

A Transgender Primer

An introduction to transgender people
and some of the issues they face



FLAMINGO

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Introduction

This booklet forms part of the ‘Ten Trans Lives’ research project conducted by Flamingo for Channel 4, in 2011. The project sought to assist the Commissioning Editors at Channel 4 in their aim of better understanding the lives of transgender (‘trans’) people and the issues they face, in order to be “in the position to commission programming which presents the wider viewing audience with transgender portrayals and representations which are realistic and sensitive”.

The purpose of this material is to give you a brief introduction to some of the themes you may encounter in developing programme material in this area. It is broken into key sections, designed to be digestible and accesible. The hope is that it can be read in full or referred to as required. Please do refer to the Further Reading/Links section at the end to learn more.

First Things First...

“Gender is between your ears, not between your legs”

Chaz Bono

How we approach the concept of gender is something that has occupied society for thousands of years. Driven by prevailing social constructs, different cultures have over the centuries, and in different parts of the world, understood it in different ways. Whilst modern western (Judeo-Christian) society frames its understanding around a bipolar model rooted in Biblical tradition and determined essentially by an inspection of a child’s genitals shortly after birth, other cultures have long embraced more fluidity, or even ambiguity. In Ancient Greece, some male priests dressed and lived exclusively as women. Native American tribes identified, and venerated, ‘two spirited’ people (the Lakota’s Winjkte and Navajo Nádleehé, for example – individuals who were typically born with ‘male’ biology but who lived and behaved as females). In India, the Hijra are a well established part of society, and are often seen as a third gender.

Equally, ‘transgender’ people (as they might now be called) are littered throughout history. From Joan of Arc, King Henry III of France or Queen Christina of Sweden to Alexis Arquette, Chaz Bono and Alex Reid; via New Zealand ex MP Georgina Beyer, Bond girl Caroline Cossey and French eighteenth century diplomat Chevalier Éon de Beaumont, trans people – who have challenged prevailing beliefs about what gender means – have been part of society since the idea of society began.

Which is not to say that all transgender people feel the same way about themselves – or identify in the same way. Far from it. Much depends on the unique blend of psychology, biology (including events that happened to them before birth potentially – it is believed – affecting brain structures) and culture in which they are embedded.

Every trans person has to find for him or herself (pronouns themselves display our preconceptions about the binary) a sense of their own identity and who they are. For some, the answer will be clear. Though assigned one gender at birth, some will **know** that they are – inside – of the other. That knowledge, and the world’s attempts to have them display an identity to others which they feel to be completely wrong, can cause huge inner trauma. They may decide to take steps to ‘transition’, a process that involves social, psychological, emotional and physical changes to live in the gender role that makes sense. In our culture, this means moving from living as a man to doing so as a woman, or vice versa. This is the journey of the transsexual person.

Others will understand themselves to be made up of a combination of male or female characteristics – seeing themselves as standing in their own place between one end of the gender spectrum and the other. They may feel that they need to make certain changes in their lives to accommodate this understanding of themselves. They may present themselves to the world in the guise of one gender sometimes, at others as the other. They may feel at ease publically bringing together a blend of aspects. They may describe themselves as ‘pangender’,

or ‘Genderqueer’, or using a number of other terms. Or – labelling what they **do** rather than who they **are** – a ‘Crossdresser’.

Up front – to understand transgender people it is key to appreciate that you may have to check-in some unexamined assumptions at the door!

When you approach another with the term ‘man’ or ‘woman’, know that you are using a code you have learned, grounded in our culture simply on the briefest of inspections of a small, externally visible, part of the anatomy in the first few minutes of life. These precepts may be long-established, and customary, but they may **not** be as grounded in biological reality as you think. And there are more people who struggle with society’s assumptions than you may have previously thought.

A trans person may tell you that the authenticity of his or her experience of being one gender or another, or something in between, is not for you to decide. Transgender people – who have often grown up with a world trying to coerce them into an identity that they have known to be wrong – can feel strongly about the right to own and define their own identity – for themselves. Some will tell you that being able to say who you are, and be believed, is a basic human right.

Don’t feel daunted about approaching the subject though. If you don’t know what to call them, or how to describe their experience, rule number one is to ask them! Until you can do so it is usually OK to use the pronouns appropriate to how they are presenting to the world. And the term ‘transgender’ or ‘trans’ is a useful general term to describe them (as in ‘trans person’).

“I had lunch with an old colleague I hadn’t seen for a while. I had emailed him about my transition, and not heard back from him – something I was quite disappointed about. Eventually he got in touch, and over lunch he said, ‘When you told me, to be honest, I was shaken. I went home and talked to my girlfriend about it. It seemed like something that I had assumed to be absolutely permanent, and unshakeable, wasn’t. Like an earthquake. I didn’t know how to deal with that. But the more I thought about it, the more I realised that it was my problem not yours and I should just get over it.’ I thought he was really courageous saying that, and we had a lovely lunch.”

Melanie

The Terminology

Becoming involved in this arena can bring with it challenges of terminology. This is because trans people often need to find for themselves a self-defining vocabulary that works for them, in a world that constantly tries to impose upon them labels which don’t seem to fit. And the English language – built around binary definitions – can be unhelpful!

Here, though, are some basic definitions and explanations to guide you.

Terms using ‘trans’

Transgender (‘Trans’) (adj) *An umbrella term describing people who feel the need to present themselves to the world in a gender other than the one they were assigned at birth. Transgender people may go onto describe themselves as transsexual, transvestite, crossdressers, intersex or by a number of other terms (including, simply, man or woman).*

Transgender is a useful general term often shortened to ‘trans’ as in ‘we’re making a film about trans people’.

Transvestite (adj, occ n) *A person who wears the clothing of the gender opposite to the one they were assigned at birth, but does not feel the requirement to live permanently in that role, and does not fundamentally question the gender with which they were assigned at birth. (See Crossdresser.)*

Transsexual (adj) *A person who holds the belief that they should be living full time in the gender role opposite to that assigned to them at birth may be said to be transsexual (NB not ‘a transsexual’). Transsexual people often (though not always) take steps to change their bodies to reflect their deeply held understanding of their inner gender (see Transition).*

Transsexualism (n) *A better term than ‘transsexuality’, transsexualism is an internationally recognised medical condition, a status that brings with it mixed blessings to transsexual people.*

On the one hand, its recognition in this way creates for it some credibility amongst the medical community that means that trans people can – in some countries, in some circumstances – get medical help and support to make the changes in their lives that they need.

On the other, some feel discomfort with its classification as a medical condition. Indeed, in many medical reference works, transsexualism is still listed as a disorder. This disquiet can become very powerful when discussion turns to the continuing presence of transsexualism in the influential American psychiatric reference work 'Diagnostic and Statistical Manual of Mental Disorders' (DSM). Transsexualism appeared **first** in this reference manual in 1980 (as moves were afoot to remove homosexuality).

Opponents of classifications of this kind point to emerging scientific evidence of the influence of biological developments on the foetal brain which can influence gender identity development. This is no 'medical condition' they suggest, still less a 'disorder'. It simply reflects the natural variation within the human population, like right or left-handedness, or eye colour. And, they point out, left-handedness was for centuries regarded as aberrant.

Transition (n, vi) *The process of moving from living in one gender to living in the other, usually undertaken by transsexual people. Transitioning involves major social and emotional adjustment, and can be a period of great stress and vulnerability. It is often a time when the individual can be abandoned by family, friends or colleagues, and become vulnerable to abuse and discrimination for transgression of society's gender codes. The media plays a significant role in shaping public attitudes to transitioning people, and there is research evidence that casual bigotry in the media can lead to increased hostility towards trans people and hurt for those around them. Transition often (though not always) includes surgery of various kinds.*

Other terms you'll come across

Crossdresser (n) *An alternative word for 'transvestite' (which in some cultures (eg US), is pejorative), a crossdresser is a person who wears the clothing of the gender opposite to the one they were assigned at birth, but does not feel the requirement to live permanently in that role, and does not fundamentally question the gender they were assigned at birth. Sometimes people seek to understand themselves as a crossdresser for a certain period of their lives because it is a mechanism by which they can deal with an emerging but as yet unfaceable deeper truth that they may actually be transsexual. But many crossdressers are entirely reconciled with meeting their needs by occasional 'dressing' and do not move beyond this point. It is vital to understand that transvestism / cross dressing and transsexualism are not the same thing.*

Drag Queen/King (n) *A person who dresses in the clothes of the gender opposite to the one in which they live for much of the time, often for performance reasons. People who use these terms as the primary way of describing themselves may be less likely to be gender dysphoric, and are often entirely content to live in their assigned gender role.*

FtM (adj) *Female to Male. Describes a person who is transitioning from living as a female to doing so as a male.*

Gender Affirmation Surgery (GAS) (n) *The best term to use to cover the range of medical interventions a transitioning person may undertake. Gender Confirmation Surgery (GCS) is also used. You will hear the term Gender Realignment (or Reassignment) Surgery (GRS) This is in wide use but is less accurate. Sex Reassignment Surgery (SRS) is now obsolete. Sex Change (see below) is inappropriate.*

Many trans people go through a range of procedures to bring congruence and peace to their lives, and this term covers the range of interventions – not just those concerned with genitalia.)

Gender Dysphoria (n) *An underlying and incessant disquiet or anxiety centred on the understanding that who you are is not reflected by the gender of your body. Gender Dysphoria can exist in a range of intensities, from the mild and intermittent, to the permanent and disabling. Transsexual people who transition have typically suffered very deeply from it, and a successful transition can alleviate it entirely. People can be said to be 'gender dysphoric' or suffering from 'gender dysphoria'.*

Gender Identity Disorder (GID) (n) *Another term for gender dysphoria. Widely disliked by trans people as the word 'disorder' marginalises and pathologises rather than simply recognises difference (see 'transsexualism'). 'Gender dysphoria', or – better still – 'gender incongruence' are regarded as more accurate terms.*

Gender Identity Clinic (n) *A specialist NHS clinic to which transgender people may eventually be referred by their GP after presenting with the symptoms of gender dysphoria. The best known, and the largest in Europe, is at Charing Cross Hospital in West London, though several others around the UK see patients too. GICs diagnose and supervise treatment up to and including referral for Gender Affirmation Surgery.*

Gender Recognition Act (GRA) (n) *2004 UK legislation which gives transsexual people who have transitioned, full legal rights as a member of the gender in which they are living, including the right to have their birth certificate revised, and to marry. The GRA established the Gender Recognition Panel, which issues Gender Recognition Certificates (GRCs). Acquisition of a GRC allows the holder to apply for a new birth certificate. It is an offence for an individual working for a public body to reveal that an individual has a GRC, or to reveal their personal gender history. It is also unlawful for an employer to demand to see it as 'proof' of gender – just as it is not required of non trans people ('cisgender' people) to 'prove' their gender.*

Genderqueer (adj) *Individuals who call themselves genderqueer may regard themselves as having aspects of either gender, or none. They will typically feel uncomfortable with using language that fits only into a binary interpretation of gender.*

Other terms in use in this area include 'polygender', 'pangender', 'androgynous' and 'neutrois'. Each has specific connotations, often best understood by talking to the person who identifies this way, but all broadly fall into the space that is not catered for by a binary definition of gender.

Gender Variant (adj) *A general term which describes all those who express their gender in a way at odds to society's 'normative' binary. Or those who feel that they are not described by the binary.*

Intersex (adj) *A medical term covering a range of recognised conditions, which create an ambiguity around the physical sex of an individual. Chromosomal differences, or hormonal action, may have prompted the development of physical characteristics that are not clearly either male or female, and/or prompted an understanding within the person that he/she is truly of neither gender.*

Many intersex people do not identify as transgender but it is common for them to be the targets of transphobic prejudice. The term intersexual should be avoided because it leads to confusion between physical sex and sexuality. 'Hermaphrodite' is not appropriate.

MtF (adj) *Male to Female. Describes a person who is transitioning from having lived as a male to living as a woman.*

Real Life Experience/Real Life Test (RLE/RLT) (n) *Clinical protocols recommend that a transsexual person transitioning must live for one year in their 'new' gender, full-time and uninterrupted, before being referred for GAS. In England, the NHS has adopted a two year system; elsewhere it is one year. The moment at which this process starts is often called 'Going Full Time'.*

In the UK, in many instances, transitioning people may be denied medical support (e.g. hormone therapy) until they have demonstrated that they are willing to do this for some months, and produce confirmation that they have done so. This early period in transition, when they are finding their feet in their new role but have had little chance to undertake any of the physical changes which will help them be accepted by society, can be particularly daunting.

Again, if you are working with a trans person and are in any doubt about any of this language, ask! But remember that within these broad parameters, everyone's experience is his or her own, and the temptation to extrapolate one person's definitions on to all trans people should be avoided.

Language to avoid

There are some terms over which the large majority of trans people do agree. Here are some terms that should always be avoided. Sadly, many of them continue to be in wide use, in the media and elsewhere.

Sex Change (n, adj) *Transitioning individuals are confirming their gender not 'changing their sex' (with its connotations of sexual identity). This now obsolescent term emerged in the medical community as an external observation of transitioning people by psychologists and psychiatrists and was never based upon the experience of the individuals themselves. Still in wide use in the media as a verbal 'wrapper' around which ridicule or insult can be tacitly expressed, it is now widely regarded as offensive. 'Sex swap' and other demeaning plays on words are even worse.*

Tranny/Trannie (n) *Whilst still a term that may be used within the trans community (with understanding, or ironic affection), use by those outside it has come to be seen as highly abusive by most trans people. Used widely by the media, and adopted by some as an insult to be used as means of ridiculing trans people, parallels have been drawn with the usage, meaning and effect of highly offensive terms like 'dyke', or even 'nigger'.*

Pre-Op (n, adj) *Many trans people detest having their experience reduced to a surgical event. The use of 'Pre-Op' (as in 'Pre-Op transsexual') qualifies transsexual, creating the impression that only 'Post-Op' is valid or real. It also adds to the impression that transsexual people need to be 'labelled' by others, defined by an operation (and by extension simply by their genitals), and that those who have gone through 'the op' may have a status or authenticity unavailable to those who haven't. Usage of 'Pre-Op' as a term of abuse, sparked by reductionist media usage, has emerged recently.*

In addition, like everyone else, transitioning transsexual people regard their medical history as private, and not the business of society, or the media, unless they explicitly choose to make it so.

Other offensive language includes, 'She Male', 'He/She', 'Gender Bender', 'Hermaphrodite', 'Sex Swap', 'It', and any 'comedic' reductive reference to genitalia

How many Trans People are there in the UK?

The issue of 'prevalence' is one that is not always easy to pin down. How you define 'transgender', who falls within the categorisation, and the social stigma that continues to prevent people from coming forward to get help or identify themselves in research, remain complicating factors.

Nevertheless, work has been done by GIRES (The Gender Identity Research and Education Society), in partnership with the Home Office, to provide data that seeks to quantify the number of transsexual people in Britain, but also estimates the size of transgender community more widely.

Number who have completed transition in the UK:	7,431*
Gender Recognition Certificates issued:	2,531**
Estimated number who have sought treatment to date (doubling every 6.5 years):	12,500**
Estimated prevalence of transsexualism:	25 per 100,000***
Estimated number who would like to transition, but may not feel able to do so:	50,000-90,000 ***
Estimated number of transgender people – feel any form of disruptive gender variance:	300,000-500,000 ***

* Defined by HMRC statistics – numbers who have changed their records by March 2010

** Issued by Gender Recognition Panel by March 2010

*** GIRES estimates based on combined data sources

The rate of growth of people presenting for treatment is 11% per annum, a trend that has remained consistent since the late 1990s.

Gender variant people may present for treatment at any age. Government data suggests that the median age is 42. The emergence of this statistic took some researchers by surprise, given that many studies have confirmed that trans people become aware of their 'difference' from a very early age (usually before 10 years old, often as soon as they are able to conceptualise the difference between genders). But trans people often become aware of the social stigma and unacceptability associated with their feelings almost as soon as they first start feeling them, and pressure from school or family to conform has a very powerful inhibiting effect upon many. This means that the majority of trans people have historically sought to live with their feelings, often alone, until well into adulthood.

Only around 100 under 16s per annum are referred to Gender Identity Clinics in the UK. Historically, British clinicians have refused to treat this tiny number of young people with temporary 'puberty blockers' (drugs which delay the onset of the 'wrong' puberty – an event in a young trans person's life which can cause immense confusion, distress and even prompt suicide). But evidence from the United States and Europe has emerged that these drugs are of help – as the young person makes decisions about his or her future (their effects are fully reversible), the UK looks set to begin prescribing them in a small number of carefully selected cases.

Trans People in UK Society

“Transgender and transsexual people face a lifetime of inequalities and discrimination, despite often being amongst the most well educated members of society. As children, they can be bullied and abused for being gender different. As adults their families, friends and neighbours can reject them once their trans status is known, and they are very likely to experience assault and abuse at home, in the workplace and out on the streets”.

So wrote Stephen Whittle MBE, Lewis Turner and Maryam Al-Alami, at the close of the largest ever study into transgender people’s position in UK society, the 2007 ‘Engendered Penalties’ Report ¹. This study, which drew upon 86,000 emails received by campaigning groups Press for Change and the FtM Network, also included a major quantitative element (872 completed questionnaires from trans people around the UK). In this extremely under-researched area ‘LGBT’, or ‘LGB & T’ studies have for many years said little or nothing about the ‘T’ element), ‘Engendered Penalties’ remains the benchmark study, and the largest sociological study of trans people anywhere in the world. It was influential in framing thinking that appeared in the 2010 Equalities Act and continues to be essential reading for anyone seeking to learn about the issues.

Whilst the position of trans people in UK society is gradually improving, many positive steps have been achieved through the courts, not, according to campaigners, given freely by government. Legal process has included use of European directives to force the British Government into compliance. Whilst there is guarded hope that the current coalition Government will deliver on promises to end discrimination in the workplace, and elsewhere, some campaigners remain wary, conscious that they have few friends on the political right. Some look back to a previous ‘consultation’, in 1998 when plans were put forward to amend Sex Discrimination (Gender Reassignment) Regulations. Initial proposals “included extending the right to managers to decide when a transsexual person looked ‘reasonable enough’ to use the appropriate gender toilets; a general exclusion from working with children, and an exclusion for trans doctors and nurses providing any personal care” ¹. The trans community regarded such provisions as little short of barbaric, and rapid lobbying was successful in removing aspects of the proposals – but as Whittle, Turner and Al-Alami point out, “they set the tone for the debates on trans equality that have continued to this day” ¹, and are sustained by a discourse in the popular media which many trans people feel contributes to misunderstanding or hostility.

¹ ‘Engendered Penalties: Transgender and Transsexual People’s Experiences of Inequality and Discrimination’, Manchester Metropolitan University/Press for Change 2007 www.its-services.org.uk/silo/files/the-equalities-review.pdf

The Legal Setting

Hard fought success for trans people has appeared in the last ten years though, chiefly in the form of two cornerstone pieces of legislation – The Gender Recognition Act (2004) and Equalities Act (2010).

The Gender Recognition Act of 2004 which the UK government was compelled to pass after the ‘Goodwin vs UK’ case in the European Court of Human Rights found the UK Government in breach of Articles 8 and 12 of the European Convention on Human Rights ² gives transsexual people, who are receiving medical intervention for their gender variance, the following rights:

- To apply for a Gender Recognition Certificate (GRC) from the Gender Recognition Panel (GRP) for 3. This certificate entitles the holder to legal recognition in their ‘acquired’ gender ‘for all purposes’. Importantly, it is not a condition of receiving a GRC that the applicant must have surgery, recognising that for some people surgery is neither a medical possibility nor appropriate for other reasons. However, significant supporting evidence of their condition is required from the GRP in all cases.

It is against the law for anyone who has received information about an individual’s possession of a GRC ‘in an official capacity’ to disclose it. There are certain exceptions to this, including (after significant lobbying from some groups, religious communities, plus the medical profession and credit reference agencies.)

Despite clauses in legislation indicating that a trans person is not required to show a GRC to ‘prove’ his or her gender, trans people are often asked to provide it when making changes to personal records. This is a particular issue when dealing with the financial sector (covering banking, insurance, pensions etc), where many institutions refuse to amend records on gender until compelled (unlike other sectors, including HMRC, NHS and the Identity and Passport Service which generally comply on receipt of supporting medical paperwork and a Deed Poll document noting change of name). This practice remains legally dubious, but, unsurprisingly, has been untested in the courts – for a trans person to do so would involve him or her disclosing his or her background to a wide audience – the very situation he or she is trying to avoid.

Having received a Gender Recognition Certificate, to apply for the reissue of their Birth Certificate in their ‘acquired’ gender. New birth certificates are (finally, as of 2011) entirely identical in all detail to others. However, the initial record of the birth remains on the Register of Births.

- To marry a person of the gender opposite to the one recorded on their GRC, or to form a civil partnership with someone of the same gender.

² <http://tiny.cc/31twi>

³ <http://tiny.cc/6gd3b>

It does however remain impossible for a person who has received a GRC to stay married if he or she was married before. In fact, a full GRC will not be issued until an existing marriage has been dissolved. This continues to cause some trans people great distress, denying them and their spouses – who have fought against daunting odds to keep their marriages intact – the rights embedded in the Gender Recognition Act. An attempt in the European Court of Human Rights in 2006⁴ to challenge this failed.

Trans people are encouraged by recent thinking in Europe – an arena to which they have long looked for support. In 2009, the Commissioner for Human Rights of the Council of Europe, Thomas Hammarberg, gave the most extensive statement on the situation – by a European official ever, saying, “The human rights situation of transgender persons has long been ignored and neglected, although the problems they face are serious and often specific to this group alone. Transgender people experience a high degree of discrimination, intolerance and outright violence. Their basic human rights are violated, including the right to life, the right to physical integrity and the right to health.”⁵

More recently, the UK’s **Equalities Act 2010** broadened the definition of people against whom it was illegal to discriminate in the workplace, and other arenas. This piece of legislation, designed to bring together a range of other legislation covering discrimination into a single framework, was received by the trans community with a mixture of responses. Whilst it was applauded for specifically mentioning protection for transsexual people, it ignored requests by trans groups to build in protection for individuals who identify as transgender but do not wish to, or cannot, go through gender affirmation surgery (referred to here as ‘gender reassignment’).

“Gender reassignment:

A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person’s sex by changing physiological or other attributes of sex.”

It thus remains legal to discriminate against an individual (in employment, or in the provision of goods and services) if that individual presents in a gender variant way but is **not** going through, or does not intend to go through, a medical process as described by the Act.

⁴ <http://tiny.cc/ycz5t>

⁵ www.gires.org.uk/genderrecognition.php and [www.gires.org.uk/assets/Legal-Assets-CommDHIssuePaper\(2009\)2.pdf](http://www.gires.org.uk/assets/Legal-Assets-CommDHIssuePaper(2009)2.pdf)

Discrimination in society

‘Engendered Penalties’ speaks in depth about the discrimination faced by trans people in the UK, and whilst it is now almost 5 years old, it remains the most recent, statistically robust study available. Anecdotal evidence from within the transgender community suggests that whilst the situation **has** improved in some areas, many of the situations recorded in the report remain familiar.

Amongst its data, much of which correlates with smaller studies conducted previously, or in the US or Australia, the report recorded the percentage of respondents to the survey who had experienced various types of discrimination.[†]

Harassment in Public

73% Experienced harassment in a public place

This can take the form of physical, verbal or sexual abuse or threatening behaviour. The report’s authors suspect it is underreported here. 10% of respondents had been physically threatened.

“I was attacked in the Student Union at ‘x’ University for being ‘A transgender cunt’ and had a knife thrown at me which hit me just above my right eye.”

“They followed and started hitting me again on the street. I managed to get back on the bus but so did they. When it stopped again I again tried to escape and again I got a beating. This went on for at least 10 minutes in total. I took at least 20 punches in the head and about the same on my body.”

*“When I transitioned in 2003 I got a lot of abuse from local jobs. I had someone throwing stones at me and calling me a f***** nonce. I had someone threatening to stab and shoot me. I had gangs of boys throw stones at me and call me a slag. I was surrounded by a gang of lads once. Thankfully I had not got out of my car and I was able to drive away. They did chase the car down the street.”*

[†] Verbatim comments are from the report unless otherwise indicated

Access to Services & Facilities

47% Do not use public social or leisure facilities* because of fear of discriminatory treatment

Many trans people avoid public facilities because of, at best, lack of knowledge and understanding by staff and at worse, abuse.⁶ This covers both private and public sectors.

"We had somebody call us in tears the other day who had been denied access in a leisure centre. Another user said you cannot go in there, if you do I'll beat you up, and she was actually there with her small son so she found the whole thing very distressing." (Bernard Reed, GIRES).

"(I) was told by the manager of the establishment that my sort wernt (sic) allowed in because whenever he's allowed my sort in there's always trouble."

"Visitng (sic) Weymouth, group of four trans women, empty restaurant, said they were full and closed, shoved us out, locked the door, re-opened for business five minutes later after we had left."

"At a beauty college where I was receiving electrolysis the college principle intervened and told me I could not be treated there because I had not had GRS and the college was for women only."

* e.g. Leisure centres/swimming pools etc

⁶ The fear of how they might be seen is captured in this piece from 'Little Britain', as David Walliams' portrays transvestite character Emily Howard on a trip to a local swimming pool <http://tiny.cc/1wybv> A significant number of trans people have raised disquiet about the hurtful caricatures of trans people presented by Walliams and partner Matt Lucas in this series

Family Life

45% Experienced family breakdown

37% Excluded from family events

36% Have family members who no longer speak to them

Ostracisation by friends or wider family remains common. Whilst transsexualism is a medically recognised condition, and UK law disallows divorce petitions based upon medical conditions, the acceptance of transsexualism as "unreasonable behaviour" by the courts is routine. Divorcing transsexual people agree to punitive divorce terms as they deal with feelings of guilt at 'destroying the family'. These statistics are likely to be much higher if the sub sample of transitioning transsexual people is broken out.

"I gave her pretty much everything. I remember we went to 'mediation'. Amazingly, the mediator knew a counsellor who had experience in this field, and this woman came to one session with some literature she had about the condition, some stuff from charities and so on. My wife just turned to her and said 'Why would I want that propaganda?' And then she walked out."
(Male to Female Transsexual woman)

Suicidality

34% Attempted suicide at least once as an adult

14% Attempted suicide more than twice as an adult

Data for attempted suicide amongst the general population are difficult to acquire as attempts are often unrecorded. However, a context is offered by the statistic that in 2009, 5675 people in the UK killed themselves, out of a population of around 61 million. This represents a percentage of 0.00009%. Beyond these figures, qualitative data suggests that the majority of trans people contemplate suicide at one stage or another, especially if they are seeking to transition.

Workplace discrimination

29% Experienced verbal harassment at work

23% Changed their jobs or planned to because of trans status

22% Required to use the toilets of their former gender at work, whilst transitioning and living through their Real Life Experience

6% Physically assaulted at work

10% Verbally abused at work

Workplace discrimination is an area addressed by the Equality Act 2010 and employment legislation, and there is evidence that progress is being made. However, charities working in the field still routinely deal with major problems in this area, either overt or tacit.

As employers become aware of the legal protection offered to some trans people, stories of more subtle discrimination – with individuals being ‘moved sideways’ into positions where they are vulnerable to redundancy or cannot flourish; suddenly receiving ‘poor appraisals’; being unexpectedly overlooked for promotion; or being offered sums of money to resign, continue to circulate.

*“I started work with ***** who had team meetings and outed me [as trans] to everyone in team meetings before I started in my department and also told them my birth name! This resulted in me receiving anonymous threatening notes at my desk”.*

*“I work for the ***** store and have been there for seven years. Last December I was diagnosed with gender dysphoria, and approached my personnel manager about transitioning at work...”*

*We had a verbal agreement that I would use the ladies locker room and the customer disabled toilet, I started back to work as ***** (new name) put my stuff away and started work. Half an hour later I was summoned to Personnel, told there was no way I could use the locker room and was made to take my stuff out and carry it through the whole shop and keep it in a computer games cupboard... I was not allowed a key and had to ask a supervisor every time I needed my bag or coat, I was also sitting on the checkouts and getting abuse from customers which led to panic attacks, but they refused to take me off them. I managed to get in touch with my Regional Manager and he arranged a meeting with the Manager, my Store Manager and myself. They told me they had wasted too much time and money on me and that they didn't know what to do with me and that they would not be supporting me... I was given a filing cabinet in the car park attendants office for my bag and, they also decided to keep the disabled toilet locked because it had been vandalised so often and my only alternative was to cross the car park and use the garage toilet.”*

“... most firms “claim” to be trans friendly... but, although it is illegal to discriminate they do... but they find another reason to justify it.”

As recently as 2006, Press for Change, a leading charity working in the field, received a letter from a transitioning woman, detailing the response she had received from her large public sector employer, with respect to their refusal to let her use appropriate toilet facilities. Part of this letter reads...

“(HR) confirms that you cannot legally change your sex from that which is on your birth certificate until you have undergone the operation to remove your penis, therefore I have to inform you that you will not be able to use the female changing facilities until this has taken place”.

As ‘Engendered Penalties’ points out: “This employer is misinformed. It is not legally necessary to undergo genital surgery for legal recognition of one’s acquired gender and to receive a Gender Recognition Certificate. Neither is there any law about what genitals you need to access gendered facilities”.

Healthcare

30% Felt that being trans had adversely affected the way they could access non-trans related treatment on the NHS

19% Felt that their GP has been unhelpful, or actively refused help

The responses of the medical community to trans people remain a concern, with lack of knowledge of trans issues and needs still widespread. A significant minority of trans people continue to experience what they see as obstruction from their GPs and others.

“I had to change GP because he just could not accept gender dysphoria as being real.”

“I went to a GP having persistent problems with my digestive system and getting an upset stomach a lot. The GP was very dismissive, did no tests and said it was my own fault for putting something into my system that is not meant to be there – Sustanon [hormones].”

“A doctor supposed to be treating me for appendicitis exposed my genitals for a group of students to see.”

Education

Experienced harassment whilst at school:

64% Female to male identifying respondents

44% Male to female identifying respondents

Experienced physical abuse whilst at school:

24% Female to male identifying respondents

26% Male to female identifying respondents

Experienced sexual abuse whilst at school:

4% Female to male identifying respondents

4% Male to female identifying respondents

Transphobic bullying in school remains a serious problem, and trans campaigners are concerned that the government fails to recognise its prevalence. GIRES works in this area, together with Mermaids – an organisation set up to support trans children and their families.

Other data suggests that bullying of transgirls (e.g. male bodied individuals who identify as female) is here underreported but the report’s authors speculate that the “there is evidence to suggest that those brought up and living as boys learn to hide their cross-gender behaviour or identity – because of an awareness of the peer pressure for gender conformity. Indeed, there is evidence to suggest that under these circumstances, gender conformity is increased to avoid social rejection”.*

Shockingly, whilst the majority of bullying at school was at the hands of other children, of those who had reported it, between 26% (male to female respondents) and 39% (female to male respondents) reported bullying by *teachers or senior staff* – the very people in whose care they had been placed.

* Rudman and Kimberley 2004

"I learnt to live in stealth as a boy in order to survive. My schools were transphobic in that transness was not even remotely an option".

"I became solitary, insular and insecure. I went to great lengths to conceal my trans characteristics".

"I never felt I fitted in. You learn very quickly to hide who you are".

"In my first year I was sent to the headmaster's office and humiliated for refusing to wear a skirt. In the end I had no choice. I avoided going to school as much as I could get away with."

The effects of this kind of treatment at school can be unsurprising:

"I tried to go to school as little as possible as I hated wearing a skirt and being treated like a girl."

"I had to skip a lot of classes because I developed severe anxiety and was unable to cope with the pressure of constant abuse."

"I did not complete my studies".

Catherine's Journey

Every trans person's story is different, and individual trans people identify in different ways. Some trans people do not transition. Some do not want to. Some cannot. Some are left, as they feel, unsupported – with medical professionals not recognising the nature of their feelings. Others approach the medical establishment, start the process and then for various reasons pull back.

This is the story of the medical treatment through which 'Catherine', a male to female transsexual woman, has gone – told in 10 steps. It's important to note that the moment in which she has 'the surgery' by which society typically defines people like Catherine is just one stage of the 10. It's an anonymised account, but is based broadly around the story of one such woman, and every event in it is based on things that have happened. It is not intended to be taken as 'representative' of the majority experience but seeks to tell only one story.

It does however, chart some of the most important medical waypoints through which one 'type' of trans person must travel as she goes through transition, under the UK system.

Stage 1: Seeing the GP

Catherine has been struggling with an increasing sense of desperation about her inner feelings for many years. Living as a man, married with children, she has tried to explain what she is going through to her spouse for many years without success. Her marriage has now broken down, in some acrimony and mutual misunderstanding.

Walking into her GPs surgery to ask for help means giving up on decades of struggle, but now at last she feels she is coming to grips with what she has to do. She knows she has fought this moment for years, trying strategy after strategy to make her feelings disappear. More and more it's felt like she has been trying to hold up the wall of an enormous dam – behind which the water level was rising relentlessly. She's seriously investigated suicide, stopping herself through love of her children. She's terrified of losing everything – her children included, plus her job, her friends, her home, and of being ridiculed in the street. But the dam has collapsed. Now, in her early forties, she knows she desperately needs help.

The GP is bemused, but tries to be supportive. He doesn't know much about the feelings Catherine seems to be describing, and he doesn't know what to suggest. Catherine has done her research and suggests that the only place where she can be seen by experts is at one of the UK's Gender Identity Clinics (GIC)⁷, the biggest of which is at Charing Cross Hospital in West London. She tells the GP this, but he says that he must look into it further.

⁷ Newton Abbott, London Charing Cross Hospital, London Portman & Tavistock Clinic (specialising in children and adolescents), Leeds, Nottingham, Sheffield, Norwich, Glasgow, Edinburgh, Belfast

A week later she is back, and he tells her that he cannot refer her directly to a GIC, but that she must be seen by a local psychiatrist within the Primary Care Trust area for an initial assessment. He says he will write a referral.

Stage 2: Seeing the local Psychiatrist

Four weeks later, Catherine – by now living alone in a hastily rented flat, and with only limited contact with her children – receives a letter from the local Mental Health Team. She has an appointment for two weeks time.

She goes to the appointment 'en femme' (dressed in her preferred, female gender), trying and failing to avoid the smirks of passers by and people in the waiting room at the clinic. The psychiatrist sees her. He has no experience of this issue either. He asks a lot of questions and she ends up telling him much of her life story. She senses that there is a 'narrative' that professionals like him are seeking to hear, and she tries to order her thoughts so that he will understand. He is open minded but, like her GP, seems baffled. He doesn't know where she should be treated, so Catherine explains that she needs to go to a GIC.

He tells her that he cannot refer her there, because he needs first to check whether there is another specialist psychiatrist in the area who can advise on her case. Catherine, who has a friend locally who has been through this, tells him that there isn't one. "I know," he says, "but I still have to go through the pathway".

Catherine then hears nothing for six weeks. The psychiatrist has been busy, she is told when she rings. Eventually, she receives a letter, writing up their conversation. It is thorough, but full of inaccuracies. Hurtfully, it uses the male pronoun throughout and refers to Catherine by her male name. It says that an enquiry has been made within the Health Trust to establish whether another person can see her.

Catherine writes back, correcting the errors, and explaining that she would prefer to be referred to in the female (persisting in the use of old name, or using incorrect pronouns is amongst the most hurtful things one can do to a trans person as it implies disregard for the authenticity of his or her experience).

Ten days later she receives a revised letter. She notes that it certifies that she is not suffering from mental illness, or psychosis and rather unexpectedly (as this often comes later) it diagnoses her with transsexualism. Having been told over the years, variously, that she was 'sick', 'insane' or 'perverted' for feeling as she did, by members of her family, or indirectly by the media, she is pleased to have a professional assurance that she isn't any of these things.

She then waits a further three weeks, before receiving another letter in which she is told that no other clinician being available within the Trust, a letter of referral has been sent to Charing Cross GIC in London (after an application was made on her behalf to PCT's 'Exceptions Committee' – the body which approves or declines funding for treatment over which there is no set procedure). She has been frustrated at the delay, but knows she is lucky not to get 'stuck' at this point in the process, as she knows others who have had to see their local, non specialist, psychiatrist several times before a referral is made.

Stage 3: Contact with the GIC

Three weeks after this, Catherine is pleased to get a letter from Charing Cross GIC. But when she opens it, she discovers that they are not prepared to offer her an initial appointment until she signs a form to say that she commits to coming to the appointment, and funding by her local PCT for the appointment has been provided.

She calls her GP, who says he will do what he can, and a week later she discovers that funding for necessary appointments have been granted. There is no question of any funding for treatment of any other kind (e.g. surgery should she need it), at this stage.

A week after that, she receives another letter from Charing Cross GIC, telling her that her initial appointment has been scheduled. Depressingly, it is not for another six months.

It is now over five months since she went to see her GP, and it looks like it will be approaching a year before she sees a specialist for the first time.

Catherine has waited almost forty years to ask for help. She is feeling fragile and alone. In the meantime, the situation with her ex spouse has deteriorated, causing great stress, and discussions around the terms of her divorce are not going well. Almost all the friends she made when she was married want nothing more to do with her, some have been vitriolic about the "selfish choice" she has made, and her spouse's family have cut her off completely. She feels lucky to have the support of her parents. She has yet to tell anyone at work about what is going on, but she worries about it. She is presenting as male for work, but the rest of her time is living as her female self. She has had no facial hair removal treatment yet (a vital aspect) and no hormones, so she knows she attracts attention from others, and she is frightened when she goes out as Catherine. But being able to be herself at last – even at this stage – brings with it an immense sense of peace.

Stage 4: Getting private help

Catherine now makes a decision that she knows is not open to the majority of trans people – and one driven by the isolation and delay she feels has been imposed upon her. She decides to see a private specialist. She feels she needs to develop a parallel track – keeping her 'place' in the NHS process (she is worried that she might not be able to afford private care long term), whilst augmenting it with private support. She worries that she won't get the help she needs from the NHS, that her PCT won't pay for it, that the people she sees won't understand (as none have so far).

She gets an appointment at the leading private Gender Clinic in London and sees the specialist there. It is a very expensive visit, but they talk in depth about Catherine's experiences and she feels listened to. She wants to know about the possibility of hormones. She knows that under the NHS, these are denied to patients until they have completed at least three months living full time in their new role, including changing their name (she is aware of the need for caution, but does not relish the thought of having to go 'full time' without the physically feminizing effects of hormones to help at least a little). The specialist tells her that he is satisfied that she needs them, and his other major criterion – that patients undertake a period of counseling before embarking on hormone treatment – has been satisfied for him by a period of therapy Catherine has already been through.

She needs to get 'baseline' blood tests done, and then she can start on oestrogen patches. Three weeks later, she is back in his consulting room with her blood tests and he agrees to write to her GP to ask him to prescribe hormones.

At this point, Catherine is aware that her GP may refuse. She knows people to whom this has happened. The specialist is – in essence – requesting the GP to embark on treatment that is unfamiliar to many and remains 'unlicensed' in the UK, despite the thousands of people who go through this process since the late 1950s. She is also asking her GP to 'convert' a private prescription to an NHS one. This saves the patient a significant amount of money. Luckily, Catherine's GP agrees.

Catherine now starts on facial hair removal. She knows that the NHS won't pay for this, an anomalous and distressing situation for some who cannot afford private sessions (and many are required). She looks into the methods available, eventually settling on Intense Pulsed Light (the others are Laser and Electrolysis). All are painful, with electrolysis generally regarded as having the best, but slowest results. IPL is said to have good results with dark facial hairs (though over the next 18 months she has mixed experiences with it). Catherine eventually spends over £1700 on this treatment, for 14 sessions, and it partially clears her dark facial hair.

Catherine also decides to get speech therapy. Changing her voice is, she knows, going to be critical if she is to be accepted in the world – and though she is bothered at the thought that society's expectations of her might be a factor here, she feels she has to be realistic. She knows that the NHS does fund speech therapy – sometimes – but she is unsure when she will get that funding and she has heard waiting lists are long.

She signs up for sessions with a leading speech therapist in London. Again, they are expensive, but Catherine is pleased by the progress she makes. She eventually has 12 sessions – with travel, it costs her over £1400. Her therapist tells her that the length of treatment does vary significantly from one person to the next.

Stage 5: Going 'Full Time'

Just under a year after she began her formal process of transition, Catherine decides that it's the moment to go 'full time'. She has been wanting to do this for as long as she can remember but since leaving the marital home has been very conscious of the need to get her divorce over and to help her children to start to come to terms with the situation (something for which she seeks therapeutic and medical help and finds none), and to prepare her employer. She knows that the timing of this moment is something that varies widely in the lives of transitioning trans people. Some seek to take this step as rapidly as possible, when the opportunity arises. Others take longer, as their circumstances dictate.

'Full time' means for Catherine, as it does for other transitioning people, the moment when her previous gender identity is left behind – permanently and for the rest of her life. It means changing her name by Deed Poll or Statutory Declaration and then contacting the many organisations and bodies holding records of her identity (she counts 44) to have them changed. She reads that standard practice is to send each organisation an official copy of Deed Poll document, plus a supporting letter from her clinician. Another paid for visit to her private specialist produces the letter she needs.

Contacting each organisation takes some time. Some respond rapidly. She finds the Credit Reference agencies very willing to help. Some demand inappropriate and unnecessary documents. It feels humiliating and intrusive going through everything with strangers on the phone, as she is still working on her voice and she is called 'Mister' by most of them. Catherine has particular difficulties with her private medical insurance (which has also refused to pay out for any private treatment for her medically recognised condition), her bank and her pension company. Confusion reigns from some – they seem to have no policy at all in this respect and over the course of many phone calls, she hears various stories about why they won't change her records, or will do so only partially. Eventually she gets most of it sorted out, but a number of organisations refuse flatly to change the gender signifier on her records until she provides them with a Gender Recognition Certificate. This is something Catherine will not be able to even apply for, for another two years. She is aware that, in law, she cannot be made to produce it when she has one – but the demands to see it are arriving already.

For months to come, Catherine continues to receive mail in the wrong name, as records from obscure parts of the organisations she has contacted remain unchanged. She is trying to establish herself in her new role, and each of these events is emotionally hurtful.

Going full time also means telling her work colleagues about her intentions. Catherine has been talking to the HR Director of her firm for sometime, and preparations have been made, which involve Catherine's manager. The HR Director invites her team to a meeting to discuss Catherine's changes and Catherine explains to them what is about to happen. She emails the wider company, explaining things. There has been some debate about which lavatory Catherine should use during her transition, but her manager understands that it's entirely appropriate for Catherine to use the female facilities, and her team understands this. Many of Catherine's colleagues are shocked to hear her news, but the large majority are supportive. Some clearly find it beyond their experience and subsequently become more remote to Catherine but she is lucky in not experiencing significant prejudice against her, and in working for a supportive employer. Catherine explains that she will take a week off and then return to work as her 'new' self. The day she does so she describes as both one the most terrifying and the most liberating days of her life.

Going full time is important to Catherine because from this moment the clock is running. In two years she will qualify for a surgical referral for her gender affirmation surgery, and can apply for a GRC to get her birth certificate changed.

Stage 6: Seeing the GIC

Things with the GIC haven't been going smoothly. Twice before the appointed date, it writes to Catherine to cancel her first appointment because of staff shortages, and offer her another date. Catherine moves the dates, and tells her employer, but then realises that the second date is impossible for her. It clashes with a vital work commitment; a day on which a project she has been leading will come to fruition and all eyes will be on her to demonstrate that even in her 'new' gender she is still able to deliver for her employer.

She calls the clinic to ask for another date. She is told that if she (as a patient) does this, she will be put at the back of the queue for appointments. The clinic tells her that the next available appointment will then be over seven months later still. Catherine explains

the importance of the meeting she must attend, but she suspects that – apart from being overwhelmed by referrals – she may be on the receiving end of a widely suspected policy designed to force patients to demonstrate their commitment to treatment *whatever the personal cost*. Catherine eventually elevates her complaints, angrily, explaining all she has been through, and after further attempts a new date is offered to her close to the original one.

Eventually, Catherine arrives at Charing Cross GIC for her initial assessment. It's been almost a year now since she first asked for help.

Slightly unusually for a patient there, she has already gone 'full time' and is on hormones. Her body shape is changing, her skin is softening and her breasts are developing. She is given a form to fill in which tells her that she will be denied treatment if she fails to attend future appointments, if she is asked to stop smoking or drinking once on hormones and then doesn't; plus other 'rules'. It talks about 'surgery' as if this was a predetermined conclusion of all interaction with the clinic, and though she feels she wants it, she'd like the chance to talk to a professional about it. She wonders if patients attending clinics for other conditions face such regulations. She has heard that GICs suffer from a significant 'no show' rate, but she is upset by this approach, before she has even seen a clinician for the first time.

The Consultant she sees takes her life story down once more, and asks questions about how long she has been feeling as she has. At the end of the session she is told she is to come back for a second appointment for further assessment. She is worried about disclosing that she is being seen privately. Despite clear NHS guidelines, which entitle patients to care from the private sector without loss of parallel support from the NHS, she has heard of instances in which GICs have reacted badly to this information. Nevertheless, she mentions it, and that she has been on hormones for some months. The Consultant also notes that she is now living permanently in her new role.

Catherine receives a letter in two weeks later informing her that her next appointment will be in six months time. She is bitterly disappointed about continual long waiting times. It is difficult getting time off from work, as she has to travel some distance to London, but with such long delays in being seen at least she has notice.

Two months later, Catherine's appointment is cancelled by the clinic. She is given a new date, two weeks after the old one. She changes her arrangements at work.

A couple of weeks later, she receives another letter, saying that the appointment has been cancelled again. Once more she is given a new date. Once more, having held two appointments, Catherine finds that she cannot do this third one. She calls the clinic and explains. They can do nothing, they say. They have been overwhelmed. It must be refixed and there will be a substantial additional delay now, as the appointment was changed by her – the patient, and not by them at the clinic.

Catherine thinks about making a fuss, but she simply can't find the energy. Her work is demanding and some people at work are avoiding her. One or two clients with whom she used to work are now being handled by others, and she's not sure why. Her family situation is difficult, her children struggling. Money, which used to not be a problem, is a concern. And there is the problem of the sniggering in the local shop and the youths who shout

names at her in the High Street when she's shopping. She tries to ignore it, though she found being filmed on a mobile phone in a pub very demeaning and it was horrible to be spat on in a shopping centre.

The new appointment arrives. It is for almost a year after her first one at the GIC.

For all the barriers she is facing, Catherine's resolve is undimmed. Being herself, she tells a friend "is like walking out of prison and seeing the sky". Her heart is breaking for her children though and she is losing faith in the NHS.

Stage 7: Facial Surgery

Whilst she is waiting for her next appointment, Catherine makes a momentous decision. She knows that specialist surgeons around the world offer a range of techniques that can help 'feminise' her face. She has long turned over the pros and cons of such a procedure, on the one hand resenting suspicions inside which suggest to her that society wants her to look a particular way, but on the other gradually realising that she will have to carry the burden of being stared at or ridiculed for the rest of her life if she does nothing. She has always disliked the way she looked – like many trans people she would look in the mirror each day and feel a sense of profound disappointment somewhere deep inside that the face looking back was the wrong gender. That it wasn't somehow *her*.

But this is major, expensive, surgery. She knows that most trans people in the UK simply cannot afford it, and that it is not available on the NHS. Nor is it without risk, both aesthetically and neurologically. Catherine starts an extensive process of research, joining internet groups, looking up websites, contacting surgeons. She rapidly rules out surgeons in the UK, and is drawn to a handful in Europe and North and South America. She knows there are good people in Thailand doing this work too. Eventually she settles on a surgeon in the US. He has a strong reputation, she has seen examples of his work, and his price, though high, is just within reach for her if she uses almost all her savings. She also likes what he has to say about seeking to ensure that she remains completely recognisable, "like your sister might look" and without an "operated on" appearance.

Catherine takes unpaid leave from work, and a friend goes with her for the ten hour operation. Catherine has a total of eight procedures, reshaping her jaw line and chin, grinding down her brow bone, advancing her scalp line and raising her brows and upper lip, lifting her face and neck and removing some fat. She leaves hospital three days later to convalesce in a local hotel for a couple of weeks. She has 400 stitches and staples in place, and the swelling is intense. But as soon as she takes the bandages off, and looks in the mirror, she knows it has been a cosmetic success. Though hugely bruised and swollen, in the mirror, is her.

The swelling takes three months to disappear fully, and the surgeon tells her that the full results won't really be apparent for a year. Catherine is delighted, though there has been significant nerve damage around parts of her face, causing tingling and numbness which will never recover. For her, it's a price worth paying.

Stage 8: Back to the GIC

Eventually, Catherine sees the clinic again. She notes to herself that had she not been getting private support, this appointment would have been the first moment at which she would have been considered for hormone treatment, now almost two years since she first saw her GP. She notes also that she would have been denied it if she had not gone full time, at least three months previously, and changed all her records, or if she had indicated that she still needed to present in her former male self at any stage at all. She has a friend who was denied hormones because she mentioned that she still needed to present in her former role for one afternoon a month to help her traumatised son, with whom she had almost lost contact. She reflects on how lucky she is to be able to afford private treatment.

She sees a different Consultant this time. She feels this new Consultant is aggressive with her, trying to catch her out. For the fourth time in succession she goes through her life story to a medical professional. She explains that she has been full time for over fifteen months now, but he doesn't seem to believe her. He wants written proof from her employer and clients, some of whom don't know her story. She is upset and angry about this. But she has heard stories that some people are refused referrals for surgery if they cannot prove they are working. Eventually he accepts that she is telling the truth.

She leaves with the promise that the next time she comes in they will discuss moving towards a surgical referral. Catherine is now beginning to abandon the belief that the NHS will offer her surgery. She has in fact long been hearing stories that, despite legal obligations to do so, many PCTs try to avoid funding gender affirmation surgery, citing it as 'low priority'. Legal action has been taken against several to force a change, but the battle continues in many areas. She starts to think about going abroad once more, aware that she has already fulfilled the worldwide standard for 'living in role' of one year, and that only the NHS in England insists on two years.

The situation is now complicated for Catherine by a change of address. She needs to move house, and her new home is in a new PCT area. The 'postcode lottery' of which she has heard is a very real concern for trans people, and whilst her previous PCT was relatively cooperative, she soon discovers that her new one takes a different view. Worse, she needs to change her GP, moving from one who has supported her with sensitivity throughout her process to a new one, who, she discovers, is disinterested and uninformed.

Her first interaction with her new GP makes her very upset as the GP says that she will not prescribe one of the two drugs she needs as it is "too expensive", and the PCT will not "allow it". In addition, a range of false clinical data is brought up by the GP about this drug, which Catherine knows to be untrue in her case, but she is not believed. Once again, Catherine finds herself having to tell her life story to a medical professional, and after several appointments, and more costly visits to her private specialist, the GP agrees to give her the drugs she needs, temporarily. But her problems with her new GP continue, as she tries to have herself referred to an NHS endocrinologist (as her previous doctor had done) without success, and as she tries to explain what the results of the blood tests she needs regularly should look like. Catherine can see that there are serious hormonal problems indicated (confirmed later by her specialist), but her GP has missed them and downplays them when she points it out.

Four months after her second appointment, Catherine is back at the GIC, for a third appointment. She sees her original Consultant, who is sympathetic and interested in her challenges. He agrees that, once her two years of living in role expire – she can be put forward for genital surgery.

He needs another clinician to co-sign the referral, but he says that the next thing Catherine should expect will be a letter from the surgeon for a consultation.

Six months later it still hasn't come.

Stage 9: Gender Affirmation Surgery

It seems to Catherine that the NHS process has ground to a complete halt. She starts to make enquiries about having her final surgery abroad. She knows there are surgeons in the US, Canada and Thailand with worldwide reputations, but she knows also that they come at a price. Once more, she is aware that the vast majority of trans people seeking surgery in the UK need to go through the process of using NHS GICs and have no alternative but to deal with delays as they arise. But Catherine needs this done to get on with her life and has worked hard to put enough aside (about £10,000) to have it done privately. It is part of her journey – a vital piece of the jigsaw – and though she knows that society and the media tend to 'fixate' on this moment amongst all the other 'moments' of transition, it is nonetheless a hugely powerful aspect of the process she is going through. As well as fixing something that she feels has 'gone wrong' with her body, and giving her at least the chance of having a love and sex life again in the way she wants it (though other trans people find their own ways through this), it will resolve many practical problems too, she hopes. She can go swimming again. She can travel through airports without fear of public humiliation. There are parts of the world she can now visit if she wants or needs to – without fear of potential arrest, imprisonment, or even execution.

The trail in the UK seems to have gone cold. She rings the GIC to find out what has been happening about her surgery. She is told that her PCT has withdrawn funding for gender affirmation surgery until the next financial year at least. This makes Catherine's mind up for her.

She talks to her employer, and is grateful for their understanding about her needs. She knows that many employers can still make trans people's lives difficult around their medical requirements. Catherine gets a private referral from her specialist (one of two she needs) and books her surgery in Thailand.

She goes to Bangkok, to see a world-renowned surgeon, using up the last of her savings. Her surgery takes six hours. It's a great success, and the surgeon is pleased, though the aftercare regime is extensive, intense and will last many months. The nursing staff are kind and attentive and as Catherine spends time in a local hotel regaining her strength, she reflects on how far she has come. She spends three weeks in Thailand, before making the eleven-hour flight home. She knows that having had surgery abroad, the NHS may be unwilling to support her should she develop post-operative complications, but she has made the choice to go to one of the best surgeons in the world in the hope that these complications will be minimal. She hopes that if she does face any they will be minor and can be treated by her GP.

Stage 10: Gender Recognition

Catherine looks forward now to bringing together a range of paperwork so that she can apply for a Gender Recognition Certificate. This will allow her Birth Certificate to be changed. She has to pay for this. She knows that she could have applied for one before her surgery, and that having genital surgery is not a prerequisite of gaining a GRC. But she also knows that the Gender Recognition Panel is generally more likely to turn down an application if the applicant hasn't had surgery.

Afterwards: The Rest of Catherine's Life

Catherine will continue on hormones for the rest of her life, and she will need regular blood tests to monitor her health, with special focus on her liver function. She has read that her life expectancy may be reduced now. She has years of electrolysis still to go through – whilst the hairs on her face have been diminished drastically and are invisible under make up, they are tenacious and she still needs to shave every few days to ensure they don't become a problem.

But the rest of her life is now beginning. Most of all, Catherine simply wants to be able to live it as the woman she knows she is and has fought to be accepted as, without being endlessly labeled by a medical condition she was handed, but never chose. People ask her about what she has lost, and it is considerable. By far the most painful aspect of the whole process has been seeing the trauma caused to her children. She has been through many dark nights of guilt and pain about how her children are feeling. Happily, they have now all accepted what she had to do, and why she had to do it, and whilst they all have some way to go their love of each other is as strong as ever.

For all she's lost Catherine has found something beyond price. Herself.

And, no, she wouldn't go back...

Trans People and the Media

Though little formal work has been done in this area directly, all the related evidence supports the view that modern British society remains poorly informed about transgender issues. Many trans people have long adopted a policy of seeking to avoid attention and even danger by living out their lives in secrecy. Only in the 1980s did the clinical practice of advising a transitioning person to cut all ties with his or her past, leave home family and job, and start a new life with a new identity far away, die out.

In as much as trans people can 'take the temperature' of society's current understanding of them, they look to the manner in which the medical profession treats them, how legislation brought forward by government affects them, and critically, how they are portrayed in the media. For many years, anecdotal evidence has circulated widely within the community that media portrayals were having a direct contribution to the prejudice – and worse – being faced by trans people, and that trans people were being verbally and physically assaulted to a vocabulary provided by an ill informed media which at best presented them as bizarre and at worst as perverted and dangerous. The tabloid press was often cited as the most consistent culprits, but television, with its 'demeaning' comedy and focus on sensationalist characterisation was also widely mistrusted. This entry from The Gender Trust's website, recounting a story from 2006, says it all.

'Hostile stares awaited us outside. An old man of Asian origin turned and followed us, shouting: "Men! Abominations! Disgusting... fake hair, fake tits: fake woman!" but my new friends seemed unsurprised. Many other men hung around the district looking amused. I alone was flabbergasted.

"It's OK once we get past here – they love us in the town" Alex assured me. But children on bikes followed us, shouting 'Fucking trannies!' and throwing bits of rubbish at us. I was livid. Alex and her friend saw this as much a part of going out as putting on one's shoes. For them, it was.

We encountered a few rude stares after that, but on the whole we were fine on the hot streets of Bethnal Green, with its outdoor drinkers and quirky fashion boutiques to rival Camden. But returning to the house we experienced more abuse: "I'm a lad-ee!" mouthed a large group of men whilst chasing us towards the stairwell. I was scared.

*Safe inside, Alex told me such harassment was her everyday life, but the council refused to rehouse her.'**

Alex Silverfish, the subject of this piece, later committed suicide.

* <http://gendertrust.wordpress.com/2010/06/06/internal-transphobia/>

Many trans people have historically tended to protect themselves by turning away from hurtful characterisation in the media, seeking to avoid or ignore it whilst they managed their own lives quietly and privately. This remains the strategy adopted by many.

Some – perhaps those whose personal circumstances mean that they may be more insulated from public ridicule or abuse (not transitioning, living within a supportive family setting, or transitioned years ago, for example) - may take a more assimilationist stance, endorsing the normative social discourse and even criticising campaigners for ‘over sensitivity’.

However, the general trend within the trans community, accompanied by its growing confidence and self-awareness, has been towards anger towards treatment of trans people in the media. Parallels have been drawn with the emergence of political consciousness amongst second generation Black and Asian communities in the 1970s and 1980s, and those parallels gain further pointedness when the vast improvement in the relationship with the media achieved by this group is explored. 40 years ago, British tv audiences saw non-white people through vehicles like ‘The Black and White Minstrels Show’, ‘Love thy Neighbour’, and Jim Davidson’s feckless ‘Chalkie’ character. Now Asian and Black British newsreaders are well established, many more media figures come from these backgrounds, and Black and Asian comedians have primetime exposure – without note.

In 2006 ‘Engendered Penalties’ had this to say:

‘When asked what they would like to see happening if they could wave a magic wand, most survey respondents stated that they wished that people in British society were more tolerant towards them:

“For the media to stop portraying trans people as freaks and deviants, and give society the right information.” (Survey Respondent)’

Trans Media Watch (TMW) was formed in 2009 in response to the first coordinated outcry by the transgender community in response to an item of broadcast output (and episode of ITV1’s sitcom ‘Moving Wallpaper’), leading calls for Ofcom to censure the programme makers under ‘harm and offense’ clauses of the Broadcasting Code. Despite 100 complaints, and two appeals, Ofcom refused to rule against the programme makers – but a dialogue was opened which has led to contacts between the trans community and the media (led by Channel 4). TMW has become the principle voice in the transgender community in the area of transgender portrayal, and also advises trans people on how to respond to enquiries from the media.

At the end of 2009, TMW conducted the first significant piece of research ever carried out in the UK (and possibly the world) into how the transgender community feels about its portrayal by the media⁸.

The results of this study – based on 250 self completed online questionnaires – painted a picture of anger and alienation which took even campaigners by surprise.

At an immediate level, the large majority saw the media as entirely disinterested in portraying trans people accurately:

95% of respondents said that they did not believe the media cared how trans people were portrayed.

78% believed that portrayals of trans people were either inaccurate or very inaccurate

70% said that portrayals of trans people in the media were either negative or very negative.

The effect on the quality of trans people’s lives was clear, and TMW was particularly concerned to discover that 1 in 5 respondents felt *fear* as a result of media portrayal:

67% of respondents said that seeing negative items in the media about trans people made them feel ‘angry’

51% said that these items made them feel ‘unhappy’

35% said that they felt ‘excluded’

20% said that they felt ‘frightened’

⁸ www.transmediawatch.org.uk/tmw/documents/201004TMW_0001.pdf

Said one respondent:

“Negative experiences can be so very damaging. What troubles me is how common it is to see almost throwaway references to trans people that are so cruel and damaging no one would consider saying it about anyone else or group... And what is even scarier is how commonplace and accepted it is. There are weeks when I will see several examples, especially in sitcoms or discussion programmes or films that will simply reference how freaky, disgusting or hilarious trans people can be. Sitcoms especially seem to have picked this group recently... and more and more I see cheap bad jokes made at the expense of trans people”.

Respondents were also asked about the results of media portrayal for them:

21% of respondents reported experiencing verbal abuse which they believed was associated with representations of transgender people in the media

8% reported receiving physical abuse which they believed was associated with representations of transgender people in the media

The report noted:

‘The most common form of verbal abuse clearly associated with television referred to the ‘Laydee’ characters in Little Britain (‘Emily Howard’ and ‘Florence’)...

Three received abuse relating to Thomas Beatie (a trans man who became famous for his pregnancies). One reported frequently being asked aggressive questions of a sexual nature which related to items about Mr Beatie.

The verbal abuse reported by respondents was often described as being aggressive, with the implication that some of the respondents felt they might be in physical danger from their abusers. It also frequently involved sexual references, such as demands to see genitals. Several respondents reported that they had endured multiple instances of abuse and in some cases these incidents were connected, with one referring to “a month long hate crime campaign” which she believed may have been connected to negative stories in the media. Media-related verbal abuse was reported as occurring at home, in the street, at work, in supermarkets, and even, in one instance, in a lesbian bar. Both men and women, and often teenagers, were responsible for the abuse.’

‘Several noted that their attackers (in incidents of both verbal and physical abuse) had used language that is generic to media descriptions of trans people. It may be inferred that this differs significantly from the language they would use to describe themselves. One respondent specifically referred to “comments that imply I might be a sex worker” and linked this to the associations between trans people and sex workers frequently made by the media.’

The role of the media in promoting social isolation was also clear:

34% of respondents reported that they felt media representations of trans people had precipitated negative reactions from their family or friends

5% reported that serious ongoing family problems/ complete family breakdown which they linked directly to negative items in the media

Respondents commented on the effect of media portrayal on family life:

“I lost my family - parents and siblings - because of the way this is portrayed by the media”.

“My mother’s perceptions of trans people derived almost exclusively from what she’d seen portrayed on television - she referenced various programmes in an attempt to paint trans people as pathetic, unconvincing and inherently narcissistic. She rejected all suggestion that transsexual people could ever be in any way ‘normal’. She has now refused contact for several years”.

The effect in the workplace and amongst service providers also showed up:

34% of respondents reported negative reactions at work in relation to items about trans people in the media

12% reported negative reactions from service providers, including the NHS, which they felt were related to items in the media

With respondents commenting...

“(Colleagues laughed and mocked trans people GRS)... due to seeing comedy shows and poor quality documentaries on tv”

“Anything trans related in the newspapers/media was made fun of”

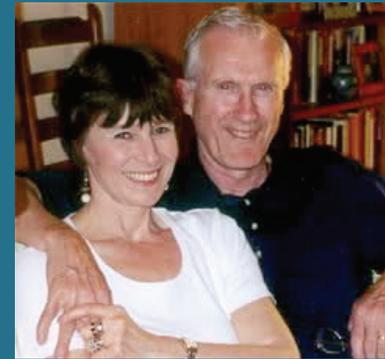
“A female transvestite...like something from a British sitcom (GP talking to a transwoman)”

Trans Media Watch and Channel 4 signed a Memorandum of Understanding in March 2011, under which Channel 4 undertook to work towards

- Eliminating transphobia in the media.
- Ending the provision of misinformation about transgender issues in the media.
- Increasing positive, well-informed representations of transgender people in the media.
- Ensuring that transgender people working in or with the media are treated with the same respect as non-transgender people in equivalent positions.

TMW is continuing to work with Channel 4, the BBC, and media regulators plus other broadcasters and newspapers.

Hearing from the experts: The Charity



**Bernard Reed OBE
and Terry Reed OBE**
The Gender Identity Research and
Education Society (GIRES)

Husband and wife team, Bernard and Terry Read run GIRES, one of the UK's leading charities working in this field. Founded in 1997, Bernard and Terry joined following a four-year industrial tribunal case after their transitioning daughter was subject to serious discrimination at work and unfair dismissal. The experience left a deep impression. Says Bernard, “The people our daughter worked with were not only ignorant but vicious”.

GIRES remains a charity of modest means, but has established links from grassroots to government level. Terry explains that its core work is, “making the lives of trans people better... (by helping) people understand the condition so they approach people who experience these conditions – as there's not just one – in a humane and respectful way”. GIRES puts its emphasis on education, research and training, on the one hand advising government departments, and presenting papers at conferences around the world, on the other taking calls from distraught trans people who have been the subject of abuse, or hate crime, at work, in public, or in school.

GIRES punches above its weight, influencing policy and the medical profession. Terry cites an example, “We had quite an important paper on the aetiology of the condition, published some years ago, in the International Journal of Transgenderism. It was forcing psychiatrists to look again at their preconceptions of what makes people trans and how they should be treated. That in a sense is a dialogue that is still going on, it is certainly not popular with the medical community”. GIRES has established a series of annual awards presented each year to clinicians who in its view have contributed most to understanding trans issues.

Whilst Bernard and Terry are keen to develop understanding around the medical basis of transgender conditions, they are aware of the complexities in play, and the hesitations of some in the trans community. Terry explains, “There is a danger that if you try and determine how this condition comes about you create several difficult situations. One is that you might be able to tell whether someone was going to be trans prior to birth in which case people might be offered terminations and...that worries people. (Another is) the possibility of creating a hierarchy where some people say well ‘I'm really trans and I should get this treatment because I can prove this

biologically' – so that is the downside". Nonetheless, she believes that the search for full medical understanding is still of value. "The upside is it shows people this is not a lifestyle choice. It is actually who someone is. It's the way their brain has developed. In the main people try desperately hard to overcome this and repress it for many years before admitting they cannot go on. At that point in their lives it could be a life or death decision...it's the only way of continuing life at all for many people".

Despite having made many successful changes to the law and educating countless public bodies and employers, Bernard is realistic about the work still to be done. Throughout the rest of 2011, much of GIRES' efforts will be framed around working with around 20 other transgender organisations to develop a specific contribution to the Government Equalities Office National LGB & T Action Plan. GIRES aims to focus on eleven areas:

- **Employment.** Whilst sex discrimination legislation and both the Gender Recognition Act and Equalities Act give trans people some protection, Bernard identifies the continuing need to "get employers to behave properly towards trans people via proper policies and training".
- **Education.** GIRES is working with the Department of Education in this area, and whilst the law 'prevents' discrimination, abuse of trans children at school is still widespread. "Trans children are being horrendously bullied and discriminated against by their schools. Teachers sometimes refuse to change pronouns, or names and just don't treat children who transition with respect," says Terry.
- **Discrimination** continues to be endemic in certain areas. "We had somebody call us in tears the other day who had been denied access in a leisure centre. Another user said 'You cannot go in there, if you do I'll beat you up', and she was actually there with her small son so she found the whole thing very distressing. Even robust people fear something will happen when they go out. Another person contacted us said that for the second time in as many weeks she'd had a brick through the window", they both explain. Terry continues, "Usually what happens is of course is the local authority, if they respond at all, moves that person, (but doesn't) stop the bullying".

Discrimination in the workplace remains widespread too, with trans people suffering both abuse and ridicule. GIRES is working hard to educate the commercial world, but is keen to see the force of the law brought to bear on those who act with prejudice against trans people.

GIRES is particularly concerned that discrimination within the medical profession remains, in their view, embedded into treatment protocols. Says Terry, "(Trans people are) still required to behave socially in ways that would not be acceptable for any other patients. So if you look at the Equality Act you'll see examples of things that trans people have to do in order to access and to justify treatment which would be considered a breach of human rights in any other field". She goes on, "Partly because even if lip service is being paid to the fact this is not a mental disorder, historically that is the way its always been treated so people are not felt to be able to make their own decisions"

Bernard continues, "This extends into really quite draconian things. For example if they are prescribed hormone treatment but not seen to be full time in role, the medical practitioner feels that he or she is entitled to withdraw hormones". Or (a patient will be) "given a deadline that in x months if you have not gone full time and can demonstrate it, then we will take your hormones away. I cannot imagine any other situation with other patients where this would happen."

They talk of the medical establishment in the UK as "self protecting...too cautious...(with) a mindset that they know best".

- **Identity and Privacy** remains a major battleground, says Bernard. "The press is a major problem...truly transphobic and they take every opportunity to diminish the stature of trans people and exaggerate their position very deliberately to create a sensationalist effect". He is supportive of Channel 4 "getting in behind Trans Media Watch trying to improve the media representation of trans people" and of programming like Hollyoaks and Coronation Street.
- **Healthcare.** Beyond broader concerns of discriminatory attitudes, GIRES remains concerned that PCTs – who fund healthcare (at least until the current government's NHS reforms are in place) – have historically regarded support of trans people as low priority "They haven't got the money to do it", says Bernard, "which is hugely damaging as 34% of trans people have made at least one serious attempt at killing themselves and in the adolescent group 23% of them have already engaged in self harm or overdosed". In addition, the definition of core treatments remain a problem, with partial treatment bringing with it difficulties of its own. Bernard continues, "It would help if they had a proper commissioning policy which treated this as an urgent necessity and funded it properly across all aspects - not just surgery. For a woman with facial hair, (it can mean), 'We'll give you genital surgery but make you walk around with a beard!'"
- **Safety and Support.** In this area, Bernard and Terry compliment efforts made by Police Authorities in engaging with the issue, and investing in training, but the issue of the safety of trans people in public remains a major one. Equally, the need to offer support to families of trans people (GIRES runs workshops) as they go through transition remains critical – and an area where much more can be done.
- **Community and Capacity.** Commenting on the situation they both faced in the early '90s when their daughter transitioned, Bernard says "there was very little out there, literally nothing available locally". GIRES is committed to working with other trans groups around the country to share resource and build infrastructure, and is concerned how economic conditions and funding will be impacting many. GIRES is in touch with 125 groups around the country, and has recently developed a portal bringing many together in one website (see Further Reading/Links).

- **LGB & T.** The trans community has had a complex relationship with the LGB movement over the years. Divided by the simple factor that the LGB movement sprang from questions of *sexual* identity, whilst trans people are dealing with *gender* identity, the two have nonetheless found much common ground over the years, and the ‘T’ first appeared on the end of the LGB acronym in the 1990s. As one trans activist put it, “We are beaten up by the same people”. But issues remain, with small parts of the LGB movement (notably those with a radical feminist agenda) displaying deep hostility to trans people. Alongside this, the trans community itself has in the last ten years grown in confidence immensely. Meanwhile, other LGB groups (ie Stonewall Scotland, Queer Youth Network) are more inclusive. Bernard and Terry remain committed to deepening connections. “We are very keen there is a proper understanding and respect between these communities and a real willingness to work together”, says Bernard.
- **Religion.** The hostility of parts of the Christian Church to trans people (tending to come most strongly from Catholicism or the Evangelical/Charismatic traditions) is well known. GIRES is working to build connections, but sees a huge task ahead in some of these arenas.
- **Procurement and Integration.** In this area, GIRES sees work to be done by local authorities and other government agencies in ensuring that equality messages affecting trans people are carried through into supplier policies.

Running the organisation between the two of them, with the support of a handful of Trustees, and a small group of others, Bernard and Terry are realistic about what they can achieve. Asked if they could ever envisage a day when they wouldn’t need to educate, train and campaign, they say “Not in our lifetime”. They have, however, already achieved an immense amount – a contribution for which they both received OBEs in 2010. They remain driven by the experience their daughter went through. Terry sums it up, “It can be a very painful journey, but a joyful journey for many. There are many successful people out there who wouldn’t have been able to survive unless they made that transition.”

Hearing from the experts: The Voice Therapist



Christella Antoni

Christella Antoni is recognised as the leading clinician in the UK working in the field of voice with the transgender community.

Christella has long been interested in the voice and had speech therapy herself as a child. The interest became her profession and she finds particular fulfilment, and success, in working holistically with her clients – a subject she spends time on in our interview. “I love working with the whole person”, she says “I loved voice from being a child, singing and controlling voice, all that stuff”

Christella worked in Australia and on returning to the UK got a job working at London’s Charing Cross hospital. Her exposure to transgender clients was initially by chance, but as her interest and expertise grew, her reputation increased. Working with trans people both for the NHS and privately now takes up the majority of her time. “I’ve been to conferences all over the world,” she says. “It’s difficult as (trans) clients are often very demanding but it is also very rewarding”.

Christella feels that society often misunderstands trans people. The idea of gender change is a concept that some can grasp given the time and information but the idea of some people existing somewhere on a gender spectrum, can be very difficult for society, she believes. She senses that this is driven more by the manner in which we are taught to understand gender, than through pure prejudice.

She sees ignorance and confusion widely. It often starts with basic misunderstandings; “What people can’t conceive - if they are not a part of this world - is that a transsexual (person) is not a transvestite. TV could have a valuable role in changing this perception”. She goes on to talk about the way that society conflates trans people and themes to “sex and kinkiness” and that the media continually fuels this misperception. This leads to beliefs from some that “it is a perversion and that people get off on it. Or that trans people are not safe with kids. All ridiculous.” She points to her knowledge of her male-to-female clients, “Some of my transsexual people have had their feelings very strongly from childhood and have no interest in their penis at all, some are quite asexual. Perceptions about sex are so wrong”.

Christella also talks about the tendency for some trans people to draw unwanted attention to themselves by the way they dress as they “learn the codes” of being female. She talks about older patients wearing teenage clothes or waist length wigs in the early stages of transitioning. She sometimes offers style advice to the people she sees.

Whilst she is aware of the abuse suffered by many trans people, she also sees many who are successfully getting on with their lives. She sees economic resource as a major factor; those who can fund some of the changes they wish to make often have more scope to manage their transition more successfully. Equally those lucky enough to be employed in industries or professions that will make an effort to understand can sometimes have an easier journey. Society would be “amazed”, she says, if it knew the range of people she sees and understood the vast range of jobs they did.

Working with the voices of transgender people brings with it a range of challenges, but Christella points out that not all trans people wish to change their voice. “I think some of them are a bit too long in the tooth to take on changing their voices or they think it is too big a challenge or sometimes they are politically active and they think ‘whatever I am, society will have to accept me’”. Many do however want to change or find their real voice as it’s seen to be an important part of fitting in and of transitioning. There is a significant NHS waiting list to see Christella. “Some people can’t function without the voice change. They won’t leave the house”, she says.

Christella is very clear that for a trans person, working on his or her voice is not about “putting on an act” and she has to explain this to people who are not familiar with her work. “What happens is people take on a new voice, it becomes their voice, they grow into it because the intent to change is so strong. They lose their old voice and cannot bring it back even if they want to. They actually get used to using their larynx in a different way”, she says. Christella emphasises that the process is about finding the individual’s real voice.

There is also a difference in how far people wish to go with the process. “Some clients are happy with a workable voice, some want one which will work well on the phone. The level varies”, she explains.

The process can be challenging. Christella says that fear and embarrassment often causes barriers. “It’s usually fear that stops them and they get really nervous and feel stupid about changing their voice. It’s the area that most therapists neglect. If you don’t work with the psychological adjustment then they won’t get it”, she says.

People rarely like the sound of their voices and trans people are often initially negative about what they can achieve. She talks about trying to build self belief, “You work with a lot of negativity, which is fine, I’m used to it, but you put in 120% to build their confidence and you get 10% back”. However often a breakthrough comes relatively quickly “when you play the voice back to them, they are shocked, it’s not usually female by any means but compared to their original male voice which was so deep and gravelly they’re usually enthused to carry on. If they are not, then you lose them”.

Ultimately her goal is to help her clients work towards finding a voice they can ‘own’. “Many people don’t actually love (their voice, but), it’s not about getting them the prettiest voice - it’s about finding a voice that works with the way they are now presented”. It can take many months of regular sessions and practice to make progress, though the speed at which individuals travel through the process can vary greatly, with remarkable results sometimes achievable.

Christella feels that the more trans issues are discussed the more tolerant society will become but she agrees that the media needs to represent trans people far more sensitively. Working in London, she feels the city is relatively well served to offer trans people support services, but she acknowledges that there will be some “shut away in their homes” who she will never see, who are “confused and afraid”.

She tends not to tell people a great deal about her work. This is partly because so many questions are asked, driven by the fascination society has with trans people. She has also met with some hostility over whether services of this sort should be funded by the NHS.

Hearing from the experts: The Specialist GP



Dr Richard Curtis
Transhealth

Dr Richard Curtis runs a private service for transgender patients. He worked as GP before taking over The London Gender clinic and launching Transhealth - which works with individuals suffering from gender dysphoria, provides hormone prescriptions and referrals for surgery all over the world. Richard also advises on counseling and hair removal treatment. Of his patients he says, “the majority are at least looking into transitioning; some full time and some part time but most are looking into making a social and physical gender change”.

Transhealth is the leading private transgender care practice in the UK. Richard sits on the Gender Recognition Panel, the UK body that issues Gender Recognition Certificates, is a member of WPATH (The World Professional Association for Transgendered Health) – the organisation responsible for establish international protocols of care - and is a Trustee of GIRES.

Although Richard sees many patients who are exhibiting the signs of gender dysphoria, he’s keen to point out that by no means all want, or go on to have, gender affirmation surgery. He points to society’s obsession with the “the sex change operation” but adds that only in the region of 60% of transitioning male to female transsexual people actually have it. “People think of sex

and gender as a genital thing” he adds, “but it’s not the whole story”. Amongst the reasons he sees for not having surgery are:

- The cost of surgery privately
- The difficulties of having the operation on the NHS (delays in the NHS pathway, funding deadlocks etc)
- A partner who is not supportive of it
- Health issues (especially for older transwomen)
- Fear of the operation
- Taking time off work

He talks also about his older patients, some of whom simply do not feel that surgery is important to them. “They say, ‘I’m happy to be single, I don’t care about sex, I’m happy living as I am, why put myself through this’ ” he explains.

Some of the patients Richard sees are well informed and clear about what they want, understanding realistic timescales and the feasibility of their changes. Others are however misinformed - going on positive but empty hearsay from friends. He often feels that he needs to warn people of the issues associated with various treatments. “I try to be very flexible and let people work out what it is they really want and need but I am honest about the health related issues associated with hormones or surgery”, he says. Many of the transwomen (transitioning MtF people) Richard sees are embarking on a very steep learning curve, he points out, and starting on hormones takes many into a stage almost like a second puberty. “They learn how to dress, how to do their hair and make-up”, he says. Although many hope to simply blend in, they may at this stage make choices that mean they stand out and which society finds difficult. “(They’re) lovely women”, he says, “but (they) dress like teenagers when they are 55. It’s a stage and I think they are happier when it is over”.

For a small number there is a temptation to want to be noticed and to seek attention and celebration around their transition. “With some transwomen in particular, they just want to be in the club, be different, get noticed, shout about it”. For others, it’s different, of course. “If you have somebody who has a bit of money and who has an eye for style, colour, gets the whole body language, can sort out the voice – you would never know about her past”, he says.

Though transmen (female to male transitioning people) face their own specific issues, he feels that they tend to transition more quickly and blend in. “Society in general tends to accept a softer or prettier looking man more easily than a masculine looking woman”, he says. Equally as they go through the process, they may encounter less overt hostility than transwomen. “It’s more difficult for society to see a man dressed in female clothes than it is to see a woman dressed in men’s clothes – they just see her as a bit of a butch funky woman”, he says.

Richard sees fewer transmen looking for surgery than transwomen, and ascribes this to the quality of the surgical techniques available. “Most transmen won’t do it, mainly because the surgery isn’t very good,” he says. “There are a lot of complications aesthetically, functionally, (plus) risk and cost”.

However trans people identify, Richard understands that society struggles to understand because trans feelings are so incomprehensible to the majority. “You can’t get it, period, unless you are in that position”, he says. “Most women have a huge drive to have children, many men

want to be as masculine as possible and have sex with women”, he adds. “It’s understandable why people don’t understand someone who is gender dysphoric”.

Abuse, he says, comes from fear of difference. “Society does not like anything that detracts from the norm. People mock what seems different and what they don’t understand”, he says. Accepting that some trans people do suffer greatly, he nonetheless sees the UK as a relatively tolerant environment in which to transition – in comparison with many parts of the world.

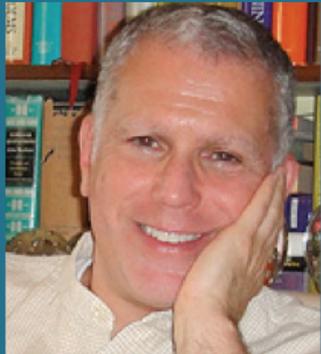
Uppermost in Richard’s mind when he assesses a new patient is the need to establish whether he is seeing a case of gender dysphoria or not. This is an area in which he has to tread extremely carefully if he believes his patient’s difficulties may have a different source. One typology with which he is familiar is the older man who may be homosexual but cannot face the knowledge and seeks the ‘solution’ that he should be female instead. “I meet some people who are blatantly homophobic and (seek to) transition in order to square it with themselves so that they can have sex with men”, he says. He also meets some people who feel that transitioning will solve other issues in their lives and bring them the attention they crave. He feels strongly that the medical profession should help people to really understand themselves before they make irreversible decisions.

Richard treats many people for whom transition is a lifesaver and the beginning of the life they should always have been leading. However he is conscious that there are a small number who transition and then regret having done so. For others, it can be something of an anticlimax. He says that the transgender community has difficulty facing up to this and seeks to ignore it, though he does add that evidence suggests the true ‘regret rate’ is very small, just 1 - 2%. He adds that he sees people for whom the challenges of life remain as before and for whom ‘the big moment of euphoria’ never really came, a risk he tries to make his patients aware of. He’s keen to emphasise that transitioning is not the panacea for all life’s troubles that some trans websites almost suggest. “I think some people over egg it to convince themselves that it is all worthwhile but if you try to say this to the trans community they will shout you down. Many relationships will fail, I say to people from the outset – you’ve got issues now and you are likely to still have them on the other side”.

He goes further. “I have a view as a professional in the field and the campaigning trans people will not want to listen to me. Of course they want to paint a wholly positive picture, everyone wants to suggest that on the other side life is perfect and marvellous, but very few people really get there in the end. Life just isn’t like that.”

Richard is aware of the effect the media can have on the lives of trans people. He cites Hollyoaks as a positive step forward, but condemns the press. “The print media is the worst,” he says, “they rip into trans people with no thought for them”. Elsewhere he is concerned that magazine editors and documentary makers often seek only to sensationalise the issue. Comedy he is less concerned with, although he wishes there were a trans comedian to speak on behalf of trans people.

Hearing from the experts: The Psychologist



Dr Kenneth Demsky

Dr Kenneth Demsky is an American psychologist working in London. Born and raised in New York City, Kenneth previously worked in private practice in Boston, Massachusetts. A graduate of Harvard, he has a doctorate from the University of Texas and is a former postdoctoral fellow of the University of Minnesota Medical School. He works with clients seeking to deal with a range of issues, but his work with transgender people has in the last few years put him at the front rank of this field in the UK.

His interest in the area began as a teenager. Whilst researching thinking on sex and gender he came across the work of German endocrinologist Harry Benjamin (Benjamin went onto to establish the first accepted protocols for the treatment of transsexual people, the 'Harry Benjamin Standards' in the 1960s. These remain the basis of most practice today, and have been embraced by the international body, WPATH). Kenneth recalls, 'I recall seeing a picture of Dr Benjamin surrounded by all these very attractive, elegant ladies wearing their beehive hair dos and these were all people who'd originally been males and I just found it fascinating. I found it amazingly freeing to think that there was something more fluid than male or female and that people could in fact be more complex than that'. He adds, "It was a very hopeful era, the mid 60s, when people were thinking beyond categories in many ways, a very positive era in terms of human potential. And to me transsexualism always seemed a part of that".

Working in the field of mental health in Texas in the mid 1980s brought Kenneth into contact with trans people, and this was followed by working in more depth with transitioning individuals at the University of Minnesota Medical School. He has continued in the field ever since.

He's conscious it remains a relatively 'new' field in psychology, but is keen that it be seen as "just another aspect of the human condition which is as old as humanity itself". He is reluctant to see it as a pathology – but rather as part of the human spectrum of experience. As such he's conscious, but unsure, of the value of the ongoing debate that seeks to identify the origins of 'primary' transsexualism (in those who might be said to have a biological or neurological reason for their experience) versus 'secondary' transsexualism (in those who feel as they do because

of unusual psychosocial experience early in life). Kenneth is more concerned with helping trans people lead successful and satisfying lives than in isolating the causes of their feelings.

About a third to half of his work is with "people wondering about their trans status, exploring it mentally, (or) people who are quite aware of their trans status and wanting to transition. It can also be people many years post transition who are dealing with issues in employment and intimacy". He's aware that his trans patients may have many complex questions to unpack, but is wary of the temptation – which he detects elsewhere – to ascribe all the issues on the table to an individual's questions about gender. Transsexualism can be an "over fascinating topic for some clinicians" he says, adding, "Trans people like to work with someone who has an understanding of what being trans is and isn't, if they are working on other issues (too), because (then) they do not have to explain it. (But) it's not presumed to be the basis of everything they are talking about...whereas someone who doesn't know about transsexualism might attribute everything that is going on to the person's transness. Which might not be relevant at all."

The spectrum of people Kenneth is seeing is growing. He's encouraged by a growing number of parents who are willing to bring their children to see him. "This is new, very exciting and a complete shift from when I began working" he says, talking of "enlightened parents who realise their children are not just gender atypical but possibly trans. I have seen these parents and I must say...some of these stories are heart rendering as the UK does not support parents of young trans children...I'm seeing parents coming in wanting to support their children in being who they are. These parents are fantastic, so invested in the wholeness and separateness of their children. They really understand their children are not possessions...and they respect that their role as parents is to steward them in finding themselves, making the most of who they are."

Kenneth feels strongly about failures, as he sees them, to understand the needs of trans children. He speaks of "stories of where these parents have been hounded by the authorities (and) they have almost lost custody of their children...thinking they are imposing this gender atypical behaviour on (them) rather than giving their children permission to express themselves...a very painful raw edge of being trans".

He goes on, "The UK has a horribly conservative view, officially in the NHS, where someone has to reach puberty before they can be assessed as trans*. That is a criterion that goes back 40 years and we have learnt a lot since then. In the States and in the Netherlands there's a much more enlightened view - which is that interventions can be brought in near puberty so that people don't have the life long unwanted consequences of puberty... It's very clear when you meet these children – and somehow the medical community is imposing an abstract principle on them with terrible cost. The difference between completing puberty and having it suppressed for a young trans person is just vast in terms of psychological and physiological consequences".

This conservatism Kenneth blames on a medical culture driven more by fear of 'false positives' and it's an attitude that in his view can create frustration and pain. Working in his field, he is less worried about this danger, saying, "People tend to know themselves and sometimes psychology is better at granting people that self-awareness than medicine can be. Psychology can say 'I believe you are telling me what its like in your world'. Sometimes medicine will say 'I can tell you

* Since this interview took place London's Tavistock and Portman Clinics have announced a review of this policy and the possibility of earlier, puberty delaying treatments in the UK, seems more likely

what is going on'. It's a bit more top down than psychology. I don't find many people coming to me not knowing what their gender is, they might not put a word on it...but in my experience, over a little over 20 years, people tend to know on some level. And so the British teams' fear that people will be wrong about this seems excessive. I'd be more concerned about failing people when they are telling you what they need and want and depriving them of this because of a fear of false positives"

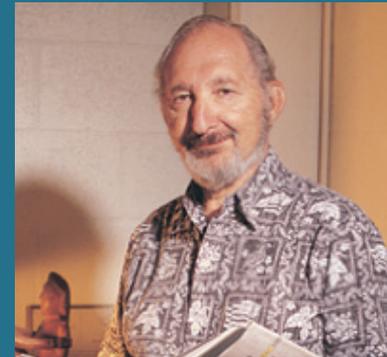
Reflecting on the way the therapeutic community approaches the issue, he comments that whilst still in its relative infancy, a refreshingly international flavour of practice has developed, with therapists across countries seeking to generate cross border practices. Closer to home, he remains surprised when he is training juniors that assumptions are made about special difficulties in working with trans people. He explains; "One of the problems I think is that other clinicians think they need some special skills for working with trans people as if they were Martians with different emotional systems or something. Maybe it is good for people to err on the side of caution in that way but I think to become a clinician working with trans people you need to be free of prejudice, understand something about the experience of being trans, and be educated to what the process is. But its just therapy or counselling as in any other way, helping that person achieve completion".

Kenneth feels that the media is making progress in its portrayals. He sees people who have been prompted to get in touch by a documentary or magazine piece, though the tabloid media remains a problem. For him, the deeper issue is what he and colleagues call 'Internalised transphobia' - something that makes trans people vulnerable to the hurtful attitudes of others as it allows prejudice to achieve purchase inside them. Internalised transphobia - which causes a trans person to take on externally created shame and guilt about who he or she is and play it constantly, internally to him/herself - can be highly corrosive. You need to feel good about being trans. The real heart of internalised transphobia is that because you're trans, somehow that is a bad thing. You need to feel good about your experience. Sometimes people say being trans is tragic. Trans is not tragic, its life saving! What's tragic is internalised transphobia, that's life threatening"

For Kenneth, much of his job is about removing internalised transphobia. He sums up what he wants for his patients: "Being free of internal conflicts, self aware and accepting, with an adequate level of self esteem, a reasonable feeling of entitlement, being capable of deep intimacy, having enough of a core set of values to be true to themselves despite messages out there. Being trans is another piece that needs to be integrated into your life. But these are (the kinds of) goals I would have for anyone in therapy."

And for the future, he puts it like this, "If you just get to know in a real way a trans person the light bulb will go off in your head and you'll go, 'Oh, I see. *That's* what it is'. I think its willingness to see what is there. The message that being trans is just part of human experience needs to be gotten out there."

Hearing from the experts: The Professor



Milton 'Mickey' Diamond
Professor (Ret'd) of Anatomy and
Reproductive Biology, The University
of Hawaii at Manoa
Director, The Pacific Centre for Sex
and Society

Mickey Diamond is a well known and widely published figure whose research into gender and sexuality has been highly influential over the last forty years. He first came to public prominence during his involvement with the case of David Reimer, a man whose parents had agreed to allow doctors at Baltimore's John Hopkins University undertake surgery so he could be raised as a girl. This followed a surgical accident in 1966, when as a baby, David's penis was destroyed in a botched circumcision operation.

David was subsequently brought up as 'Brenda', and treated with oestrogen, whilst the progress of his life was monitored, for a decade, by the psychologist who had recommended the treatment, John Money. Money saw the David Reimer case as an opportunity to prove his assertion that gender identity and sexual orientation were socially constructed and malleable through human intervention, and his recommendations were in tune with emerging surgical practice at the time for children born with ambiguous or malformed genitalia - going on to influence clinical attitudes for several decades to come. Money reported throughout the early years of David's life that the experiment has been a success, with 'Brenda' developing normally as a girl.

Others had their concerns, amongst them Mickey Diamond. When Mickey met David Reimer, and revealed to him that the account of his case given by Money to the world had led to many children around the world being treated the same way, Reimer agreed to tell his story in full. When the facts (co-authored by Dr. Keith Sigmundson) were published* it made front pages around the world.

David's experience could scarcely have been more different to the version Money had publicised. David, living as 'Brenda', had at age 2, refused to wear female clothes. She disliked playing with dolls and fought with her identical twin brother. In school, she was relentlessly teased for her boyish looks, tastes, and behaviour. Complaints to her parents and teachers that she felt like a

* Archives of Pediatrics and Adolescent Medicine in March 1997

boy met with silence – the adults around her were sworn to secrecy by Money. Meanwhile, her remorseful mother attempted suicide; her father turned to alcohol. Eventually, aged 14, a local psychiatrist persuaded David's parents that he must be told the truth. From shortly afterwards, David began to live permanently in his male role, later having extensive surgery to remove breasts and rebuild an artificial penis. He also embarked on testosterone injections. But the trauma of his upbringing, and the complexities of his life led him to descend into drug use, crime and depression. Despite eventually marrying, he attempted suicide twice in his mid twenties, plagued by the shaming memories of his annual visits to Money's consulting room, where Money "used pictures of naked adults to "reinforce" Brenda's gender identity and (where he) pressed 'her' to have further surgery on her "vagina."¹⁰

Sadly, David Reimer's final suicide attempt, in 2004, was successful.

The case had interested Mickey Diamond for some time, and he had noted that Money had been silent about the outcome of the case as David had reached puberty and beyond. As a graduate student in 1959, Mickey had been involved in a ground breaking study, which saw pregnant guinea pigs, carrying female foetuses, injected with male hormones. The offspring were not reexamined until adulthood, when it was discovered that they behaved like males. Thus began an exploration of the profound effects of prenatal development on sexual and gender identity, in which Mickey has been involved throughout his career - a career which has seen him work to develop the medical world's understanding and acceptance of the multiplicity of factors which go towards developing sexual and gender identity.

"Chromosomal sex, internal accessory reproductive structures, hormonal sex, secondary sexual characteristics, gonadal sex and external genital morphology, all vary far more than most people realise. So do people's notions of 'masculinity', 'femininity', 'gender identity', 'sexual identity', and 'sexual preference or orientation'. he says¹¹ Or, as he puts it in our interview, in a phrase for which he has become known, "Nature loves variety. Unfortunately, society hates it."

For Mickey, all the evidence points towards gender being better described along a spectrum than in terms of a strict, socially defined binary. He points towards recent research, "We do have some evidence to say that there are different brain structures (in transsexual people)", he says, adding that such evidence is "worth looking for", but "far from the whole story". He points to endocrinology, and the effect of androgens (compounds, usually steroid hormones which are critical in the development and maintenance of male physical characteristics) in the developing foetus. "There is evidence that trans people's *hearing* is different", he adds. "We even know that they may have different *dentition*, and perhaps, more white matter (in the brain)". But the search is complex, he accepts. "We look where the light is best", he says, admitting that in many respects, "we don't know where to look. I don't think the answer will come from that." The picture he paints is of a worthwhile, but perhaps never ending search to categorise the almost uncategorisable – given the diversity of biological characteristics in play, and their unique mix within each individual.

He returns to the 'nature versus nurture' debate to talk about how the trans people must respond to both factors their lives. His 'Biased Interaction Theory' works to explain how the individual develops with certain biological or psychological predispositions – of varying intensities – but

that these predispositions must operate in a cultural context. "We're not taught to like vanilla or chocolate ice cream", he says, "we just do. We have a predisposition". Thus are trans people born with certain characteristics in place which will drive them to a particular understanding of themselves – which may be at variance from the evidence they see from their physical bodies, or what society around them is telling them. "But society is very strong", Mickey continues. Despite this internal certainty, in some parts of the world, "you might not come out (as trans) because they'll hang you." In less daunting circumstances, each trans person needs to deal with a blend of both their internal instincts – rooted potentially in biological factors we are slowly beginning to unravel – and the societal setting in which they live. The latter can threaten complete social rejection (loss of family, job, friends etc) if they 'go public'. Answering the challenge put to some transsexual people who have transitioned later in life - that if they were *truly* transsexual, they would have been compelled to do so years earlier irrespective of the consequences, he says "People do respond to society. It is nature and nurture". And talking of the phenomenon of the trans person who suddenly 'announces' to the world that he or she needs to transition, in his or her forties or fifties, to a seemingly baffled and unsuspecting world, he says, "they may not have said anything to me. But they may have been saying it to themselves, for years. Making the transition, at aged 8 or 80, is always done with a lot of forethought, and that forethought could be internal".

Looking to the future, Mickey sees prejudice affecting trans people still. "Being different, and unfortunately trans people are very different – becomes disturbing, unsettling. It always fascinates me how some people put so much store by whether you wear a skirt, or which bathroom you use. That seems to me to be ridiculous." But he adds, "I think change is occurring...slowly. There are prejudices that have been dealt with, but others that still need dealing with." He identifies a need for more accurate data on the prevalence of transgender people – as a mechanism to make society take the phenomenon more seriously, but accepts that with the term offering so much interpretative diversity, "drawing the line is very difficult. My way of seeing the world doesn't have to be your way. How do you define it?"

¹⁰ John Colapinto www.slate.com/id/2101678/

¹¹ www.changelingaspects.com/Technical/Prof%20M%20Diamond-bio.htm

Hearing from the experts: The Academic



Natacha Kennedy
Lecturer in Education,
Goldsmith's College,
University of London.

Natacha is a teacher and academic, whose career spans both primary education and the tertiary sector. She campaigns for a better understanding of transgender people, has written for *The Guardian*, and has recently focused on the challenges faced by transgender children. In 2010, she published a well received paper, 'Transgender Children. More than a Theoretical Challenge', with co author Mark Hellen*. This paper explored evidence that many trans people become aware of their 'difference' from a very young age, and that most live with this knowledge through their entire education, often concealing or suppressing it for fear of the social consequences. The effects of this phenomenon and the internalisation of rejection, with feelings of guilt and shame, can lead to problems with self esteem and under achievement later in life, she asserts. Natacha is currently working for a PhD, exploring the position of transgender people across cultures, including the Western, Far Eastern, Native American and Hawaiian.

Natacha's exploration of the experiences of trans children began with a piece of research in which she invited trans people – via an enquiry on an internet forum – to share their experiences of "first understanding that they were transgender", in any way. Unbidden, she received many replies which volunteered an age, and a rapid calculation produced a mean of 8.1 years. Fascinated by this result, she developed the findings into something publishable for an education journal – in a paper that attracted interest.

This initial exploration led to further research in which she asked the question more explicitly. The findings very closely matched the results of her initial stage. "I dug into the data", she says, "and recognised the pattern, especially amongst male-to-female people. This realising something was wrong quite early, realising it was socially unacceptable, the praying you'd wake up with a different body in the morning, the suppressing it."

* Graduate Journal of Social Science, Dec 2010, Vol 7, Issue 2

In her work, Natacha classifies trans children as 'apparent' or 'non apparent'. The former are those who through circumstances, social, familial or educational support, feel able to disclose their true gender identity. The latter are those who need to hide their feelings, taking with them a sense of their 'unacceptability' into adulthood. Whilst things may be slowly changing, the latter group has historically been far larger and without question still is, she says. Like the dyslexic child who sits undiagnosed or unnoticed in the classroom, the 'non apparent' trans child also presents educators – and society - with important challenges.

Elsewhere in the world, in different cultures, over different times, transgender children have been treated rather differently. In the classrooms of Thailand and the Philippines, says Natacha, the phenomenon is often treated as "quite normal". She recounts a conversation with a teaching colleague from Thailand who spoke of seeing trans children (who would be described as 'male to female' in Western terminology) happily mixing with the girls, exchanging make up and so on. Her colleague noted that some of the children were subject to some "mild ribbing", but commented that other children were teased more (ie children with weight problems). When she asked one of the trans children about the occasional 'jokes' of others directed at them, the response was telling 'It's because there are *only* eight or nine of us in our year group".

In some Native American cultures, Natacha goes on, 'two spirited' individuals, who may have been born with male physiology, were "spotted early and given the opportunity to choose the gender in which they wanted to live. They were quite high status". She suggests that this was because of an essentially "collaborative" social structure, unlike "competitive" Western culture. These individuals were able to bridge a gender divide, helping to create cohesion and support the wellbeing of the tribe. They lived as women, and remained in camp when the men went to hunt or fight – but their greater strength often meant they were able "do some of the heavy work when the men were away". The Western attitude to gender, Natacha calls "very material," amounting to, "you've got a penis, you're a bloke. You've got a vagina, you're a girl." She reflects on alternative models of understanding which are "more to do with your spirit, or what we would call your personality or character. That's where I think we probably need to start thinking." After all, she adds, "your most important sexual organ is your brain!"

Like others approaching the issue in depth, Natacha supports the view that gender is a concept best understood in terms of fluidity and spectrum, not polarities. She talks of the manner in which the study of evolutionary biology brought with it from the nineteenth century sacrosanct social beliefs about gender which remain unchallenged despite widespread evidence from nature to the contrary (she cites species of salmon with "several genders", and fish that change gender). "Being trans is a natural part of the human race because it's a natural phenomenon", she says. "It's part of diversity. It pops up through the population. It's random". Yet attempts to apply this thinking in Western culture, and in human biology, still run up against very powerful opposition. She talks of Professor Joan Roughgarden's work at Stanford University in this area, which "almost got her sacked".

The inability of Western culture to accept the possibility of ambiguity beyond the gender binary has implications in other ways too. She talks about how trans children often start with feelings of "difference", though lacking the language to be able to describe that difference they are left with only 'boy' or 'girl' to describe who they inwardly must be. This leads to accusations from radical feminist writers that the interpretation trans people give to their feelings are false – that they are 'borrowing' a binary structure which reflects standard cultural constructs but not who they truly

are. These critics attack trans people, some claiming the phenomenon doesn't even exist and level charges against trans people and those who treat them of trying to 'retro-fit' a label of 'male' or 'female' onto a confusing early experience that might have had nothing to do with it. Natacha rejects this argument, saying "Just because you couldn't interpret these feelings at the time doesn't mean they didn't happen". She points to the drive to conceal feelings, and asks where that drive comes from if not from a latent understanding of something inside was dangerous to the gender norm. "The roots of suppression come from before there was a word", she says.

The cultural beliefs embedded in the binary have implications for clinical practice too. Natacha talks of the way in trans people still have to "prove" the authenticity of their experience to clinicians, to get treatment. "Knowing you have to fit into a structure psychiatrists construct, to get help", creates a Catch 22. That trans people may feel they need to fit the 'orthodox (binary) narrative' of transsexuality to be recognised as worthy of help means there is a risk that they may not express their feelings as they might have wished. But the alternative may be to not have their feelings recognised at all and to be left unsupported. Natacha speculates on whether this might ever have driven some crossdressers to identify as transsexual and even to transition, (for fear of being left in some – to the therapists – socially baffling, gender ambiguous 'middle ground'), though she hopes that clinical safeguards though the process make this very difficult to do.

Returning to the theme of the lives led by trans children, she mentions data which suggests that 1% of the population may identify as trans in some way – meaning a 450 pupil school could expect to have 4 or 5 trans students. But she says "the chances of any of them being out are very low". She points to parents as one of the primary barriers to progress, and the fear of backlash felt by Head Teachers. She cites a recent case in which a Primary School was forced after a year to accept a young, self identifying trans girl (aged 7) after a battle which involved the Local Education Authority, Child and Adolescent Mental Health Services and finally the Equalities Act. Uncooperative at every turn, the school is now doing nothing as the child is "bullied by ten and eleven year olds every day". It is a far from unique case, she says, adding that trans children have no role models to look up to, whilst the teaching profession – again fearful of parental hostility - remains widely resistant to allowing trans teachers to work (despite ostensible anti discriminatory employment legislation).

She mentions a Head Teacher with a spotless career, who since her transition has applied for 200 jobs, without receiving a single interview. "There's a view out there, amongst parents, that trans people are weird", she says. "In the US, there was a case when a teacher transitioned and all the parents took their children out of the school, all of them, on the first day of term and went to another school. There is a view that trans people are perverts. A friend of mine, in Kent", she adds, "was attacked the other day. People were shouting 'Paedo! Paedo!' at her."

Western society's 'fixation' with the gender binary, Natacha roots in its desire "always to put the responsibility for difference on the individual". Yet trans people, says Natacha, in effect ask little. "At the moment, our society wants to change the individual 100%. In fact society needs to change its thinking 0.01%".

And she sees the role of media portrayal as fundamental to that change.

Selected Bibliography and Links

Organisations:

Trans Media Watch:

BM TMW, London, WC1N 3XX
www.transmediawatch.org

The Gender Identity Research & Education Society (GIRES)

Melverley, The Warren, Ashted, Surrey, KT21 2SP
www.gires.org.uk

The Gender Trust

Gender Trust, Community Base, 113 Queens Road, Brighton, BN1 3XG
www.gendertrust.org.uk

Press for Change

PFC Equality Project, Yew Bank House, 24 Mauldeth Rd, Stockport, SK4 3NE
www.transequality.co.uk/PressForChange.aspx

TranzWiki (portal to groups throughout the UK)

www.gires.org.uk/tranzwiki/index.php/Main_Page

Transgenderzone

www.transgenderzone.com
 Including extensive records of trans portrayal in the media
<http://forum.transgenderzone.com/viewforum.php?f=15>

World Professional Association for Transgender Health

www.wpath.org/index.cfm

Mermaids

BM Mermaids London, WC1N 3XX
www.mermaidsuk.org

Further reading:

True Selves: Understanding Transsexualism - For Families, Friends, Coworkers, and Helping Professionals:

Mildred L. Brown/Chloe Ann Rounsley

Provides a good overview of transsexualism and the issues facing transsexual people.

My Husband Betty – Love, Sex and Life with a Crossdresser:

Helen Boyd

Boyd's perceptive account of her life with crossdressing husband Betty.

Gender Outlaw: Kate Bornstein

Bornstein, transwoman, feminist thinker, unpacks and challenges perceptions of gender.

Whipping Girl: A Transsexual Woman on Sexism and the Scapegoating of Femininity: Julia Serano

Serano's powerful feminist piece debunks many myths about transsexualism. Dense but worth it.

Becoming Drusilla: Richard Beard

Beard writes about the transition of his friend Dru. Beautifully written, accessible and full of insight.

She's Not There - A Life in Two Genders: Jennifer Boylan

New England college professor writes with honesty and wit about her transition.

Conundrum: Jan Morris

Morris' memoir of her own transition in the early 1970s remains a classic.

Luna: Julie Ann Peters

Fictional story of a young trans person told through the eyes of her sister. Powerful and perceptive.

Films and Documentaries:

Many film makers have approached transgender territory, many with unsatisfactory consequences. Those below are useful introductions to some important themes.

M2F A Journey in Gender Identity

<http://m2f.filmfinder.com>

An admirable attempt to come to grips with some of the issues.

Boys Don't Cry

The true story of Brandon Teena.

Soldier's Girl

The true story of the relationship between transwoman Calpernia Adams and a young soldier.

TransAmerica

Essentially a road movie, contains some insights into the trans experience.

Breakfast on Pluto

Cillian Murphy plays transgender girl Kitten Braden with sensitivity and intelligence.

Different for Girls

Fairly lightweight but thoughtful exploration of life and love after transition.

“I grew up drowning in the lies and dishonesty of who I am. It is not easy to grow up pretending to be a non-existent person, you always have to lie. Now I have crossed the void and into existence.

I’m now learning what happiness feels like.”

David

“Before, I was happy with my family, happy with my relationship, happy with my work life, happy with my home life and deeply unhappy with myself. I had betrayed myself. In that respect I was miserable to my core.

Now, the simple joy of actually liking myself is a happy thing. I smile a lot, I laugh a lot, I cry a lot. All that comes right from my soul, without going through a filter. I am happy with my family, unhappy to have lost my relationship (and my best friendship), happy with my work life, happy with my home life and finally happy with myself. Waking up each day is no longer the disappointment it once was.

So, I’m happy to the core, my soul is singing and I am better equipped to live my life to the end. Including dealing with the rubbish stuff that happens.”

Lucy



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