I still find that there is no simple answer to the question of what gender is. The best answer I have come up with so far is that gender is a historical and biopsychosocial construct (Binaohan, 2014; Iantaffi & Barker, 2018).

The word biopsychosocial captures the fact that, for all of us, our gender is a complex mix of our biology, our psychology, and the social world around us (Fausto-Sterling, 2012). Given that everybody's biological makeup, psychological experiences, and social context intersect in unique and complex ways, our gender really is something like a snowflake: no two of us are quite the same. Yet, just as we can recognize what a snowflake is, we can still find people who share some aspects of their gender

identities and experiences with us. This means that we can recognize categories and terminology related to several gender identities, roles, expressions, and experiences, while also acknowledging that, within each category or term, there can be differences between individuals. Therefore, even though this theme issue offers several glimpses into gendered experiences relevant to nursing, they are just that—glimpses, rather than the definitive answer for how to best approach the complex yet simple construct of gender in health care. One thing I have noticed again and again is that when we talk about gender, we often really mean other people's gender; this makes sense, as we might feel familiar with our own gender. Yet I have found that one of the most effective ways to address gender is to start from our own gender journeys, as well as listening to other people's experiences. So, whereas this theme issue gives you an opportunity to read about various experiences from various standpoints, I encourage you to pair these readings with reflection on how they might impact your own clinical practice, training, and/or research. Reflection when it comes to gender can be vital, as we are not, in the dominant culture, generally encouraged to reflect on our own, or other people's, gender(s). In fact, quite the opposite is true. We are supposed to just go along with what other people tell us about our gender, and to not question it. If we do question the way things work, we might be labeled as troublemakers, nonconforming, and/or agitators of some kind

(Barker & Iantaffi, 2019; Iantaffi, in press; Iantaffi & Barker, 2018).

This is something that even young children pick up on. Many trans and nonbinary people, for example, have described knowing early on, as young as 4 or 5 years old, that talking about gender in ways that challenged the status quo was not acceptable. In teaching about gender since being a doctoral student 25 years ago and, at the time, a second-wave feminist, I also know how many stories of pain most people hold, regardless of their identities, when it comes to gender. There are stories about not being able to express feelings because of being assigned male at birth, and about being viewed as “ugly” because of not conforming to stereotypical beauty standards for those assigned female at birth. There are stories of not being able to play sports, or to wear what you want; of being punished for how you sit, walk, and talk, and who you hang out with. I have yet to meet someone, of any gender identity, who does not have at least one painful story when it comes to rigid gendered expectations (Iantaffi, in press). Reflection can help us pause, breathe, notice: how have we been impacted by these rigid gender binaries in the past? How are we impacted now? How do we sometimes perpetuate these harmful stereotypes in our own practices? How have we internalized them? What is the relationship to gender that we want to cultivate and nurture moving forward?

If we do not pause and reflect, we keep perpetuating the same trauma, the same ways in which we were hurt, simply because we do not know that this is what we are doing. Feminist, scholar, author, and activist Rachel Hare-Mustin (1994) spent much of her career writing about gender in my field, psychotherapy. One of her seminal papers on “Discourse in the mirrored room” warns us that, if we do not pay attention, we end up reproducing the same systemic, dominant, and oppressive discourses in places such as therapy rooms, which are supposed to be healing (Hare-Mustin, 1994). This is why I consider reflection to be essential to the work of dismantling rigid gender binaries. This theme is very much a part of this work, given that both providers and patients can end up experiencing more cultural and social trauma when it comes to gender, if we are not aware of how these patterns are played out in our everyday practices. Further, gender, like other aspects of our lives, intersects with other aspects of our identities and experiences, such as Indigeneity, race, ethnicity, citizenship, disability, class, socioeconomic status, geopolitical location, and so on (Barker & Iantaffi, 2019). This complicates the discourse, as we cannot ever consider

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gender by itself, isolated from other aspects of who we are, individually and collectively. Storytelling can be an effective way of conveying the rich textures of gender identities and experiences. Storytelling is not only informative, but also creative. It can access emotions rather than just cognition, deepening both learning and understanding. Unfortunately, when it comes to gender, the stories that are told in popular culture are often monotonous and repetitive. For example, for a long time, stories told about masculinity and femininity perpetuated harmful stereotypes. These stories have been gradually changing, as we can see in portrayals of more recent Disney princesses who are no longer just beautiful love objects waiting to be rescued by a handsome prince. This trend can be seen in movies such as *Brave* (2012), *Frozen* (2013), *Moana* (2016), and *Frozen II* (2019).

The narrative in popular culture has been changing not only for more binary constructs of gender, but also for transgender and nonbinary identities. Early representations in Hollywood, for example, included movies like *The Crying Game* (1992), which perpetuated lethal tropes of trans women as “beautiful tricksters,” a trope far too often used as part of the trans panic defense in real-life legal cases in which trans women, usually trans women of color, have been murdered by cisgender men (Iantaffi, 2015). More recent portrayals vary, and sometimes even evolve during the lifespan of a TV series, such as with the popular TV show *Transparent* (2014). Initially the show came under heavy criticism for both its casting and its representation of trans identities and experiences. The show’s creators responded to this criticism by hiring more trans writers and actors, which strengthened the representation of transgender identities and experiences.

No matter where we look, gender is ever-present in the stories we are exposed to, from fairy tales to medical case studies. Therefore, paying attention to who is telling whose story is vital. What are the narratives we are exposed to? Who is the storyteller and who is the subject? Health care is no stranger to the power of learning through storytelling. In many ways, clinical case studies, whether shared in a training program or in the pages of a peer-reviewed

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journal, are stories told about a patient, an illness, or both. Research studies too can be viewed as stories, whose plot is often laid out by the researchers through the methods chosen and the questions asked. This is why journal issues like this one are important, because the stories shared here might not be as familiar as those presented in many training programs or clinical contexts.

Given how little training most health-care providers receive about issues impacting gender and sexual minorities as well as other people with marginalized identities and experiences, seeking more stories can be vital to our professional development. Other sources of relevant stories can come from films like *Patient No More*, a feature documentary by Diana Fraser (2019) highlighting barriers to affirming health care for LGBTQ women, or *To Treat Me You Need To Know Who I Am*, a training video developed by New York City Health and Hospitals (2011) that shares stories from LGBTQ patients. The Internet is a valuable tool for accessing stories and experiences that differ from our own, so that we can become more culturally humble and aware of how much our experiences can differ.

For example, a story I often share in training is a video poem titled *If I Die Would It Matter* by Damien Mills (2014). At times, I have trained challenging audiences who did not seem convinced about the health disparities faced by LGBTQ+ populations, especially LGBTQ+ people who are also BIPOC (Black, Indigenous, People of Color; Balsam, Huang, Fieland, Simoni, & Walters, 2004), even after being presented with robust data. However, this poem could make those numbers meaningful by humanizing the experiences of people who might seem so different.

Finally, I want to end this guest editorial with another story. I truly believe that health-care providers want to do their best by their patients, and yet, as mentioned earlier, we can often inadvertently

perpetuate harm. One of the ways we perpetuate harm is by being unable to move beyond a binary understanding of gender. The monologue reproduced here, *Do No Harm*, by Eddy Samara (2016), was originally written for a series of monologues by trans and nonbinary voices called *Naked I: Self Defined*. I chose to end this editorial with this piece because I believe it captures much of the spirit of this themed issue.

Do No Harm

By Eddy Samara

First performed and published in the Naked I: Self-Defined, 20% Theatre Company, 2016. (Reprinted with permission)

I was strapped to the table
Waiting for them to run the PIC line
from my elbow to my heart.
The nurse bent over the bracelet that shackled me
to an
identity I couldn't shed despite the fresh scars
across my chest.

My smile met hers in a preemptive plea for mercy.
You see, I knew the routine:
She would read the bar-coded band and ask me
To verify my full name—for my protection, of
course.

I tried to strike first,
Hoping humor would hold the inevitable
humiliation in check.
I said, "Yes, that's my Band Name. But please, call
me Eddie."
She laughed, but not with me.
"I'm just going to call you by your real name,
Miss So-and-So . . ."

Tears slid off the table because I couldn't.
I was stuck weighing the relative cost benefit
analysis
Of pissing off the person pushing a sharp needle
deep into my blood supply,
All the while speaking blunt trauma into my
bones.

Now, I would like to tell you
That I metaphorically and heroically stood up for
myself and for queers everywhere right there in
that moment.
But that is not my story.
That is not my truth.

Truth is—I was tired, y'all.

I'd been having variations on this demeaning conversation
 Multiple times a day during my hospital stay—
 Courtesy of the finest medical care San Francisco
 has to offer.
 Before every blood draw, every test, every
 procedure,
 The question of my “real name?
 More times than I can erase
 Someone saying right to my face—
 Essentially—

“I refuse to see you.”
 “You do not exist.”
 “You are not a man.”

In each dismissive refusal to address me properly
 I heard—repeatedly,
 That I am not even human enough to own my own
 name.

So when the IV tubing stopped just short of my
 heart,
 The nurse's words went deeper,
 Tearing into cardiac cavities
 Leaving their echo to beat like an arrhythmia
 In the hollow space that passes for my chest:
 I am not a man . . . I am not a man
 I am a man . . . I am a man
 I am not a man?
 I am a man
 I am not a man
 I am a man
 I am a man . . .
 I am . . .

(Samara, 2016).

I hope that by reading this theme issue of *Creative Nursing*, you will be able to live up to the ideal of doing no harm. If you are already aware of all the information that is presented here, this journal issue can maybe serve you as a helpful teaching and training tool.

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