

Professionals Kit



Contents

Service Brochure
About the Gender Centre
Training Brochure
Exploring Gender Issues
Concerns For Clients
Concerns For Service Providers
What Is Female To Male?
Female To Male 101: The Invisible Transsexuals
Testosterone Hormone Information 1
Testosterone Hormone Information 2
Testosterone Implants
Cross Dressing Information
Oestrogen Hormone Information 1
Oestrogen Hormone Information 2
Hormone Implant Information
Hormone Replacement Therapy & Osteoporosis
Electrolysis Information
The Transsexual Person In Your Life
Intersexuality 101
Recommendations For Infants & Children
Transsexualism: The Current Medical Viewpoint

The Gender Centre Inc.

Services for People With Gender Issues

7 Bent Street Petersham N.S.W. 2049

Phone: (02) 9569 2366

Fax: (02) 9569 1176

Website: www.gendercentre.org.au

Supported by the New South Wales Health Department through the AIDS and Infectious Diseases Branch.



The Gender Centre Inc. Fact Sheet
Service Brochure
Of the Gender Centre Inc.

Reviewed July 1st 2008

The Gender Centre is committed to developing and providing services and activities which enhance the ability of people with gender issues to make informed choices.

The Gender Centre is also committed to educating the public and providers about the needs of people with gender issues.

We offer a wide range of services to people with gender issues, their partners, families and friends in N.S.W.. We also act as an education, support, training and referral/resource Centre to other organisations and service providers.

We specifically aim to provide a high quality service which acknowledges human rights and ensures respect and confidentiality.

Counselling Service

Provides counselling to residents, clients and partners, families and friends of people with gender issues. Also provides education, support and referrals to a range of specialist counselling. For an appointment please contact the Counsellor.

For Service Providers and Others

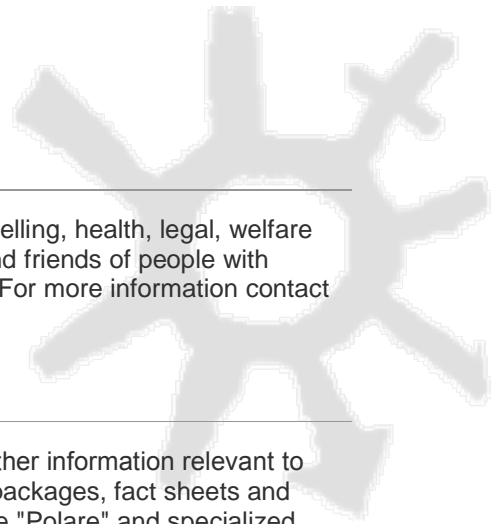
Training, support and workshops are available to employers, service providers, students and other people interested in gender issues. Topics covered include implications for staff and clients in relation to anti-discrimination legislation, E.E.O. issues, workplace harassment and provision of goods and services as well as many personal aspects of the transgender process. For more information contact the Coordinator of The Gender Centre.

Social & Support Service

Provides social and support groups and outings. Also provides referrals for medical, H.I.V./AIDS, education, training, employment, legal, welfare, housing and other community services to residents and clients living in the community. For more information, contact the Community Worker or the Outreach Worker.

Outreach Service

Available to clients in the inner city areas on Thursdays from 10:00am – 5:00pm and Tuesday nights from 6:00pm – 2:00am. Also available to clients confined to home, hospital or gaol (by appointment only). For an appointment contact the Outreach Worker.



For Partners, Family & Friends

Support, education and referrals to a wide range of specialist counselling, health, legal, welfare and other community services are available for partners, families and friends of people with gender issues. There are also social and support groups available. For more information contact the Community Worker, or the Counsellor.

Resource Development Service

Produces a range of print resources on H.I.V./AIDS medical and other information relevant to people with gender issues and their service providers. Information packages, fact sheets and other printed materials, including a free quality bi-monthly magazine "Polare" and specialized advertising supplements. For more information contact the Resource Development Worker.

Residential Service

Provides semi-supported share accommodation for up to 11 residents of age 16 and above. Residents can stay up to twelve months and are supported to move towards independent living. During their stay they are also encouraged to consider a range of options available to meet their needs. A weekly fee is charged to cover household expenses. Assessments for residency are by appointment only and can be arranged by contacting the Residential Program Worker or the Counsellor.

Drug & Alcohol Service

Provides support, education and referrals to a broad range of services by appointment only. For an appointment contact the Outreach Worker.

Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only. The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au



The Gender Centre Inc. Fact Sheet
About the Gender Centre
Founded in 1983

Reviewed July 1st 2008

Tiresias House

In the very early 1980's, a small band of transsexual people held weekly support meetings at the Wayside Chapel in Kings Cross, Sydney. A transgendered woman, Roberta Perkins, who had completed an honours thesis on transsexuals approached Reverend Bill Crews of the Wayside Chapel Crisis Centre to ask if he would consider the use of the chapel for a regular meeting place offering support to the transsexual girls of the Cross.

Many of the girls working the streets of Kings Cross, from Darlinghurst Road to William Street were vulnerable to assaults, robberies, rape and harassment. Other issues of concern were incidences of transgenders being evicted and discriminatory treatment by landlords and some service providers. The problem of homelessness was significant and providing transsexuals with a safe refuge was crucial. Most refuge services at the time would not cater for transsexuals.

Problems of increased dependence on prescription and illicit drugs were also an issue. Often drugs were a means of managing a multitude of issues as a transgender individual, such as limited employment opportunities, no secure housing, verbal and physical abuse, violent attacks etc. These negative experiences reduce an individual's already low self esteem.

After consultation with Reverend Bill Crews and Reverend Ted Noffs together with Roberta Perkins, regular weekly support meetings for transsexuals commenced.

During this time, the media became involved in the issues of transsexuals and produced a documentary movie titled "Man into Woman". This film highlighted the plight of transgender people in Sydney, particularly the Cross. As public awareness was rising, Roberta contacted the state minister for Youth Affairs & Housing, Frank Walker M.P. (Member of Parliament)

She made a submission for funding to open a refuge for transsexuals. Frank Walker approved this plan and in 1984, Tiresias House was founded as a refuge for young transsexuals.

The premises in Petersham was approved by the Department of Main Roads, and Tiresias House was the first government funded service specifically for transgenders in Australia. It was funded entirely by the New South Wales (N.S.W.) Department of Community Services (DOCS) through the Supported Accommodation Assistance Program (S.A.A.P.). Two "annex" (semi-supported) houses located at Haberfield and Ashfield opened soon after.

By 1993, DOCS and the N.S.W. Department of Health entered into a joint funding agreement. This meant that Tiresias House was funded to provide services to minimise the effects of Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome (H.I.V./AIDS) on the transgender community. These services included Outreach and a Community Worker position. At this time, Tiresias House was incorporated and renamed The Gender Centre Inc, to reflect the change in services and service philosophy.

The Gender Centre Inc.

Rather than targeting simply young transsexuals, the service began to target people with gender issues, which included people who identified as transsexual or transgender, cross-dressers and any other person who experienced issues, problems or difficulties relating to the gender assigned to them at birth.

The introduction of amendments to the N.S.W. Anti-Discrimination Act in 1996, recognised the legal existence of transgender persons. The term transgender replaced the term people with gender issues which had been used to identify the target group served by the Gender Centre.

By 1997, many links had been formed with both the public and the private sectors. Training among employers and employees began to take steps in easing transgender individuals' path to maintaining their employment during gender transition and raised the awareness of gender issues throughout society.

Today the Gender Centre remains committed to the support and well-being of transgender people, employing 9 staff and housing up to 17 residents at any one time, in 3 refuges and 6 exit houses.

Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only. The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au



The Gender Centre Inc. Fact Sheet
Training Brochure

For employers, organisations and service providers

Reviewed July 1st 2008

Topics Covered in Training

We cover a comprehensive range of topics addressing the specific issues facing transgender people. Depending on the needs of your organisation, these may include:

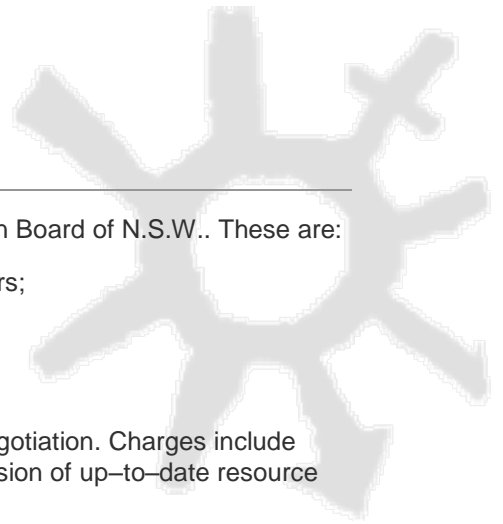
- Implications for staff and clients in relation to Anti-Discrimination;
- E.E.O. Issues;
- Workplace Harassment;
- Provision of Goods and Services; and
- many other aspects of the transgender process.

All participants are encouraged to ask even the difficult questions and clarify any issues, so that any concerns or areas of interest can be addressed.

Training Benefits

What are the benefits of training for my company/organisation?

- Understanding of legislation;
- Understanding of transgender identity;
- Knowledge of periods of transition;
- Dealing with workplace transition;
- Raised awareness for staff;
- Improved service to clients;
- Productive use of human resources;
- Potential preferred employer status;
- Assistance with policy development;
- Knowing your rights;
- Knowing the rights of the transgender employee/client; and
- Minimising the risk of costly legal action.



What Does Training Cost

Our current charges are matched to those of the Anti-Discrimination Board of N.S.W.. These are:

- \$350.00 + G.S.T. for sessions up to one and a half hours;
- \$750.00 + G.S.T. for sessions of four hours; and
- \$1375.00 + G.S.T. for full day sessions

Longer sessions or ongoing sessions for larger organisations by negotiation. Charges include preparation time, consultations with your organisation and the provision of up-to-date resource material for each participant.

Where travel is required to locations in excess of one hundred kilometres from Sydney, then an additional charge for travel and any necessary accommodation will also apply.

Testimonials

"We had an attendance of some 35 staff and managers attend the well-structured, informative and professional presentation by Gender Centre staff, Dash and Elizabeth. The interactive session had good audience participation and all issues that were raised were adequately explained and the difficult questions answered. The presentation was pitched at the right level for the audience and positive feedback was received from attendees. Overall I rate the presentation and feedback from staff as very high. I would have no hesitation in recommending the presentation to interested agencies.

Ken Sweeney, National Manager, Comcar.

"Elizabeth is a polished professional adult educator who encourages her audience to be open minded, and leave their comfort zone. She has unique communication skills, which enable her to read the audience and pitch her presentation, which on the one hand is non-threatening, yet is stimulating and confronting. Her presentation is a must for inclusion in all E.E.O. awareness programs."

Narelle Stone, E.E.O. Practitioner and E.E.S.A. Member.

"Cellblock staff responded with genuine enthusiasm to an excellent presentation which raised our awareness of people with gender issues."

Cellblock Youth Health /Arts Service.

"Elizabeth presented a comprehensive and informative program which fully addressed the participants needs. Evaluated highly."

Martyn Wilson, N.S.W. College of Nursing.

"The Gender Centre consultants are the experts in transgender issues. They can explore and help answer the difficult questions your managers and staff will ask."

Anthea Lowe, Manager Education Services, Anti-Discrimination Board.

"Training was excellent. Information was presented in an informative and objective manner. The Consultant answered a lot of questions one wants to ask, but does not know how to."

Andrew de Wynter, Human Resources Manager, City Rail.

"Staff enjoyed the in-service presented by Elizabeth from The Gender Centre. She was informative, professional and approachable. Elizabeth assisted in developing the skills and confidence of our staff."

Sally Lynch, Manager, Gorman House.

Bookings

It is generally preferable to make your bookings a few weeks in advance to:

Coordinator
The Gender Centre Inc.
P.O. Box 266 Petersham N.S.W. 2049
Phone: (02) 9569 2366 Fax: (02) 9569 1176
Email: coordinator@gendercentre.org.au 

Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only. The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au

Exploring Gender Issues

For people with gender issues and their loved ones

Reviewed July 1st 2008

The personal experiences of people with gender issues and those close to them vary widely. It is outside the intention and scope of this article to provide people with advice in relation to specific personal issues. We hope to identify some of the major concerns that may impact on partners, friends and families of those experiencing gender issues, and to clarify some aspects of gender issues. We would also like to make it clear that partners, friends and families of those experiencing gender issues are welcome to access a variety of our services and resources.

There are a number of very important points to consider:

- Gender is a fundamental part of who we are: we perceive ourselves and others through the lens of gender much of the time. Because gender is assumed to be fixed and fundamental, it can be very challenging to people when a person explores different ways of expressing or experiencing gender, or changes gender altogether. Many people experience emotional distress as a result of their own gender issues.
- Partners, families and friends often experience distress as well in relation to the person's gender issues. They may feel left out of the support process or do not realise that there are support structures that they can access. They may feel that, not being "the one with the problem" themselves, it is inappropriate to access support services.

Yet, the questions associated with this process are enormously important:

- What does it mean to a person when their partner no longer identifies as the gender they originally were?
- What is it like for children (and adults) when a parent changes gender?
- How does a person feel when their brother becomes a sister? (or vice versa?)
- What is it like to be a parent and have your son or daughter change gender?

Partners, families and friends have a great need to receive support for the impact this has on their lives, and to have access to information that assists them in understanding what gender issues actually are. Many relationships (with partners, families or friends) break down under the strains placed on them by confusion, fear, ignorance, shame and embarrassment. Some of these relationships may have broken down in any case without the advent of gender issues, but others can be resolved through open discussion in a supportive environment, and with a good understanding of what the real issues are for all the people involved.

All relationships are dynamic; that is, they constantly change over time in response to a variety of influences or experiences. Relationships are also constantly negotiated in terms of these influences or experiences. How well relationships survive through change is due mostly to the willingness of people to look honestly at the changes taking place, acknowledge their own feelings, and decide whether or not the relationship can cope with these changes.

In some circumstances, it can be less distressing to both people to acknowledge that it is better to put the relationship on hold or relinquish it altogether than to attempt to salvage it at the wrong time. In some cases, time can alter things significantly and a relationship that seemed beyond

repair has resolved itself in some way after a period of time; in other cases the relationship is simply better off being dissolved.

Support

The Gender Centre offers counselling support to people experiencing gender issues and their partners, families and friends. This can be done as a joint session (with the person experiencing gender issues and their partner, friends or family members taking part) or individually, with a partner, family member or friend accessing counselling—support on their own.

However, the purpose of counselling is not to tell any person that they are "right" or "wrong". Counselling is a process of mediation and exploration, rather than being a formulaic process that ensures a particular resolution if the "right" steps are followed. Counselling is not designed to change people's minds – the purpose is to encourage people to understand each others' viewpoints, even if they do not agree. People who come along for joint counselling in the hope that it will "bring back the person I knew", or "make the situation go away" are likely to be very disappointed when this turns out to be neither the case or the strategy.

The Gender Centre aims to provide accurate and up to date information about all options available to people with gender issues. These include medical treatment, cosmetic and other surgery, alternative treatments, lifestyle, peer support, legal, political and spiritual options. The Gender Centre does not consider one client's choice to be better or worse than another's choice. We provide services to all people who present with gender issues regardless of their race, religion, sexual orientation, self-identity or gender. It is an essential part of the philosophy of The Gender Centre that exploring gender is not, in itself, a problem.

What tends to be problematic tends much more towards being;

- the lack of resources and information regarding gender issues;
- the unwillingness of most aspects of culture to recognise that gender is not a fixed concept; and
- the fact that gender issues have traditionally been misrepresented and sensationalized by the media.

Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only. The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au



The Gender Centre Inc. Fact Sheet

Concerns for Clients

Accessing Government Agencies or Service Providers

Reviewed July 1st 2008

Fear/prior experience of insensitive treatment/curiosity/ridicule.

Many people within the transgender community report high levels of insensitive treatment by services. Staff who undertake counselling at the Gender Centre have listed as examples of insensitive treatment described by clients:

- Deliberately being hidden in inconspicuous areas;
- Being asked to stand or wait in non-private/conspicuous areas;
- Being asked questions several times in disbelief;
- Being questioned in a public setting;
- Seeing Staff members being called out to "have a look";
- Seeing incredulous expressions;
- Being openly laughed at;
- Being addressed inappropriately, by using an "original" name and not having a change of name acknowledged;
- Hearing themselves referred to as "her" or "him" when this is not appropriate; and
- A refusal on the part of staff to treat a transgendered person as a member of their preferred gender.

Clients may feel that their confidentiality is being breached due to curiosity from people working within services. Some clients have mentioned feeling certain that once they leave an agency the staff will look at or discuss their file inappropriately. In other instances, a person may find their file contains the word "transgender" or "transsexual" where this information is completely irrelevant to the services provided by the agency.

Clients may find themselves having to justify or explain their transgender status, or explain parts of their history not relevant to the service they are currently accessing. It is not unknown for staff to claim that they "just wanted to know more in order to deal with the client more effectively". However, services should not, except in exceptional circumstances, have to gather details from one person that they do not need to gather from other clients.

There are very few reasons to treat one client differently from another if they are accessing the same treatment or services. If there is a genuine reason for requesting additional information or varying procedures used with other clients, this should be explained. If a staff member is unsure of how to work with particular client (i.e. does the client want to sit in an open waiting room or would they prefer to sit somewhere more private), then usually questions can be asked in a way that does not impinge on a client's dignity. If unsure whether to address a client as him or her, ask them.



Fear/prior experience of discriminatory/unfair treatment.

Clients may be reluctant to return to a service where they have experienced insensitive or discriminatory treatment. For instance, some people with gender issues do not claim/continue with their welfare entitlements because they have experienced unfair or insensitive treatment from Centrelink in the past.

Transgender people may be reluctant to seek help/benefits in the first place due to a fear of discrimination. Clients may discontinue health/medical treatments or simply not seek medical help for the same reasons. Either of these can certainly be detrimental and/or dangerous to the individual. Ultimately it is up to the client to seek help if required.

There are ways to get information across to the general community that particular agencies are for all people (i.e. ACON's posters and ads promoting the fact that "ACON is for women", to counter the once widely held perception that ACON only dealt with gay men).

The only other thing that services can do is to treat all clients equally when and if they do present.

Being treated/seen as part of a stereotyped group rather than as an individual.

While it is possible and often practical to talk in terms of a group or a community (for funding or planning resource development, for example) it is important to recognise that every person is an individual. This line can become blurred in services, due to a number of factors. If there is media exposure about a particular "community", there may be a perception that there is a "line" or "format" for dealing with that community. Service providers are individuals dealing with individuals and one "line" may be inappropriate for one person but acceptable to another.

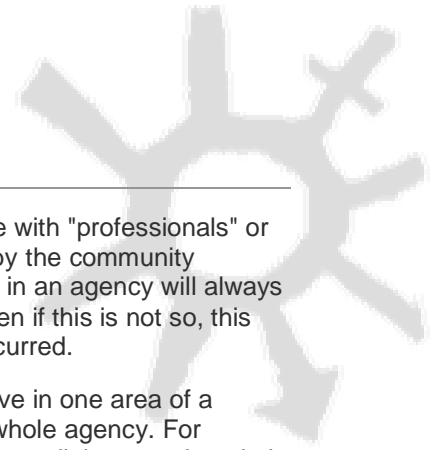
The perception that one is being treated as part of a minority group, even if "kindly" treated, can be undermining, as can the knowledge that one is being "tolerated".

Not being aware of own rights. Difficulty in enforcing own rights if they are known. Fear/prior experience of own rights not being upheld.

Clients may worry that they do not know how to find out about their rights, and that service providers may not be interested in helping them find out about these rights. Finding out about rights and entitlements within the health/welfare bureaucracy is not always easy for members of the general community, and this difficulty may be increased for members of "minority groups". Sometimes there are no special rights for disadvantaged groups despite the fact that their needs may clearly lie outside the boundaries of what is provided for mainstream groups.

When multiple difficulties are expected or experienced, it may be difficult for people to enforce their rights. Many health/welfare clients feel quite disempowered just by being "part of the system" (health or welfare systems) and may fear losing entitlements or benefits if they "make a fuss" or stand up for their rights. There is sometimes a perception that welfare recipients have no rights, or a feeling that enforcing one's rights may affect one's entitlements, even among welfare recipients themselves.

When it takes courage to walk into an agency in the first place, clients often find themselves unable to utilise the extra emotional resources necessary to defend one's rights. This is a common experience for transgender clients and many other disempowered/disadvantaged groups.



Difficult in resolving problems encountered in agencies.

Clients may not feel that they have the skills or even the right to negotiate with "professionals" or service providers. This is not an uncommon problem, often complicated by the community perception that members or certain professional bodies or staff members in an agency will always "hang together" and back each other up regardless of circumstances. Even if this is not so, this perception may stop people from resolving difficulties once they have occurred.

Transgender clients may also be concerned that the treatment they receive in one area of a service reflects the attitude that can expect to encounter throughout the whole agency. For instance, a transgender client who has a negative experience with one Centrelink or one hospital may be very reluctant to deal with another Centrelink or hospital: although the negative experience may have had more to do with the individual worker than the type of agency.

Needs not being addressed/dismissed as irrelevant or unimportant.

Transgender clients, have the right to expect to enter and leave a service with their dignity and self-esteem intact. However, transgender clients may find that their current gender is ignored and that they are treated as a member of their birth gender regardless of their stated wishes.

Transgenderers have a right, in common with other clients, to see that people who discriminate against them are sanctioned. However, it does happen that clients may be told, in all seriousness, that "so and so just isn't used to people like you, it isn't personal, just ignore it". This is an intolerable, but unfortunately, all too common attitude.

Physical issues and body image.

This is a major concern that can have a serious effect on transgender people's willingness to access health services, particularly sexual health services. Many people feel uncomfortable about sexual health check-ups and this sense of discomfort can be acutely heightened for people who may be struggling with their own gender, body image, and "physicality" in any case.

Even for those who are quite comfortable within themselves, the idea of encountering curiosity or ignorance, or having to "explain" one's body to a health service provider, can overwhelm transgender clients to the point where they just cannot bring themselves to access health services, even when this is essential to their health and well-being.

Fear/prior experience of violence.

Violence and physical hostility are not unknown in welfare/health services. Violence may come from service providers, but transgender clients may also worry that other clients may be hostile or violent towards them. It is within the legal/justice system that transgender people fear violence the most. This can mean the police, or the prison system. However, this fear of violence can also apply to residential services, such as refuges, or programs such as Drug and Alcohol rehabilitation programs.

Having inadequate/no social, legal or political redress for discrimination.

Transgender people have traditionally had very little to fall back on in the way of legislation or political representation, in common with many marginalised/disadvantaged groups.

The transgender community has only recently been included in the New South Wales Anti-Discrimination Act. It remains to be seen whether or not this will ensure fair and equal treatment for them.

Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only. The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au

Concerns for Service Providers When Assisting Transgender Clients

Reviewed July 1st 2008

Lack of general/community knowledge of gender issues. Lack of other service providers who can provide help/information in dealing with gender issues.

Gender issues are not widely discussed within Australia. Service providers coming in contact with transgender clients can feel that they are floundering in an unknown area, or worry that they lack the knowledge to deal sensitively or appropriately with transgender clients. They may feel that they do not know which questions are appropriate, which language is appropriate, and whether or not there is generally used language that may offend transgender clients. They may worry about their lack of knowledge and have no idea of where to go or who to ask in dealing with transgender clients.

There is a notable lack of services who can provide help/information to other service providers in dealing with clients with gender issues. The Gender Centre is attempting to network with a wider variety of health and welfare services throughout Australia. The Gender Centre staff are more than willing to discuss issues in dealing with transgender clients with other service providers should they require any assistance or information.

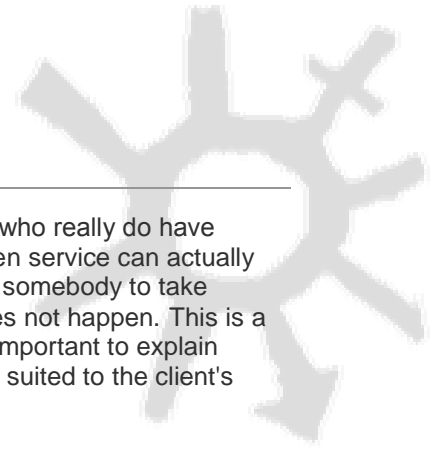
Dealing with special issues within a "Bureaucracy" and attendant difficulties.

There can be special issues involved in dealing with transgender clients, and these issues can challenge workers' own perceptions of sex and gender. Bureaucracies are not set up to deal well with issues that are not obvious; they tend to work with cultural norms that are generally taken for granted. It can be difficult for service providers to work with clients who do not fit into "obvious" categories. Even the most basic forms demand that the client fit into the standard cultural definitions of "male" and "female".

Issues of "special expectations" and "special treatment".

Because there can be special issues involved in dealing with transgender clients, workers may have to deal with other clients/staff members' perceptions that these clients are receiving "special treatment". It can be necessary for agencies to think quite hard about where and how transgender clients "fit in" and to have to put quite a lot of thought into accommodating this client group. This has been an issue for many marginalised groups, and can create unnecessary resentments and misunderstandings in the workplace.

Another issue is that marginalised groups who experience discrimination regularly may expect to be treated with a great deal of sensitivity or may take offence very easily at language or procedures that workers take for granted. This is understandable, but it may seem to workers that they are being expected to show "favouritism" towards a client by working with and upholding the client's sensitivities and preferences.



Worry about clients' possibly unrealistic expectations.

People who work in health/welfare agencies know that there are clients who really do have unrealistic expectations of services. There is really only so much any given service can actually do; however, many clients seeking help from agencies are hoping to find somebody to take responsibility from them or for them and can create trouble when this does not happen. This is a common worry that can apply to clients from many different groups. It is important to explain exactly what the agency can and cannot offer. If another agency is better suited to the client's needs, an explanation and referral is appropriate.

Dealing with reactions of other clients/staff members to clients with gender issues.

Service providers may feel uncomfortable or embarrassed by the attitudes/actions of other staff members or clients towards people with gender issues. However, they may feel that they cannot do anything about staff attitudes because it is not "their place" to do that or they worry about causing friction in the workplace. They may also feel that dealing with the attitudes of other clients may be seen as showing favouritism or advocating "special treatment".

If a person in higher authority than the service provider has a negative attitude towards transgender clients, the service provider may be placed in an especially difficult position, with a duty to uphold the rights of the client mixed with concern for keeping their job or for harmony in the workplace. The Gender Centre can provide training if necessary.

Dealing with multiple complex issues.

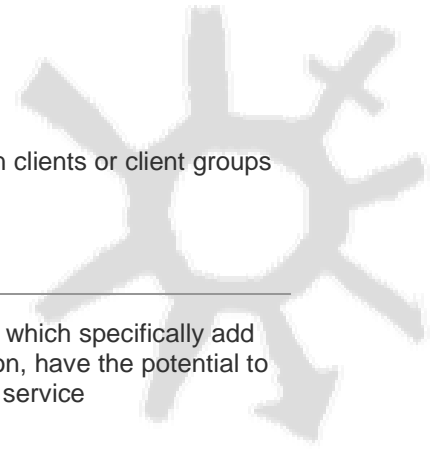
People with transgender issues may present to agencies with a complex range of issues to deal with. In addition to gender issues, there may be difficulties such as homelessness, criminality, ill-health, poverty, social isolation, drug-alcohol abuse, depression and/or others. Workers who are inexperienced in some of these areas may feel inadequate or feel that their service must be lacking.

However, services in the health and welfare sectors are becoming increasingly specialised and consequently workers need to have an up-to-date list of resources and referrals, rather than feeling that they should be able to sort out all issues on their own. All agencies deal with a limited range of issues, even though they recognise that where a range of issues exist each issue needs to be addressed. Many health and welfare agencies are over-accessed and under-resourced and thus there are time constraints that apply to clients.

Having to say, "I can't deal with this".

There still tends to be a perception in health/welfare services that staff should be able to deal with "anything". This is an unfortunate attitude that does not guarantee that the client gets what is best for them. Workers, like clients, are people with histories and private lives that impact on their working lives (perhaps especially in welfare), and this tends to be forgotten. Workers in any occupation need to be able to define their own boundaries in relation to what they can and cannot deal with.

For some workers, there will be issues or people that they just cannot deal with. Everyone has "buttons" that can be pushed; everyone will find that there are people with whom their personalities will clash. In this case, it is certainly better to acknowledge that a particular client "pushes their buttons" and organise another worker to deal with the client, than to deal less well with the client.



(This is differentiated from workers who simply refuse to work with certain clients or client groups because of prejudice).

Legal issues, particularly in relation to new legislation.

The 1996 amendments to the New South Wales Anti-Discrimination Act, which specifically add transgenders to the list of people covered by anti-discrimination legislation, have the potential to affect not only health and welfare services but all employers and general service

Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only. The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au

What is Female to Male (F.T.M.)?

Courtesy the American Boyz

Reviewed July 1st 2008

What does "F.T.M." mean?

"F.T.M." is an abbreviation for "female-to-male" transsexual, in other words, women who undergo the medical and legal procedures necessary to become men. "F2M" refers to people who are female by birth but who have male or masculine identities or appearances, which can include tomboys, butches, drag kings, gender benders, transsexuals, transgenderists, intersexuals, and other forms of gender expression.

Why do they do that?

There are as many reasons as there are people doing it. "Intersexuals" are born with conditions that give them a combination male and female physical traits; "transsexuals" seek to alter their bodies to conform to their internal concept of self; "drag kings" perform gender bending roles as a profession or hobby; "butches" are masculine-appearing women, usually perceived as lesbians, though that is not necessarily the case; "gender variant" people have spiritual, political, cultural, social or personal reasons they feel compelled to live or dress differently than conventionally expected by society. These people are often referred to by the umbrella term "transgendered", especially in a political context, e.g. "the transgendered civil rights movement."

Is it a form of mental illness?

Conventional medical diagnosis recognizes several kinds of psychiatric disorders relating to gender, such as "gender identity disorder", "Gender Dysphoria", "Transsexualism", and so forth. However any gender variant people believe very strongly that the right to identify their gender and act accordingly is not a pathology; but is instead the sign of a mature, thoughtful, and intelligent adult.

Aren't F.T.M.s just lesbians who can't deal with the homophobia in our society and pretend to be men in order to avoid being lesbian-baited?

F.T.M. transgenderism cuts across all orientations, all races, all cultures, all economic classes, and all walks of life. Some F.T.M. people prefer female partners, some prefer male partners, some prefer transgendered partners, some prefer partners who are not transgendered. Some change their preference after transition. Some do not. There is no correlation between sexual orientation and gender identity.

Who would want to partner with somebody like that?

Many men, women and transgendered people are specifically attracted to transgendered people because of their unique personal qualities and have satisfying, fulfilling relationships. But for someone who has just discovered that their partner is transgendered it can be upsetting and stressful to work through the issues necessary to regain balance in their relationship.

Is it really possible to turn a woman into a man?

A combination of male hormones, surgery and masculine apparel can remake a very feminine appearing person into a very masculine appearing person. Documentation can also be successfully changed to reflect the new name and gender.

Is it possible for F.T.M. transsexuals to have children?

Some F.T.M. transsexuals have children before undergoing sex reassignment surgery (S.R.S.). Some F.T.M.'s adopt children or their wives become pregnant through artificial insemination. F.T.M. transsexuals are infertile after S.R.S.

This information provided courtesy of The American Boyz, a national support and social group for people who were assigned female gender at birth but who feel that is not an adequate or complete description of who they are along with their significant others, friends, families, and allies.

Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only. The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au



The Gender Centre Inc. Fact Sheet
F.T.M. 101
The Invisible Transsexuals

Reviewed July 1st 2008

This paper provides an overview of the F.T.M. experience, focusing particularly on health issues, and includes basic information on:

- Hormones;
- Surgery;
- General Health Care;
- Mental Health; and
- Sexuality/Sex/S.T.D.s

Female-to-Male (F.T.M.) transsexuals have been invisible for many reasons. Among them are class issues, pressures from the gay/lesbian communities as well as mainstream society, gender stereotypes, the ease of assimilation. It is impossible to present a thumbnail sketch that defines the F.T.M. experience. There are too many ways to walk that path to give a simple explanation. Medical professionals have often commented on the stark difference between the M.T.F. hierarchy and the blur that exists within the F.T.M. community. Many M.T.F.s define themselves in the separation of pre-op and post-op and the distinction between cross-dresser and transsexual, subscribing to the premise that one is "real" and the other a mere pretense or dalliance. These clear strata do not exist for the F.T.M.. Many of us "blur," or exist within two or more so called categories. The old concept of going through the phalloplasty surgeries and becoming a "finished" man is losing currency within the F.T.M. community as transgendered and transsexual men around the world are re-defining for themselves what it "means" to be a man.

There is no specific age when a person decides they are transgendered. The F.T.M. community support groups serve those as young as fifteen years of age and those in their seventies. Many health concerns depend on when a person begins transition. Usually the younger folks adjust to the hormones with fewer side effects; sometimes migraines. This seems to be true from ages 15 – 40. Those beginning hormones in their forties to seventies need closer monitoring for high blood pressure and heart disease. Heart disease is more likely to occur with smoking, drinking, and unhealthy diet. Many F.T.M.s who choose hormone therapy in their sixties and seventies have usually started with low doses and more infrequent injections while having liver and cardiovascular systems monitored more frequently through lipid screen panels. There has been very little long term study of testosterone use in F.T.M.s, but logic dictates that many effects are cumulative. Young people should not neglect liver and cardiovascular health monitoring.

With these things in mind, we hope to present a clearer picture of some of the different needs of the F.T.M. community, as well as comment on the general needs of the larger transgender community.

Hormones

Any person on hormones is a chemistry experiment. It is very important to listen to the F.T.M. (or M.T.F.) as they tell you what is occurring for them physically and emotionally. F.T.M.s have learned to watch and monitor the changes they experience over time. On this note, it is very

important that if you have a pre-op transsexual come to you for help, you educate that person to listen to their body and know how to monitor changes. It will be up to them to guide you through their changes so that you can help them navigate their future health as safely as possible. This is also true for the individuals who choose not to do hormones or surgery. Transsexuals are often dissociated from their bodies due to the schisms they experience between the way they feel and the way their bodies are (sometimes) perceived by others, or the way they know their bodies are. Many transsexuals have extremely high thresholds for pain, or cannot differentiate pain from other experiences.

It is important for every F.T.M. to get a complete blood work-up before even beginning hormone therapy. Those who decide to go through the black market to obtain hormones are at risk for a variety of health problems. Even if someone comes to you who is not receiving injections through a program or doctor following the Harry Benjamin Standards of Care, it is important to listen closely to what they tell you. They will often times be able to tell you what it is that they need from you. (We do not wish to imply that we are telling you to throw out your knowledge or ideas. We simply ask that you not throw out the information and knowledge being given to you by the F.T.M. in your office.)

Once hormone therapy has begun, it is a good idea to do blood work-ups every three months for the first year. If there are no indicators of complications, this can be changed to every six months in the second year. After the third year, unless complications arise, once a year is not unusual practice for blood work-ups. The blood work-ups should not only monitor bilirubin levels for the liver, but should also monitor the cholesterol level. An occasional check of the serum testosterone level is a good idea, to be certain that the level is within the normal range for a male of the patient's age.

In the United States, the most common approach to hormone therapy for the F.T.M. is intramuscular injection. This is usually prescribed at 200ml/cc, 1cc every two weeks. This can vary between individuals, and it will take time to determine the proper dosage and frequency of injections. Testosterone Cypionate, a cottonseed oil suspension, and Testosterone Enanthate, a sesame seed oil suspension, are the two most common forms prescribed. There are doctors who insist on administering the shots. However, most doctors will do so only for the first few injections, and will then teach the F.T.M. how to inject himself so the F.T.M. can take care of this at home. Most doctors who insist on injecting the hormones themselves are also charging higher rates for the injections as well as the office visits. This usually occurs in rural areas or isolated areas where the F.T.M. has little choice but to comply. Oral Testosterone is still sometimes prescribed, but is strongly discouraged. The high doses of testosterone administered through this method are harmful to the liver. This method has also caused high blood pressure in many F.T.M.s.

A growing number of F.T.M.s who have been on hormones for 4 to 5 years who have not had hysterectomies, have developed intrauterine complications. These range from endometriosis to fibroid cysts, to fibrous scar tissue forming around the reproductive organs, to absorption of the organs into the abdominal muscles or even, in a couple of cases, into the intestines. The rising number of F.T.M.s who have been experiencing these complications has pushed many of us to ask for an hysterectomy earlier in our transition. Many F.T.M.s, however, do not experience these problems, and for them hysterectomy may be an unnecessary surgery. Some F.T.M.s require hysterectomy/oophorectomy for psychological reasons.

Some F.T.M.s may experience migraines in the first few months of hormone therapy. This can sometimes be alleviated by adjusting the dosage or the frequency of injections. Whether the dosage should be raised or lowered varies from person to person. This is a totally experimental stage, and also a very important time for the doctor to be listening to the instincts of the patient. Many F.T.M.s choose to weather the headaches. They usually dissipate after 3 – 6 months. Others may experience cold-like symptoms in the first few months; others may be at a higher risk for yeast infections for the first few months.

Diet is very important. Lowering fat intake will reduce the risks of high blood pressure and heart disease. Taking supplements of milk thistle can assist the liver in processing any toxicity. Smoking and drinking should be discouraged. If the F.T.M. intends to pursue any kind of surgery, he should be educated on the damage smoking does to the vascular system. Most surgeons performing any of the alterations sought by transsexuals insist that the patient quit smoking 6 to 9 months before surgery.

Hormone therapy begins at different times in life for different people. Those who start at a very early age will probably notice a variety of changes at several stages of their lives. Even people who do not walk this path experience hormonal fluctuations throughout their lives. Those who begin hormone therapy later on in life will probably have fewer fluctuations, but will need to pay closer attention to the changes that do occur. Anybody is at risk of arthritis and heart disease, but with the added factor of hormone therapy, the usual course of events may not apply. It is also important to note that all of this information will vary from person-to-person depending on age, ethnicity, diet, and current health.

Listed below are some of the differences between the cypionate and enanthate suspensions.

Testosterone cypionate; This form brings on the secondary male characteristics sooner than enanthate. However, since this is a cottonseed oil suspension, more guys have a variety of allergy reactions to it. These reactions can manifest in the form of mild rashes or itching at the site of injection. Acne is usually more prevalent and harder to control. Muscle and bone density increase is fairly rapid. However, ligaments and tendons are at risk of damage or injury because they take longer to "beef up" in correspondence with the muscle/bone increase. Any sport activity for the first two years of hormone therapy should be approached with this in mind. The voice usually begins to change at two months and settles at about nine months. Body hair appears within the first two months and can continue to grow in new places up to seven years. Balding is a very real possibility. It can begin as soon as three months into hormone therapy. Fat distribution shifts: thighs and hips may flatten out. However, fat frequently does not disappear, it merely shifts to the sides and the gut. Depending on the F.T.M.'s body type and diet, the person will gain or lose weight.

Testosterone enanthate; Since this is a sesame seed oil suspension, it is usually easier for the body to absorb. The secondary male sex characteristics usually take longer to manifest than with the cypionate – usually the process is 3 – 6 months behind, though this can vary, too. This slower body adjustment can make it easier on the tendons and ligaments, however, the risk for injury still exists. Acne is less of a problem, and for some has been non-existent.

Surgery

This is one of the more controversial aspects of the transgender experience. There are many transgender folk who choose not to have any surgery, some who pick and choose which surgeries they want, and some who feel they have no choice but to go through all of them. There are also the moral pressures to consider from internal and external sources. Average cost ranges are as follows:

- Chest: \$2100 – \$7500;
- Hysterectomy: \$10,500 – \$18,000;
- Metoidioplasty: \$8,000– \$15,000; and
- Phalloplasty: \$15,000 – \$150,000.

Please keep in mind that these costs vary from doctor-to-doctor as well as from country to country.

Most of the surgeries listed above can only be acquired by paying the surgeon cash up front. The cost is one of the weightiest factors as to whether a person decides to have the surgery or not. Many F.T.M.s are under-employed, if not unemployed. Those who do seek surgical alteration often work 2 and 3 jobs to save the money needed. Some of the younger F.T.M.s work the streets just for survival money, although a few have used this as a means to supplement other earnings for surgeries.

A few F.T.M.s have been able to acquire some or all of their surgeries through insurance. This is very rare since most insurance companies explicitly exclude transsexual treatments from their covered procedures.

When to have any of the surgeries is also an issue for many F.T.M.s. The Harry Benjamin Standards of Care (S.O.C.) clearly delineates when a transsexual can do certain things pertinent to their transition. Many transsexuals who only choose to do one or two of the surgeries circumvent the S.O.C.. However, this can mean seeking doctors through the black market. The other concern for many F.T.M.s is the condition of the body before and after taking hormones. There have been several F.T.M.s who have sought and received different surgeries before taking hormones. Reasons for this will be disclosed in the following paragraphs.

The double mastectomy and/or mastopexy is the procedure most commonly sought by F.T.M.s. The biggest reasons for this are image/presentation and comfort. Transsexuals are asked to dress and live in the world as a person of the gender they are trying to achieve for a set amount of time; usually six months to one year before they are allowed to pursue hormone therapy or any of the surgeries. The biggest obstacle for an F.T.M. is usually hiding the breasts. However, this is absolutely necessary. Far too many F.T.M.s have been humiliated, harassed, and even beaten up for walking into the men's room because their chests gave them away. This harassment is not exclusive to the bathroom situation. Mainstream society is notorious for its violence toward anyone presenting a conflicting image, period. Many F.T.M.s choose to have this surgery before they pursue hormones for several reasons. With testosterone comes body hair. The chest hair that grows in around the sutures and incisions can, at the very least, be incredibly annoying, and in the extreme can become ingrown and even cause infection. Many F.T.M.s also look to the advantage of estrogen keeping the skin more pliant as a bonus. Several individuals have gone through the mastopexy, waited 6 to 9 months to heal, and then begun testosterone therapy. It seems that most of these individuals have less visible scarring or less extensive scarring. The muscle growth into the chest with the testosterone seems to them more natural as well.

A couple of advantages to testosterone are that the healing rate (from surgery) appears to be quicker, and with the advanced muscle development, there is less chance of severed or damaged muscle.

Some of the older F.T.M.s have had the advantage of having a hysterectomy before they've sought hormone therapy. Many F.T.M.s feel there is an advantage to this as there will be less of a strain on the liver once testosterone therapy is initiated. Some symptoms of chemical/hormonal imbalance (such as migraines) often disappear after the F.T.M. has his hysterectomy. One advantage of hysterectomy is the possibility of either reducing the dosage of testosterone or extending the time period between injections, thus possibly reducing the strain on the liver. Those who do undergo this surgery are sometimes advised to then take small doses of estrogen. Many refuse because of the implications of femaleness. Many people do not understand that estrogen is present in the male body as well. Testosterone is also used to alleviate osteoporosis, though, and estrogen may not be necessary. People should also be aware that excess testosterone in the system is naturally converted into estrogen.

There are many who choose not to undergo a hysterectomy and suffer no ill-effects, although there does seem to be a greater degree of difficulty dealing with the last few days before the next injection, known as the trough. In the 3 to 4 days before the next injection, many F.T.M.s (with female reproductive organs still functioning) report irritability, shortness of attention span, headaches, fatigue, lack of sex drive, and sometimes cramping similar to menstrual cramping.

Some F.T.M.s who experience extremes of these symptoms then pursue hysterectomy, or opt for an oophorectomy.

In recent years, more and more F.T.M.s are choosing the metaoidioplasty (also inaccurately referred to as genitoplasty, and often contracted to metoidioplasty). One reason is money. It is less expensive, and therefore easier to set one's sights on as an attainable goal. Metaoidioplasty is the freeing of the enlarged clitoris (micro penis) and construction of a scrotal sack with testicular implants. The patient can opt for several choices. A urethral extension can be constructed so that the F.T.M. can pee from his freed penis. This choice carries the risk of infections, fistulas, and corrective surgeries for complications. A hysterectomy and/or vaginectomy can be performed simultaneously. If the vaginal canal is left intact, this gives the F.T.M. better options if he chooses to pursue a phalloplasty in the future.

The phalloplasty is usually a series of surgeries, not just one. The surgeries are still brutal and leave extensive scars on several places of the body; usually the inside of one forearm, the lower side of the torso, and the side of one thigh. Although these surgeries have been improved upon in the past ten years, there are still major drawbacks that deter many F.T.M.s. The amount of time spent in recovery from the surgeries is extensive.

Some F.T.M.s have spent nearly one year in recovery stages from the surgeries, dealing with infections, getting corrective surgeries, and sometimes having to deal with their body's out-and-out rejection of the graft. The emotional toll of this surgery can be incredibly high. The surgically constructed penis is also non-functional sexually. It does not get erect or flaccid on its own. Most constructions utilize Teflon inserts to achieve erections. A few surgeons use pumps similar to those used for penile reconstruction in genetic males suffering from cancer or erectile dysfunction. There is a chance of rejection with this option. The constructed penis frequently does not look like a penis. In recent years, some doctors have been fine-tuning their surgical techniques and have also teamed up with tattoo artists for better aesthetic results.

General Health Care

There are many reasons why FtMs will be reluctant to seek out medical attention or even preventative health care. Many older F.T.M.s have assimilated even without hormones or surgery. Their greatest fear is discovery. Sometimes even their own partners and families don't have a clue about their situation, and if they do, they are just as frightened of discovery. Mainstream society has not been very kind to anyone who is perceived as different. An even greater deterrent for many F.T.M.s is the very treatment they receive once in a doctor's office or in hospital. Far too many of us have stories of being treated like the latest circus attraction, or of being outed to the entire waiting room. Perhaps the greatest fear for many of us is being involved in an accident and being "discovered" on the scene or in the emergency room. The person fears being unconscious or so severely injured that he cannot defend himself while outrageous remarks are tossed about, jokes are cracked, epithets are shouted, treatment is interrupted or stopped. All of these things have happened and continue to happen to transsexuals every day. If it hasn't already happened to us, it has happened to a friend, and we know that it could happen to us.

Since most insurance companies have explicitly written us out of their policies, most of us find it difficult to seek health care through those avenues, even if they are available to us. There have been many transsexuals who have been denied even simple health care because doctors and insurers can claim that the condition would not exist if we were not pursuing transition. Unless we can find sympathetic health care workers, we are often at the mercy of the big money machine insurance companies.

For the F.T.M. specifically, dealing with the female reproductive organs can be a nightmare. Most of us do not have regular pap smears. The procedure is invasive. And again, finding a gynecologist who is sympathetic is difficult. Most F.T.M.s will not seek out a gynecologist unless they are already experiencing symptoms of a problem. Most gynecologists, when it comes to

female reproductive organs, have one goal—that of the continuation of the human race. When a male person with female reproductive organs comes into the office, most gynecologists see the organs and their possibilities, not the person. There are F.T.M.s who have been dealing with severe symptoms of endometriosis or other health problems, and their gynecologists will not remove the organs at the patients request because the gynecologist sees the possibility of saving the organs. The F.T.M. could be in severe, constant pain, not want the organs in the first place, have no intention of ever having children, even be past childbearing years, and the physician will override the patient's wishes just to save the reproductive organs. Never mind the physical, mental, and psychological strain this puts on the patient. Never mind that it is the patient's body.

Although many F.T.M.s perform their own breast exams, most do not. They will rarely go to a physician if they find anything unless they already have a doctor who is aware of their situation. If surgery is recommended, many will not follow through because of probable exposure in the operating room. This is often true of hysterectomies as well. F.T.M.s who choose to have one of the lower surgeries can get the hysterectomy at that time. If the F.T.M. has opted to not undergo alteration surgery, chances are he is not getting any kind of medical attention for any health concerns.

Diet is an on-going concern. Many of the F.T.M.s who are seeking some or all of the surgeries are working several jobs just to earn the needed money. There is little time for proper eating and sleeping. Those on the streets have an even greater difficulty meeting even the minimum dietary needs. Usually their main focus is on taking the steps they deem necessary for their transition. It is very important to point out to them that their health is one of the steps of their transition. If they do not have their basic health, they will not be able to maintain the work schedule they've set for themselves, they will not heal well from surgery or may even compromise their health to the point that they won't be able to have surgery, and that they may achieve the goals they've set for themselves and then not have the health to enjoy their new life to the fullest.

Mental Health

Mental health is tightly intertwined with general health. Most F.T.M.s tend to isolate. Not only do they deny themselves contact with society at large, they tend to isolate from each other. Even though this has slowly been changing in urban areas within the past five years, it tends to be the rule of thumb. Many F.T.M.s who meet at meetings are happy to share the physical changes they experience. They are very private about emotional and psychological changes. The struggle against gender stereotypes is more pronounced for F.T.M.s; or the majority of F.T.M.s are simply more aware of gender stereotypes. This often creates a barrier between F.T.M.s and M.T.F.s, creating an even greater sense of isolation; an isolation from those who might be best equipped to understand or help us.

It is quite often difficult for any transsexual to feel confident about themselves or even feel good about who they are when so many people in their lives (and society as a whole) have regarded them as deceivers, evil, worthless, liars, mentally ill, psychologically unfit, ad-nauseum. We are required to seek psychological treatment just for verification of our circumstances. We are told how we are to act, whom we are allowed to love what our sexuality may or may not be, what clothes to wear. Many of us have been taught to lie about who we truly are by the very people who are supposed to be helping us learn to accept who we are. It has only been within the last ten years that some therapists and psychologists have become guides to our process and let us come up with the answers to who we are. Needless to say, the trust level transsexuals have for therapy and mental health professionals is very low. Most sympathetic counselors understand that they will have to do a great deal of coaxing and laying down of a foundation for trust with most transgender folk just to draw them out.

The constant threat of being "outed," harassed, beaten/and most profoundly, the threat of being killed is an everyday concern that wears on transgender people. People in the mainstream feel that Brandon Teena "got what he deserved, because he deceived" the people in the town where

he was murdered. Sean O'Neil received the same general response from his neighbors: people felt he deserved to face the charges brought against him for deceiving those around him. Some of those charges were valid. However, the majority of them were not. (Ask us for more information about these people's cases, if you are interested.)

If the person is "out" about their transition, or has even transitioned on the job or in a small town, the risks are even greater. The emotional and psychological toll of these threats is tremendous. There is the added threat in many areas of being locked up and committed to any number of treatments, including shock treatment. These kind of mental pressures make every transgender person susceptible to mental illness of one form or another at any given point in their lives. This does not mean that we are mentally ill or incapable all of our lives. Because this is usually the perception that we encounter, our frustration level is only compounded. The suicide rate for transgender folk is very high. Substance abuse, eating and sleeping disorders, abuse as children, and domestic violence have only recently been being viewed as symptoms of the social pressures that transgender people are under as opposed to being a part of our so-called illness. Not only do we need more help around these issues, we need more education and compassion.

As more and more transgendered people come together and share their experiences with each other as well as the rest of the world, the primary emotion that arises is anger. It is usually the first barrier that must be dealt with by mental health professionals. Because of that anger, transsexuals can be marked as socially unfit. Western medicine's approach to classifying the symptom and not dealing with the root problem(s) is constantly used as a weapon against transgender folk. Until transgendered people are given space to feel safe, that will continue to be true. It is not just the transgendered folk who need help or have a problem; it is society as a whole.

Sexuality/Sex/S.T.D.'s

By and large, the transsexual condition is referred to, and often dealt with, as a sexual problem. Gender identity and sexuality are two separate aspects of our lives. Yet, it is amazing how many people have trouble conceptualizing the difference. Since transsexuals began approaching the medical community after W.W.I.I., the general view of those practitioners was one of taking a social deviant (socially embarrassing, "effeminate" men) and through chemical and surgical adjustments create a socially acceptable woman. Once it was discovered that a portion of these "new" women took female partners and identified as lesbians, the medical screening process was tightened up. Those who identified as anything other than heterosexual were forced to lie. If they mentioned any behavior that smacked of bisexuality or homosexuality, they were rejected from most gender programs. Those who felt they could not fight the system learned to lie. The medical community taught many transsexuals that their gender and sexual identity were inseparable.

One of the first people to challenge the gender programs and the medical professionals on this attitude was Louis Sullivan. He was the founder of the largest and longest-running F.T.M. organization (to date) in the world, now known as F.T.M. International, Inc. Lou identified not only as an F.T.M., but also as a gay man. He spent ten years of his life writing letters, personally visiting doctors, educating them, and persevering against the system. For ten years, he was denied hormone therapy or surgery. Finally, his persistence paid off and he was granted the right to pursue the treatment he felt he needed. He was the first F.T.M. who openly led the way for others who identified as gay or bisexual.

Within the F.T.M. experience, the entire gamut of the sexual spectrum is covered. A large portion of F.T.M.s identify as heterosexual men who date and even marry women. There are those who identify as non-sexual and others who see themselves as asexual, choosing only self-stimulation. A large number of people identify as gay or queer, others identify as bisexual. There are those who identify as pansexual or simply sexual.

Of course with the exploration of sexuality comes the discovery and exploration of sex. And with sex, the specter of H.I.V./AIDS and S.T.D.s arises. Most of the F.T.M.s on the street hustling for survival and money are fully aware of the risks they run. They face some of the tough problems that other male hustlers face on the streets. Most johns will pay higher dollar if they don't have to use a condom. In San Francisco, \$10 to \$30 dollars will get you a blowjob. These are usually performed with condoms. To kick without a condom, the asking price is \$75 to \$150. Several of the young men have commanded prices of \$500 or more for the john's privilege to not use a rubber. It seems an awfully low price for their life. The chance of drug use, mostly intravenous, is high for these young men. To our knowledge, at this point in time, the number of young F.T.M. men who work the streets is low.

The F.T.M.s who are probably at the highest risk of transmitting or contracting S.T.D.s are those who identify as heterosexual. Many hetero F.T.M.s feel they are immune to H.I.V./AIDS because it is still considered a gay disease, and not all F.T.M.s emerge from the dyke community. Their biggest risk is their ignorance and lack of education. This is probably less so in urban areas, but the attitude is still alarmingly prevalent. Not surprisingly, those F.T.M.s who identify as gay or bisexual are usually the most educated in regard to any S.T.D. as well as safer sex practices. This has not, however, kept F.T.M.s from contracting H.I.V. or other S.T.D.s. In both urban and rural areas, the number of F.T.M.s who have sero-converted has risen in the past three years. Herpes is wide-spread if not epidemic. A large number of F.T.M.s have spoken up about cases of gonorrhea as well. When asked why they choose not use condoms or other forms of protection, many state that they have felt pressured into not using them. Several have spoken of being told they won't be seen as "real" men if they insist on protection. This kind of pressure has come from straight women, bisexual men and women, and gay men. Peer pressure seems to run the gamut in the sexual spectrum as well. More education is needed about safe sex that recognizes the unique conditions of F.T.M. bodies and psyches.

Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only. The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au

Testosterone Hormone Information 1

Hormone Replacement Therapy

Reviewed July 1st 2008

What are Hormones?

As an adult, your body needs to continually replace body cells as they are damaged and wear out. The endocrine system helps your body manage this task. Hormones are chemicals of the endocrine system, which act as messengers between various parts of your body.

Hormones are produced in the body by glands. The glands that produce most of the sex hormones in a male are called testes and in a female are called ovaries. Sex hormones are carried from the glands throughout the body via the blood stream.

They travel to different areas, for example to the breast tissue, hair follicles and fat tissue under the skin, as well as to the sexual organs where they play important roles during sexual activity, in maintaining fertility and during the process of having children.

Sex hormones remind the body as it rebuilds and grows, to follow a male pattern if they are male hormones or a female pattern if they are female hormones.

The patterns they follow are already in every cell of your body. They are the kind of patterns that result in you having a nose similar to your parents and other family traits. They are all called genes.

Everyone's genes include male and female patterns. Although sex hormones are involved in many activities they are basically the messengers that remind the body to continue to follow the same pattern.

Hormone Therapy

Medical scientists early last century identified hormones and have been able to extract them from natural sources (e.g. From animal stock) or reproduce them as synthetic hormones in the laboratory.

The female hormone responsible for female characteristics like breast development is called oestrogen. The male hormone responsible for most male characteristics like beard growth and voice deepening is called testosterone.

If a person takes opposite sex hormones (eg. biological female takes male hormones), then they will block the message from their own glands (ovaries) and introduce a new message. Over time this will slowly soften some of their feminine traits and introduce male characteristics. This type of hormone therapy can be prescribed by your doctor to help you effect a change of gender role in your life.

Hormone therapy is a slow process. Changes will occur over a period of time similar to that of natural puberty.

Hormone therapy will initially involve regular blood tests to monitor your hormone levels. These tests can eventually be carried out less frequently, though at least once a year is advisable. This should be discussed with your doctor.

How Much is Enough?

The long-term development achieved from hormone therapy, for example in breast tissue or muscles, will depend on your genes. If therapy is commenced during or soon after puberty then the hormones will be more effective in achieving change.

When you begin hormone therapy, your doctor will prescribe a low dose of hormones and gradually increase the dose until it is enough to block the messages from your own glands and replace them with the new ones. This is achieved by keeping your hormones at a similar level to adults born naturally into the gender you are moving towards.

People normally have different amounts of naturally occurring hormones in their bodies. Therefore, the dose prescribed by the doctor will differ for each person.

The most important point to remember is that it will be necessary to stay on some hormone medication for the rest of your life.

If you are unhappy with the dose or the type of medication you are on, you should discuss this with your doctor and make any changes under their guidance. Repeatedly stopping and starting hormone therapy could seriously affect your long-term health.

Extra tablets or injections will not improve the long-term results. Taking more tablets or having extra injections to speed up the process will put you at greater risk of developing tumors, blood clots, heart disease or other serious illnesses. Always stay on the dose agreed to with your doctor.

Hormone Products

Hormone therapy may be given as tablets, injections or implants.

Hormone products prescribed to you will be manufactured from different sources and by a variety of methods. These products have very similar effects. However, it is not uncommon for patients to experience slight differences in how some products react to their body. This can be discussed with your doctor.

The costs of individual hormonal preparations will vary. Only some will be available under the Pharmaceutical Benefits Scheme (P.B.S.). When you start a new regime ask your doctor how much it will cost.

Taking Hormones

There are some medicines that interfere with the effect of testosterone. Tell your doctor what other prescription and non-prescription medicines you are using. When you discuss hormone therapy it will be helpful to consider the following points.

Tablets

You can get a prescription from your doctor and not return until you need another. This keeps visits to a minimum and tablets are a painless form of taking your hormones.

But, tablets maintain your hormones at safe and effective levels only if you take them with complete regularity. Some people find it difficult to remember or don't like having to organise a routine around something medical. It may be inconvenient to have hormone tablets in your home where they may present unwanted questions.

Injections

Injections are excellent if you don't want to be reminded on a day to day basis that you are on medication. As injections go straight into your body and are released slowly, they can be a very

effective way of keeping a healthy level of hormones. This may ensure maximum changes can occur, for example in muscle development in males and breast tissue in females.

But, injections can be painful or uncomfortable. You may need to make more frequent visits to the doctor and feel more dependent on their services.

Remember: If you inject your own hormones or you assist friends with theirs, never share needles or syringes. Dispose of them safely after a single use.

Needles and syringes can be obtained from the Gender Centre, any needle exchange program and some chemists. Contact the Alcohol & Drug Information Service (ADIS) on 9331 2111 for 24 hour information on needle exchange services.

Implants

Once in place, implants may last several months and provide an effective continuous dose.

But, implants are probably not a good idea when you first begin hormones as they are not available in the large doses usually required in the initial stages of therapy. They are more appropriate for people who have had surgery (involving the removal of their ovaries or testes) or people who have been on hormones for many years. It involves a minor surgical procedure under local anaesthetic to insert the small implant. Not all doctors will perform this procedure.

The Effects of Hormones

The long-term effects of sex hormones are wide ranging throughout the body. Limited research has been carried out on the long-term effects, risks and benefits relating to hormone therapy for people with gender issues.

Many health services and providers lack experience with the problems and issues involved. Despite these difficulties, experienced providers do exist and it is important if you are considering hormone therapy to obtain referrals to an endocrinologist (hormone specialist) and psychiatrist familiar with gender issues.

Treatment should be preceded by considerable thought and thorough discussion of the physical, emotional and social implications of treatment with the doctors and counselling services available. Discussions should include the medical risks associated with hormone treatment and the fact that some of the effects will be irreversible. Any other ongoing health problems also need to be considered.

Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only. The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au

Testosterone Hormone Information 2

Hormone Replacement Therapy

Reviewed July 1st 2008

Testosterone

Testosterone is the main hormone prescribed to biological females who are undergoing hormonal therapy with the intention of living in a male gender role.

Testosterone therapy is potentially dangerous and can lead to high cholesterol and associated blood vessel diseases. For this reason it is vital to have regular medical checks and that these include a multiple analysis blood screen and a lipid profile. If these are not carried out and medication adjusted accordingly then damage to your blood vessels could result in a heart attack or even a stroke.

It is possible that androgen therapy may shorten an individual's life expectancy by about five years. Biological women tend to live an average of five years longer than men. This is due partly to the protective effect of female hormones.

Alcohol and hormone therapy can put added stress on the liver so care needs to be taken with alcohol consumption.

The risk of damage to health from smoking will also increase.

The Masculinizing Effects of Testosterone

Breasts: These will not significantly alter due to therapy, however slight reductions in size may occur initially due to a loss of fat.

Genitals The first noticeable changes will be clitoral enlargement and cessation of menses. The ovaries will stop working, resulting in permanent sterility. How quickly these changes occur will depend both on individual characteristics and upon the dose of testosterone therapy.

After these changes the ovaries will no longer produce effective quantities of female hormones. This will also happen if a total hysterectomy is performed, as this involves the removal of the ovaries.

With the agreement of your doctor it will be possible then to reduce the dose of testosterone given, without the risk of any feminine traits re-emerging. It is likely that the libido will increase while on androgen therapy.

The vagina may also become dry and the tissues harden in time, making intercourse difficult and painful. At times an unexpected blood loss could occur from the vagina and if so it should be reported to your doctor and may need investigating.

Body Hair: Body hair will increase in both extent and coarseness, full development taking place over a number of years. Although the rate of development will be affected by the dose of testosterone taken, the amount of hair that grows, the colour, its texture and location on the body will be influenced greatly by your genetic makeup.

Facial hair will develop over a period of several months and is often to the extent of a full beard. Just how much facial hair develops will depend largely on family traits and once established will be a permanent change.

A deepening of the voice will occur within the early months of therapy. This will be a permanent change.

Bones will not change dramatically. The size of the hands, feet, chest, hips and height will not alter. The main concern is the risk of osteoporosis later in life. This is a gradual thinning of bone-mass which can lead to fragile bones in old age. There is clear evidence that a deficiency of sex hormones contributes in both sexes to weaker bones.

To avoid this, individuals on long-term hormone therapy will need to continue on some hormone treatment for the rest of their lives. This risk is greater if the ovaries have been removed. Bones are also helped by a calcium rich diet, exercise and not smoking.

Skin Changes will occur in the skin of the face and body. The oil glands will become enlarged and acne could result. The soft layer of fat, characteristic of female skin will diminish slowly over many months. These changes will increase the body's ability to sweat.

Emotions Mood swings including uncharacteristic feelings of aggression may require an adjustment of the dose prescribed by the doctor. These side-effects are a potential hazard to health and need to be carefully observed and discussed with your doctor.

Starting hormone therapy can be a stressful time both emotionally and socially. These factors may contribute to emotional difficulties and changes. This may be a good reason in itself to avoid alcohol and "recreational" drug use, particularly in the early stages of treatment when high doses are usually prescribed.

Muscles: The effects of testosterone are both androgenic (which means that they are responsible for the development of male sexual characteristics) and anabolic (which means they help to build and repair muscle tissue). These anabolic effects mean that muscles will begin to develop according to the male family traits and will be enhanced by exercise.

Weight gain will usually occur and for this reason it would be beneficial to pay careful attention to diet and exercise.

Herbal Testosterone Hormone Information

The following information is from an internet search on herbal alternatives to testosterone and is not an endorsement by The Gender Centre Inc.

A small percentage of F.T.M. individuals find that they are unable to take anabolic steroids for a number of reasons.

This information is not intended to provide clinically proven herbal supplements or medical information for F.T.M.s. If your doctor has advised you that it is not in the interests of your health to proceed with the usual prescribed doses of testosterone for your gender issues, this information should be discussed with your doctor.

This short information is intended to provide some direction in your search for alternative medically-available testosterone.

Tribestan

Tribestan is the closest and most potent of all natural herbal alternatives to synthetic anabolic hormones. This non-hormonal supplement increases testosterone levels in humans without any

clinically proven toxic effects. Since testosterone promotes protein synthesis and a positive nitrogen balance – the benefits of its diuretic effect promotes the lean, hard muscular look.

Other additional benefits are increased immunity, lowered cholesterol levels, increased self-confidence, improved workout attitude and better mood in general.

Tribestan is a completely natural product with no contra-indications, no toxicity and no side effects.

Supplement Facts:

- Tribulus terrestris extract: 250mg;
- Mirocell: 193mg;
- Cabosil (Aerosil): 100mg;
- Polyplasdone XL (Crosprovidon): 40mg;
- Polyvinylpyrrolidone: 30 mg;
- Talc: 12mg;
- Film coating: 10mg; and
- Magnesium stearate: 5mg.

Saw Palmetto

Acts to tone and strengthen the male reproductive system. It may be used with safety to boost the male sex hormones. It also helps to ease enlarged prostate glands.

Damiana

Damiana is well known as a herb for helping with sexual impotency and infertility in both males and females. It strengthens reproductive organs.

Yohimbe 1111

This is a herbal extract that can help your body produce testosterone naturally. Your body produces a certain amount of testosterone on its own and Yohimbe 1111 can help increase that level. Increased testosterone levels, along with proper training and diet, can increase muscle size and strength dramatically. Yohimbe 1111 is a natural alternative to steroids, safely stimulates testosterone production and works in conjunction with the body's natural testosterone production process.

The suggested use of Yohimbe 1111 is to take two capsules daily. Each capsule contains 1111mg of Yohimbe Bark extract.

Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only. The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au

Testosterone Implant Information

Hormone Replacement Therapy

Reviewed July 1st 2008

This Fact Sheet has been prepared for patients whose doctors have recommended testosterone replacement. It contains basic information about testosterone replacement therapy. You should discuss any further questions you may have with your doctor.

Introduction

Testosterone replacement for men with low testosterone levels has been available since the 1930s. The testosterone level is measured by a blood test.

Testosterone can be given as:

- A tablet or capsule by mouth;
- An injection into the muscle, usually the buttock; or
- An implant placed under the skin, usually the abdomen or buttock.

Testosterone Action

Testosterone is a hormone produced by the testes which are responsible for:

- Development of male secondary sex characteristics: Body hair growth (e.g. beard, chest, pubic hair); Genitals – penile growth; Deepening of the voice;
- Sexual behaviour: Sex drive (libido); Erections sufficient to achieve successful penetration; and
- Possibly for well-being and energy

Reasons for Testosterone Replacement

Low levels of testosterone in the blood may indicate the need for testosterone replacement, especially if there is decreased libido, or impotence. Replacement may also improve general sense of well-being and physical stamina.

The testosterone level is low if the testes fail to produce sufficient testosterone (hypogonadism). The underproduction by the testes is usually due to disease of the pituitary gland (hypopituitarism) which ceases to stimulate the testes to produce testosterone. Rarely it is due to testicular disease.

If testosterone levels in the blood remain low for many years, osteoporosis (brittle bones) may develop. Testosterone replacement can help prevent this.

Methods of Replacing Testosterone

Testosterone Tablets/Capsules

The tablets/capsules contain testosterone and are taken by mouth. They cause a rise in testosterone levels in the blood which peak in 2–4 hours and gradually decline over 8–12 hours. Therefore the tablets/capsules are usually taken with the morning and evening meals. They should be swallowed whole. The biggest dose is usually taken in the morning. The initial dose is usually 120–160mgs per day for 2–3 weeks then 40–120mgs per day. Your doctor will decide on the right dose for you based on the results of your blood tests and how you are feeling.

Testosterone tablets/capsules rarely cause any side effects but testosterone levels in the blood should be monitored regularly.

Testosterone Injections

The injection is usually given into the buttock and the action lasts for approximately one month. The injection may be a little painful, warming the testosterone before administration will lessen the discomfort. Dose: 100mg or 250mg per injection every 2–3 weeks.

Testosterone Implants

Testosterone implants allow a slow release of the natural hormone. They have few side effects and are almost always successful. Testosterone implants are formed by fusing crystalline testosterone at high temperatures under sterile conditions. The implants are about the size of a wheat grain (4.5 x 12mm). The action peaks approximately one month after implantation and lasts for 4–5 months depending on the individual.

The implant/injection is repeated depending on the results of a blood test and the way you feel. It takes a week to ten days for results of blood tests to be available.

Dose: The usual dose is between 100mg and 600mg depending on individual needs. In some cases, larger doses may be required.

Ask Your Doctor

Ask your G.P. about testosterone cream/ointment for topical application – available where injections or tablets/capsules are contraindicated.

Implantation

Implantation is a minor procedure, done under local anaesthetic, as an outpatient. It takes about 15–20 minutes.

The implants are placed into the fat layer just under the skin in an area where there is little movement, usually the abdomen or buttock.

Local anaesthetic is injected into the chosen area. There should be no pain after the anaesthetic takes effect.

A small cut is made in the skin to allow insertion of a small hollow instrument about the size of a straw called a cannula. The testosterone implants are pushed through the cannula. You may have a sensation of pushing as the implant is introduced. The cannula is then removed leaving the testosterone implant in place.

The wound is closed with a small stitch or with adhesive strips and pressure applied to ensure no bleeding occurs.

People often remove the stitch themselves in 5–7 days or go to their local doctor.

If any pain, redness, swelling or discharge occurs, or if the implants extrude, report to the Doctor.

Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only. The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au

Cross Dressing Information

Courtesy the Seahorse Society of N.S.W.

Reviewed July 1st 2008

What is a Crossdresser?

"Crossdresser", "Transvestite" or "Transgendered Person" are terms used to describe a person who regularly takes on the appearance of the opposite sex in order to satisfy a deep personal need.

We use and prefer the term "Crossdresser" as it is less limited and coloured by common usage.

Above all, however, a Crossdresser is a real person.

What causes Crossdressing?

What causes a person born physically male to need to dress and behave as a female (and vice-versa) in order to have peace of mind?

There is no present definitive answer. There appears to be a genetic predisposition and a prenatal hormonal basis for a person's gender identity – the mental perception an individual has about his or her gender – which, though subject to social influences, is in dependent of a person's physical sexual identity.

Crossdressing is simply the outward expression by such a person of this essential gender identity and Crossdressing is thus no less real or compelling for this person than the expression by the average male and female of their masculinity and femininity.

Is there a Cure?

There is no cure for Crossdressing for the simple reason that being a Crossdresser is not an illness but a state of being. Crossdressers are "born and not made".

Is Crossdressing new?

Throughout recorded history, and in every human culture, there have always been Crossdressers. In many societies, Crossdressers have been accepted for the reality they represent and their uniqueness has been utilised by such societies for the common good. It is a culture's attitude to Crossdressing that determines whether Crossdressing is or is not a "problem" to that culture.

What type of people are Crossdressers?

Crossdressers come from all walks of life and every strata of society. Spouses, parents, children and friends are Crossdressers. There are no distinctions.

Is Crossdressing Illegal or Immoral?

There is nothing in the act of Crossdressing that offends any law in mainland Australia or in most of the world. Most major religions do not consider the act of Crossdressing immoral.

Does Crossdressing influence sexuality?

A person's sexual preference or sexuality is independent of their mental gender identity. Human sexual diversity exists amongst Crossdressers in the same basic proportions as it does in the general community. In fact, as Crossdressers are part of the general community, your "average" Crossdresser is likely to be heterosexual, to have married and have children.

What is it like being a Crossdresser?

Most Crossdressers discover their need to cross dress during childhood. They have no idea why they feel the way they do, yet quickly find that the expression of this part of their nature results in reprimand and alienation from parents, family and friends – the people they love and value the most. This can result in the development of unreasonable feelings of unhealthy personal shame.

So most Crossdressers become secretive about their Crossdressing and, doing their best to deny and suppress this essential part of their being, grow fulfilling themselves as human being in all the other ways they can. But being a Crossdresser doesn't "go away" any more than the essential self can ever go away. Sustained denial of the expression of this essential self can result in severe emotional disturbance.

Shame, fear and loneliness find expression in thought with such questions as – "Would my best friends, workmates, family, father/mother, wife/partner and my children still want me and love me if they knew this part of me or would they reject me with scorn or fear?".

Many Crossdressers ultimately find it impossible and intolerable to exist like this. They feel compelled to learn about themselves and to "pen up" to themselves and to the significant others in their lives. Rejection may occur, most often Crossdressers are surprised at the level of acceptance they receive, which so often reflects the level of their own self-acceptance. They liberate themselves to enjoy the exhilaration of the expression of this essential part of their being through Crossdressing.

It is possible to be a complete and happy person and be a crossdresser!

What can you do if you know a Crossdresser?

Be open minded. Be prepared to learn some sensible realities about crossdressing.

Above all, know and remind yourself that being a Crossdresser will not change the child, the partner, parent or friend you know and maybe love, into someone different. After all the only real difference is that you know!

Continue to see the individual person concerned and allow yourself the gifts of an open heart and open mind!

What is Seahorse?

The Seahorse Society of New South Wales Inc. is a non-profit self-help organisation established in 1971 and is a Member of the New South Wales (N.S.W.) Association of Self Help Organisations and Groups (A.S.H.O.G.).

The Society's purpose is to provide mutual support for Crossdressers, their partners and families. We:

- maintain a library containing up-to-date references, medical and biographical material about Crossdressing;
- have regular meetings, which are both social and informative, regular outings to restaurants etc., provide practical advice such as where to shop and have experts assist our members in their Crossdressing;
- make available speakers and literature for interested community groups and the medical profession.
- offer free non-expert counselling, by both ourselves and our partners, to Crossdressers, their partners and families. We also offer referral to professional counsellors and medical practitioners if required; and
- above all, we offer Crossdressers a way "out-of-the-closet" to self acceptance and self-respect by being able to meet, question and share experiences with others who, as chance would have it, are Crossdressers.

Our motto is "Crossdressing With Dignity". Through promoting self respect amongst Crossdressers and their families and a better understanding of Crossdressing throughout the community, we aim to achieve just that.

The Seahorse Society of N.S.W. Inc.

Post Office (P.O.) Box 2193

Boronia Park N.S.W. 2111

Phone: 0423 125 860

Website: <http://www.seahorsesoc.org/>

Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only. The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au

Oestrogen Hormone Information 1

Hormone Replacement Therapy

Reviewed July 1st 2008

What are Hormones?

As an adult, your body needs to continually replace body cells as they are damaged and wear out. The endocrine system helps your body manage this task. Hormones are chemicals of the endocrine system, which act as messengers between various parts of your body.

Hormones are produced in the body by glands. The glands that produce most of the sex hormones in a male are called testes and in a female are called ovaries. Sex hormones are carried from the glands throughout the body via the blood stream.

They travel to different areas, for example to the breast tissue, hair follicles and fat tissue under the skin, as well as to the sexual organs where they play important roles during sexual activity, in maintaining fertility and during the process of having children.

Sex hormones remind the body as it rebuilds and grows, to follow a male pattern if they are male hormones or a female pattern if they are female hormones.

The patterns they follow are already in every cell of your body. They are the kind of patterns that result in you having a nose similar to your parents and other family traits. They are all called genes.

Everyone's genes include male and female patterns. Although sex hormones are involved in many activities they are basically the messengers that remind the body to continue to follow the same pattern.

Hormone Therapy

Medical scientists early last century identified hormones and have been able to extract them from natural sources (e.g. From animal stock) or reproduce them as synthetic hormones in the laboratory.

The female hormone responsible for female characteristics like breast development is called oestrogen. The male hormone responsible for most male characteristics like beard growth and voice deepening is called testosterone.

If a person takes opposite sex hormones (e.g. biological female takes male hormones), then they will block the message from their own glands (ovaries) and introduce a new message. Over time this will slowly soften some of their feminine traits and introduce male characteristics. This type of hormone therapy can be prescribed by your doctor to help you effect a change of gender role in your life.

Hormone therapy is a slow process. Changes will occur over a period of time similar to that of natural puberty.

Hormone therapy will initially involve regular blood tests to monitor your hormone levels. These tests can eventually be carried out less frequently, though at least once a year is advisable. This should be discussed with your doctor.

How Much is Enough?

The long-term development achieved from hormone therapy, for example in breast tissue or muscles, will depend on your genes. If therapy is commenced during or soon after puberty then the hormones will be more effective in achieving change.

When you begin hormone therapy, your doctor will prescribe a low dose of hormones and gradually increase the dose until it is enough to block the messages from your own glands and replace them with the new ones. This is achieved by keeping your hormones at a similar level to adults born naturally into the gender you are moving towards.

People normally have different amounts of naturally occurring hormones in their bodies. Therefore, the dose prescribed by the doctor will differ for each person.

The most important point to remember is that it will be necessary to stay on some hormone medication for the rest of your life.

If you are unhappy with the dose or the type of medication you are on, you should discuss this with your doctor and make any changes under their guidance. Repeatedly stopping and starting hormone therapy could seriously affect your long-term health.

Extra tablets or injections will not improve the long-term results. Taking more tablets or having extra injections to speed up the process will put you at greater risk of developing tumors, blood clots, heart disease or other serious illnesses. Always stay on the dose agreed to with your doctor.

Hormone Products

Hormone therapy may be given as tablets, injections or implants.

Hormone products prescribed to you will be manufactured from different sources and by a variety of methods. These products have very similar effects. However, it is not uncommon for patients to experience slight differences in how some products react to their body. This can be discussed with your doctor.

The costs of individual hormonal preparations will vary. Only some will be available under the Pharmaceutical Benefits Scheme (P.B.S.). When you start a new regime ask your doctor how much it will cost.

Taking Hormones

There are some medicines that interfere with the effect of testosterone. Tell your doctor what other prescription and non-prescription medicines you are using. When you discuss hormone therapy it will be helpful to consider the following points.

Tablets

You can get a prescription from your doctor and not return until you need another. This keeps visits to a minimum and tablets are a painless form of taking your hormones.

But, tablets maintain your hormones at safe and effective levels only if you take them with complete regularity. Some people find it difficult to remember or don't like having to organise a routine around something medical. It may be inconvenient to have hormone tablets in your home where they may present unwanted questions.

Injections

Injections are excellent if you don't want to be reminded on a day to day basis that you are on medication. As injections go straight into your body and are released slowly, they can be a very

effective way of keeping a healthy level of hormones. This may ensure maximum changes can occur, for example in muscle development in males and breast tissue in females.

But, injections can be painful or uncomfortable. You may need to make more frequent visits to the doctor and feel more dependent on their services.

Remember: If you inject your own hormones or you assist friends with theirs, never share needles or syringes. Dispose of them safely after a single use.

Needles and syringes can be obtained from the Gender Centre, any needle exchange program and some chemists. Contact the Alcohol & Drug Information Service (ADIS) on 9331 2111 for 24 hour information on needle exchange services.

Implants

Once in place, implants may last several months and provide an effective continuous dose.

But, implants are probably not a good idea when you first begin hormones as they are not available in the large doses usually required in the initial stages of therapy. They are more appropriate for people who have had surgery (involving the removal of their ovaries or testes) or people who have been on hormones for many years. It involves a minor surgical procedure under local anaesthetic to insert the small implant. Not all doctors will perform this procedure.

The Effects of Hormones

The long-term effects of sex hormones are wide ranging throughout the body. Limited research has been carried out on the long-term effects, risks and benefits relating to hormone therapy for people with gender issues.

Many health services and providers lack experience with the problems and issues involved. Despite these difficulties, experienced providers do exist and it is important if you are considering hormone therapy to obtain referrals to an endocrinologist (hormone specialist) and psychiatrist familiar with gender issues.

Treatment should be preceded by considerable thought and thorough discussion of the physical, emotional and social implications of treatment with the doctors and counselling services available. Discussions should include the medical risks associated with hormone treatment and the fact that some of the effects will be irreversible. Any other ongoing health problems also need to be considered.

Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only. The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au

Oestrogen Hormone Information 2

Feminising Effects

Reviewed July 1st 2008

Oestrogen

Oestrogen protects women against heart and blood vessel disease. Biological males who take oestrogen benefit also. This means life expectancy could increase, since women generally live about five years longer than men.

Oestrogen therapy can sometimes lead to damage to the pituitary gland. The pituitary is like a traffic light system that controls many of the hormone systems in the body and if this occurs then further medication and regular tests may be required for the client to avoid ill health. There is a great risk of stroke later in life particularly in the case of smokers who take oestrogen.

There will also be changes over a number of years in the ability to hold a drink. Women usually are only able to drink half the quantity of men. This is due partly to the higher fat ratio in their body mass. As oestrogen therapy progresses the ability to hold a drink will decrease.

The Feminising Effects of Oestrogen

Breasts will develop slowly over three or more years. The extent of growth will depend largely upon genetic makeup. Development however may be adversely affected by poor nutrition, excessive dieting or drug use. The nipples may also become swollen, enlarged and the pigment darken. As with all women, breast size and shape will alter slowly over the years. High levels of oestrogen can result in some milky secretion from the nipples. This should be mentioned to your doctor should it occur, as adjustments to your medication may be required.

Genitals will be slowly affected over a number of years. Initially, the fluid from the testes containing sperm will no longer flow. The fluid that appears during ejaculation will look clear and be made up of mostly prostate fluid. In some case, ejaculation may cease. Libido (sex drive) will be reduced and if low to begin with, may be lost altogether. Erections of the penis may become increasingly difficult to achieve and to sustain. Some softening of the penile and scrotal tissue will occur. The testes become damaged usually after a period of two to five years, irreversible sterility occurs.

Body Fat: Oestrogen will increase and redistribute body fat to areas such as thighs, buttocks and breasts. Muscle mass may soften. Weight gain usually occurs particularly if genital sex reassignment surgery is undertaken.

Body Hair (including facial hair) will soften and growth will slow. Neither will be eliminated by oestrogen therapy. Further retardation of hair growth on the body and face can be achieved by taking anti-androgens (Androcur or Aldactone). However, the effects of these will only last while the tablets are taken and Androcur in particular can reduce sex-drive.

Scalp hair will generally remain unaffected (oestrogens and pituitary do not reduce scalp hair). Balding will slow or stop altogether. If balding has begun, hair regrowth will not return to any significant extent.

The only permanent treatment for the removal of hair from the face and body is electrolysis. There is no Medicare or health insurance rebate for electrolysis and it can take as much as 300 hours or more of electrolysis to achieve permanent hair removal of a full beard.

Emotions: Although our moods are affected by our hormones they are also affected significantly by both our feelings towards ourselves and the events around us. When hormone therapy is commenced it may be a stressful time for a number of reasons and also a time of "soul searching" for the individual. If you feel that you are experiencing mood swings, and it is affecting your ability to cope, discuss your hormone dose with your doctor.

Skin: The softening effects of oestrogen on the skin of the face and body are noticeable over time. Softening will also occur to aged or damaged skin, although to a lesser extent. The effects are due partly to changes in the oil glands of the skin and also to the deposition of a fine layer of fat tissue beneath the skin common to women. Some changes in skin pigmentation occasionally occur around the face and a fine line may appear in the centre of the stomach area. These changes will look like fine brown freckles or smudges.

Veins: Changes can occur in the veins of the legs that may look unsightly. The small surface veins may become more prominent. If a family history exists of varicose veins, these will become more likely to develop with oestrogen therapy.

Bones: These will not alter dramatically. The size of the hands, feet, chest, hips and height will not change. The main concern is the risk of osteoporosis later in life. This is a gradual thinning of bone mass, which can lead to fragile bones. There is clear evidence that a deficiency of sex hormones in either sex will contribute to weaker bones. To avoid this, individuals on long-term hormone therapy and in particular individuals who have had neo-vaginal surgery will need to continue on some form of hormone treatment for the rest of their lives.

Voice: Upon commencement of therapy, slight changes of pitch and timbre may be noticed in the voice. However, significant changes will not occur to the voice as a result of oestrogen therapy. During puberty, a biological male experiences changes to the vocal cords that remain irreversible. Speech therapy continues to be the only healthy way to change the pitch and style of the voice. Speech therapy is not always successful.

Progesterone Therapy

Doctors may also prescribe a drug called Provera. This is also a female hormone called progesterone. In biological women, it plays an important role during the menstrual cycle and in the health of mature breasts. It is not responsible for feminisation like oestrogen therapy.

It may be given to patients who are experiencing difficulties with their breasts; for example, nipple soreness. This involves taking progesterone only at certain times of the month. As this routine may be complicated, it should be discussed with your doctor.

Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only. The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au



The Gender Centre Inc. Fact Sheet

Hormone Implant Information

Courtesy of Concord Hospital

Reviewed July 1st 2008

Your doctor has advised you to have hormone replacement therapy by the implant technique. The purpose of this brochure is to give you information about the nature of implants, their action, their benefits, possible side effects, and methods of implantation.

Hormone replacement therapy, particularly at the time of the menopause, has been available for decades. Oestrogen replacement is usually given by mouth which though effective, does not always keep the level of oestrogen in the blood within a desirable range. There is a growing trend towards the administration of hormones by non-oral routes, such as by implantation.

Although they have been available for many years, it is only in recent times there has been increased attention to the use of implants for hormone replacement therapy.

This brochure will consider the two commonly used implants, oestradiol (oestrogen) and testosterone implants.

Hormone implants are made by fusing pure crystals of the hormone in a mould. They are approximately the size of a grain of wheat.

The hormone implant is placed in the fat under the skin of the abdominal wall or the upper leg. From here the hormone is slowly absorbed into the bloodstream. The most important factors affecting the rate of absorption are the surface area of the implant and an adequate blood supply to the implant (wherever it is situated).

Sometimes fibrous tissue may develop around the implant and slow its absorption; if this occurs the implant needs to be replaced. As heat may increase the absorption rate of the hormone, hot water bottles should not be placed over the implantation site.

You may expect your oestrogen (or testosterone) implant, depending on its dose, to last many months.

Specific Information

Oestradiol implants, when inserted subcutaneously (under the skin), provide a very slow release of the natural oestrogen, oestradiol. In this way they provide a more steady release of oestrogen than oral preparations.

They have the added advantage of being in place for a long period of time and of not requiring more frequent administration of medication.

The hormone implants are available in 20mg, 50mg and 100mg sizes. Your doctor will advise you about the appropriate dose. The duration of action depends on the dose and rate of absorption and varies between individuals.

If you have not had a hysterectomy, your doctor will advise you to take tablets of the hormone progestogen for the first 10–14 days of each month. This will protect you from the very small chance of developing an abnormality of the lining (endometrium) of the uterus. If you have had a hysterectomy, for whatever reason, progestogen supplementation may not be considered necessary.

The beneficial effects of the oestradiol implant include the alleviation of premenopausal symptoms, the prevention of the onset, or the worsening of osteoporosis, and a reduction in the incidence of cardiovascular disease in the future.

Oestrogen replacement therapy (including oestradiol implants) should not be used if the patient has any of the following conditions:

- Pregnancy;
- Some cardiovascular disorders;
- Severe hypertension;
- Active liver disease;
- Known or suspected oestrogen dependant tumours;
- Undiagnosed vaginal bleeding; or
- A rare blood disorder called porphyria.

Certain pregnancy associated conditions you may have suffered including severe liver disease or itch may preclude the use of oestrogen as hormone replacement therapy in the menopause.

Testosterone is a hormone which is responsible for the characteristics of the male. However, it is responsible for libido (sex drive) in both sexes.

It is a sex hormone that is produced in the process of oestrogen production in a normal premenopausal woman. In women, testosterone is used predominantly for those who have an absent libido following either a surgical or natural menopause.

It should be pointed out that women who use this preparation do not experience masculinisation effects providing they are having concurrent oestrogen treatment.

The presentation of the testosterone implant is similar to that of the oestrogen implant and its insertion methods are the same.

Should masculinisation in any form take place, for example, excessive hair growth or lowering of the voice, in particular, you should notify your doctor immediately.

You should contact your doctor immediately if:

- Severe worsening of varicose veins occurs;
- You are contemplating elective surgery;
- Unexpected vaginal bleeding occurs;
- Severe breast pain develops;
- Abnormal pigmentation develops particularly around your eyes;
- You experience severe nausea;
- Excess fluid gain occurs; or
- Inflammation develops over the implementation site or suspected expulsion of the implant occurs.

The effectiveness level of this preparation is very high if the precautions mentioned above are observed. The usual method of assessment for replacement of the implant is the return of

symptoms. Your doctor may also monitor your blood levels of oestrogen in order to determine the appropriate time for replacement.

There are three methods of inserting hormone implants and these are discussed below:

- At the time of definitive surgical procedure such as hysterectomy, the implant may be left underneath the skin at the completion of the operation;
- The open surgery method: This method involves making a small incision in the skin under local anaesthetic. The skin is cut with a scalpel and forceps used to directly place the implant under the skin. The incision is then closed with a stitch and this is removed 2 days later. The scar fades and is virtually unnoticeable within a month;
- The implant can be placed under the skin using a small instrument about the size of a pencil. The procedure is done in the doctor's surgery. The incision may be closed with either a stitch or an adhesive surgical dressing, which is removed a couple of days later.

This implant information booklet has been prepared for issue to patients where implant therapy has been considered desirable by the physician.

by Dr. M. Gronow M.D., M.R.C.O.G. , F.R.A.C.O.G.
Text supplied by Concord Hospital, Endocrinology & Metabolism

Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only. The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au



The Gender Centre Inc. Fact Sheet
HRT and Osteoporosis
Courtesy the Intersex Society of North America

Reviewed July 1st 2008

Sex hormones (principally testosterone or oestrogen) are necessary to maintain healthy adult bones. Persons born without functioning gonads, or whose gonads have been removed, should be under an endocrinologist's care and should maintain hormone replacement therapy for life.

Many intersexuals, having developed a distrust or aversion for medical people, avoid medical care and drop hormone replacement therapy which was prescribed during puberty. This can result in extreme osteoporosis (brittle bones). Osteoporosis worsens silently, but at advanced stages it can destroy your quality of life. Persons with advanced osteoporosis are vulnerable to frequent bone fractures, especially of the spine, hip, and wrist. These fractures can be caused by a small amount of force, and are extremely painful and debilitating. Each spine fracture may put you flat on your back for one to two months.

If you have been without gonads or hormone replacement therapy for years, it is vital to get a bone density scan performed, to evaluate the condition of your bones (a simple, non-invasive procedure using a specialized x-ray machine), and to seek the advice of an endocrinologist in order to establish a regimen of hormone replacement therapy that works for you. If you have had bad experience in the past with hormones, we encourage you to find an endocrinologist who will work with you to adjust the mix and schedule of hormones until you find what works. If your bone density is low, your endocrinologist will probably recommend calcium supplements and weight-bearing exercise (not swimming!) to maintain density.

If your bone density scan is performed on a DEXA machine, make certain to do any follow-up scans on the same machine, and with the same reader.

A number of drugs currently in the biomedical news may prove useful for rebuilding lost bone density. If your bone density is low, check in with a qualified specialist regularly for the latest information.

The danger of osteoporosis is considerably worse for intersexuals than for post-menopausal women, because the intersexual will be without hormones for many decades. Do not disregard this danger!

Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only. The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au



The Gender Centre Inc. Fact Sheet

Electrolysis Information

Galvanic, Thermolysis, Blend

Reviewed July 1st 2008

Facial hair remains a difficult problem for many people with gender issues who are living in a female role. There are treatments to slow and/or soften facial hair including creams, ointments, waxing and medication. None of these however, including the use of Aldactone, Androcur or hormone therapy will result in the permanent removal of hair. Electrolysis is currently the only way to achieve this.

There is currently no regulation either legally or through professional groups to ensure that people you go to for electrolysis will have the expertise to treat a difficult facial hair problem. For this reason we recommend that anyone seeking out an operator take extreme care, as poor treatment can be a waste of money and leave the client with scarred or damaged skin.

If you are currently undertaking electrolysis treatment or are considering it in the future, then the following information may be of assistance.

Operators who do electrolysis only will be likely to have the greatest expertise and have previous experience with clients who are on a variety of hormonal treatments.

The total cost of treatment is difficult to determine, so be wary of operators who try to give you exact quotes. It would not be unusual however if the total cost to remove a full, thick, dark beard was in excess of \$10,000.

With full beard removal, 3 – 6 hours of treatment may be required each week, depending on the method used. The hours will reduce as treatment progresses. Treatment can be painful and may take between 2 – 5 years to complete.

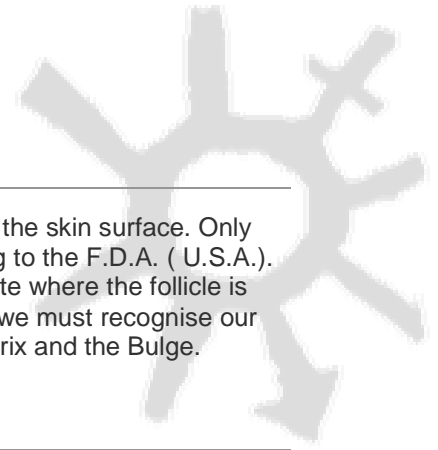
Appointments should be timed carefully by the operator to give skin time to recover between treatments and to treat hair at the correct stage of re-growth.

The client will need to be committed to arriving promptly to each and every appointment made. Experienced operators will demand this and may refuse to treat a client who does not demonstrate a clear commitment to their therapy.

Some methods require high electrical currents to effectively reduce strong hair growth and this may result in small welts and fine red scabs forming. These should change from red to brown over a few days and then heal. If they remain red and heal poorly or continue to ooze fluid instead of drying out, then permanent damage to your skin could occur. Should this occur it would be advisable to seek treatment elsewhere.

It may be helpful to choose an operator who has been recommended by someone who has achieved good results or alternatively ask for an initial consultation that involves a test patch or short treatment to see how your skin reacts to their method.

Before you start treatment, establish with the operator that the clinic pays careful attention to health and safety. All needles must be sterilized to avoid the risk of infections, including H.I.V. and hepatitis. The safest methods include disposable needles or the use of an autoclave.



Hair

The hair itself, is a dead structure, with the hair forming organ well under the skin surface. Only the needle method of electrolysis can permanently remove hair according to the F.D.A. (U.S.A.). The hair is of no practical concern to the electrologist other than to indicate where the follicle is and to act as a guide for depth of insertion. To have successful epilation we must recognise our targets. In the follicle there are two main targets that we know of, the Matrix and the Bulge.

The Matrix

Actively dividing cells found in the hair follicle bulb which produce the hair.

The Bulge

A small sac of germinating cells just below the sebaceous gland in the top third of the follicle.

The 3 Stages of Hair Growth

- Anagen – growing
- Catagen – transition
- Telogen – resting

Types of Hair

There are basically two types of hair growth on the human body. The first type is a fine, soft colourless hair called Vellus and the second type is a coarse, thicker, well developed variety known as Terminal hair. When a Vellus hair has been stimulated it is known as Accelerated Vellus.

Hair Cycle

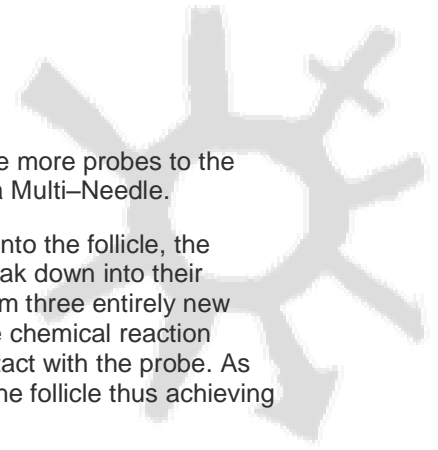
Hair has a three phase cycle. The first is the growth cycle or the active phase, followed by a brief transitional phase ending in a resting phase, reducing the follicle to one third of its normal size. The length of the total growth cycle and the duration of the alternating rest periods vary greatly from body region to body region and from person to person.

There are three methods of hair removal that have proven permanent:

- Galvanic Multi–needle – Chemical reaction liquefies the tissue.
- Thermolysis – coagulates the tissue in the follicle.
- Blend – A combination of the above.

Galvanic Multi–Needle method

In 1875 Dr. Charles E. Michel (1833–1913) an ophthalmologist, published the first account of successful permanent hair epilation by electrolysis in the St. Louis Clinical Record.



In 1916 Professor Paul M. Kree, aware of the growing demand added five more probes to the unit. This major invention which cut down the time required is known as a Multi-Needle.

This method uses a Direct (Galvanic) current. When the probe is placed into the follicle, the application of direct current causes the body salts and tissue fluids to break down into their constituent chemical elements which quickly rearrange themselves to form three entirely new substances; lye (which is highly caustic), hydrogen and chlorine gas. The chemical reaction happens all around the probe and is proportionate to the moisture in contact with the probe. As the moisture is converted into lye, it is the lye that liquefies the tissue in the follicle thus achieving permanent hair removal.

Advantages of the Galvanic Multi-Needle Method:

- Hair is successfully removed in a shorter time frame.
- Flexibility to move around curved follicles.
- Less discomfort for the client.
- Minimum re-growth.
- No disturbance to the surrounding tissue (no heat)

Disadvantages

- Requires minimum 3 minutes per hair.

The Galvanic Multi-Needle method is best suited to strong deep terminal or accelerated vellus hair (e.g. beards), plus all body hair.

Thermolysis

In 1923 Dr. Henri E. Bordier of Lyon France, was the first to use High Frequency for the removal of hair. He revolutionised electrolysis with this new method, promising greater speed and hopefully better results. Although it was not until the 1940's that it became popular. This was also known as Radio Frequency, Diathermy or Short Wave.

Thermolysis uses a high frequency current and gained its name because of its action of destroying tissue in the follicle by heat. When the probe is inserted into the follicle, it acts as a transmitter for the current. Because High Frequency current is continually changing direction, it has the ability to produce an area of friction within the moisture of the tissue surrounding the tip of the needle. The friction in turn results in heat which coagulates the fluid into a thickened mass, destroying the follicle.

Advantages of Thermolysis

- Visual results instantly
- Greatest advantage is its speed. (One to three seconds per hair.)

Disadvantages

- Very high re-growth
- Only able to successfully remove hair in anagen (growing) stage.
- Curved follicles cannot be destroyed.
- Surrounding tissue is heated, therefore treatment is limited.



Thermolysis is best suited to Vellus hair for facial down.

The Blend

In 1945 Dr. Henri E. St. Piere of San Francisco, in collaboration with Arthur Hinkel, a service engineer at General Electric, developed the Blend technique. They saw the popularity of thermolysis but also knew of the problems with re-growth. The two men thought that if they could combine the two modalities and utilise the speed of thermolysis and the effectiveness of galvanic, they would have a way of permanently removing hair quickly and easily.

The Blend uses high frequency and direct (Galvanic) current and is a dual action method. The Galvanic current produces lye while the High Frequency current heats up the moisture. When the lye is heated it will produce a much higher degree of caustic strength, it will diffuse easily into the heated mass which is very porous creating a turbulence around the needle, pushing the lye into any opening it can find.

Advantages of The Blend:

- Treatment time is 7 plus seconds per hair.
- The re-growth rate is believed to be less than that of Thermolysis.

Disadvantages

- Heating effect on surrounding tissue (limited treatments)
- Heating of hydrogen gas, by short wave, in the follicle can cause "Blow Out".

The Blend is best suited to vellus, accelerated vellus and scattered terminal hair for facial down, fine body hair and scattered coarse hairs.

The Gender Centre can provide referral to electrolysis professionals in the Sydney area. For more information contact the community worker.

Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only. The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au

The Transsexual Person In Your Life

Responses to frequently asked questions, frequently held concerns

Reviewed July 1st 2008

About this document

This was written for people who have recently learned that someone in their life identifies as a transsexual or has decided to undergo gender transition. Since many people have not previously had the opportunity to learn about transsexualism and other gender issues, they frequently have a lot of questions, and may or may not feel comfortable directly asking the transsexual person these questions.

A few notes about terminology

The community of people dealing with gender issues is large and diverse, and terminology about these issues is continuing to evolve. We will try to follow usages commonly accepted by many people in these communities, but apologize in advance if we unwittingly offend anyone who uses different words for their experiences.

About the terms "transsexual" and "transgendered"

We are using the term "transsexual" to refer to people who are undergoing or have undergone gender transition ("sex change"). "Transgendered" is a broader term, generally used to include any person who feels their assigned gender does not completely or adequately reflect their internal gender. Transgendered people may or may not take steps to live as a different gender.

About the term "opposite sex"

Modern Western culture is very invested in a strict two-sex/two-gender system, where the two categories are constructed as opposites. Many transsexual and transgendered people (and lots of other folks, too!) feel that this model is too restrictive to accurately describe their own sense of their gender. Since the phrase "opposite sex" is based on this restrictive concept, we will avoid that term in this document, in favor of such descriptions as "another sex" or "the target gender expression." (We will occasionally use the phrase, in quotes, if we are specifically referring to the restrictive two-gender system.)

About "sex" v "gender"

Social scientists make careful distinctions between these two terms. "Sex" generally refers to biology, to the actual form of the human body, including such factors as chromosomes, genital configuration, and secondary sex characteristics, while "gender" refers to the social meanings and characteristics associated with certain types of people.

In this document, we will attempt to adhere to this usage, but not too strictly. Because transsexuals combine sex and gender in various ways, sorting out exactly what is about "sex" v what is about "gender" can get a little tricky.

Contents

Section I: General information about transsexualism and gender transition;

Section II: Responses to common reactions and feelings about transition; and

Section III: Other resources, Web links, Books

Section I: Overview

What is transsexualism?

Transsexualism is a condition in which a person experiences a discontinuity between their assigned sex and what they feel their core gender is. For example, a person who was identified as "female" at birth, raised as a girl, and has lived being perceived by others as a woman, may feel that their core sense of who they are is a closer fit with "male" or "man." If this sense is strong and persistent, this person may decide to take steps to ensure that others perceive them as a man. In other words, they may decide to transition to living as the sex that more closely matches their internal gender.

What is involved in the transition process?

The answer to this question varies depending on the needs and desires of the individual choosing the transition process. An individual may choose any combination of social, medical and legal steps that will help that person achieve the greatest level of comfort with their body and social roles.

Social steps might include asking to be referred to by a different name (perhaps one generally given to people of the "opposite sex") and different pronouns ("she" instead of "he" or vice versa), dressing in clothing traditionally worn by people of the sex they wish to be perceived as, and taking on mannerisms frequently associated with that sex/gender.

Medical steps might include hormonal treatment to achieve an appearance more consistent with the target gender expression, and/or surgery to further modify the appearance. There are a variety of surgical options to alter the transsexual person's body to help them achieve the greatest comfort with their gender expression. The transsexual person may choose some, all, or none of these surgical options.

Many transsexual people also work with the courts in their area to achieve legal recognition of their new name and gender. Steps taken vary depending on the location.

What causes transsexualism?

No one knows the answer to this question, although there is much research currently in progress investigating it. Among the theories being investigated are genetic influences, in utero hormonal influences, and other brain structure/brain chemical influences.

Human sex and gender are very complex, and it is unlikely that any simplistic analysis will definitively answer this question.

What is the treatment for transsexualism? Is there a "cure?"

Treatments for transsexualism based on attempting to change the individual's sense of their own true gender have proven ineffective. Accepted treatments are based on helping the transsexual person's body and presentation match their inner sense of their gender, usually through hormone treatment and surgery.

How common is transsexualism?

The Diagnostic and Statistical Manual of Mental Disorders (D.S.M.– IV), fourth edition, says the following (© 1994, American Psychiatric Association):

Prevalence: There are no recent epidemiological studies to provide data on prevalence of Gender Identity Disorder. Data from smaller countries in Europe with access to total population statistics and referrals suggest that roughly 1 per 30,000 adult males and 1 per 100,000 adult females seek sex-reassignment surgery.

Because these numbers reflect only people who have sought traditional medical treatment, they do not reflect the total numbers of people who have some experience of gender discontinuity.

Is transsexualism a modern phenomenon?

While advances in medical science have only in the last few decades made it possible for individuals to transition with the aid of hormones and surgery, transgendered people have existed throughout history in many societies.

Jennifer Reitz's "Natural History of Transsexuality" provides a brief historical overview.

Is transsexualism the same as homosexuality?

No. Transsexualism is about a person's core sense of their gender. This is a separate issue from the gender of the people they are attracted to.

Just like any other individual, a transsexual person may identify as heterosexual, gay, lesbian, or bisexual. For example, a person raised as a man who transitions to living as a woman may identify as heterosexual, in which case she would seek relationships with men, or lesbian, in which case she would seek relationships with other women.

Section II: Responses to common reactions and feelings about transition

The person I thought I knew is becoming a stranger.

A person we know who undergoes gender transition will very likely look and sound quite different after their transition. A person we've known as a woman, for instance, may change his hairstyle, grow facial hair, speak with a lower voice, and adopt an entirely new wardrobe. But he's not likely to adopt an entirely new personality or set of values, and our history with this person is unchanged. Think of any person you care about, and ask yourself what qualities you value most about her or him. You are likely to think of qualities which are not gender-specific, such as sense of humor, intelligence, and loyalty. These qualities are not likely to change as a person undergoes gender transition. In fact, a person who undergoes gender transition is in a process of becoming more comfortable with himself or herself, and so their positive qualities are likely to be enhanced.

It can be scary when someone in your life tells you they need to make such a major change, and it's understandable that you may feel you don't know this person as well as you thought. But if you continue to spend time together, you will likely be comforted to find that they are in many ways the same person you have always known.

Altering the body through surgery seems like mutilation.

This is also an understandable response. To those of us who are comfortable with our assigned gender, the idea of altering those parts of our bodies that are most associated with our gender can feel alien, frightening, and disturbing.

Another person's decision to alter parts of their body can feel threatening. It may help to remember that a person undergoing transition from, for instance, a male to female gender expression, is not making a blanket statement about the value of malehood or the validity of your gender expression. She is simply seeking to become more comfortable in her body.

Sex reassignment surgery is the aspect of gender transition that is most difficult for some people to understand, and you may never feel comfortable with it. That's okay. But that discomfort

doesn't preclude honoring another person's choice, treating them with respect, and even supporting them through their gender transition.

I can't imagine the person ever seeming to me like the sex they want to be.

It's hard to let go of our perceptions of someone we've known for a long time. Changes in a person's appearance and behavior can occur gradually, and may be difficult to perceive if you are in regular contact. But if you pay attention to how strangers react to the person, it may help you to see these changes. On the other hand, the gradualness of the change may help you to adapt to the new gender identity step-by-step. You may be surprised, in time, at how completely you accept the person's new chosen gender.

It is true, however, that some people who undergo gender transition will continue to have significant characteristics of their previous gender identity. Some male-to-female transsexuals, for instance, may be unusually tall for women, while a female-to-male transsexual may have small features. It may help if you avoid focusing on these specific things, but rather honor the person's chosen gender, and try to see them as they see themselves.

How can I support this person in their transition?

There are many ways you can be helpful. Perhaps the most important is to convey your intention to be supportive to the person in transition. Let them know you want to be an ally, and ask them what they need from you. Then, to the extent you are able, offer them the support they've asked for.

We can offer a couple of specific ideas as well. First, you can adopt the use of the person's new name (if they've chosen one) and appropriate gender pronouns. This change can be uncomfortable at first, and you may slip up once in a while, but eventually this change becomes habitual and comfortable. This small but very important step will demonstrate that you take the person's decision seriously.

You can also try to maintain your previous relationship with the person, whether that's the intimate relationship of close friends or once-a-month bowling buddies. Gender transition is new territory for many people, and hence can be scary. "Hanging in" with the person in transition despite feelings of discomfort with the process can be a very supportive act.

Also, you may ask the person in transition how you can help in letting others know about their transition. They may want to tell people themselves, or they may be grateful for help "spreading the word." There may be certain contexts—the softball team, a church you both attend, or the workplace—where your assistance in telling others and expressing your support will be appreciated. Let them be your guide in this.

Section III: Other Resources

Internet Resources on Gender Issues: General Resources

The International Foundation for Gender Education (I.F.G.E.)

<http://www.ifge.org/>

"A leading advocate and educational organization for promoting the self-definition and free expression of individual gender identity. I.F.G.E. is not a support group, it is an information provider and clearinghouse. I.F.G.E. maintains the most complete bookstore on the subject of transgenderism available anywhere."

Gender Education & Advocacy (G.E.A.)

<http://www.gender.org/>

"Gender Education & Advocacy is a national organization focused on the needs, issues and concerns of gender variant people in human society. We seek to educate and advocate, not only for ourselves and others like us, but for all human beings who suffer from gender-based oppression in all of its many forms "

Jennifer Reitz' Transsexuality Page

<http://www.transsexual.org/>

A lot of good information for trans folks, as well as some interesting general info about gender issues. Sections include: "What exactly is Transsexuality?; The reasons to cherish being transsexual; Why you don't want to be a woman or a man; What can I expect long term?; What is it like to be transsexual?."

Paper Cuts on My Soul

<http://lisalees.com/>

Some great educational handouts and pointers to other resources. A wonderful archive of trans folks' letters announcing their transition.

Transsexualism And Gender Identity Disorder

<http://www.avitale.com/>

Dr. Anne Vitale's site. "The intent of this web site is to educate the reader to the psychotherapeutic issues of gender identity."

Standards Of Care For Gender Identity Disorders

<http://www.wpath.org/>

Issued by the World Professional Association for Transgender Health Inc.. This outlines suggested protocols transsexuals must conform to receive treatment from participating medical professionals.

Gender Public Advocacy Coalition (GenderPAC)

<http://www.gpac.org/>

"GenderPAC works to end discrimination and violence caused by gender stereotypes by changing public attitudes, educating elected officials and expanding legal rights."

F.T.M. International

<http://www.ftmi.org/>

"F.T.M. International is the internet contact point for the largest, longest-running educational organization serving F.T.M. transgendered people and transsexual men."

Resources specifically for male-to-female transgendered/transsexual people

Transsexual Women's Resources

<http://www.annelawrence.com/twr/index.html>

Dr. Anne Lawrence's page contents includes a lot of good information about hormones and surgery, plus pointers to other resources, including resources specifically for young transsexuals.

Renaissance: Transgender Information & Support

<http://www.ren.org/>

A "transgender education organization and the largest open membership support group in the world." Primarily for male-to-female trans folks, including cross-dressers and others.

Information for family, friends, employers and others

T.G.S. – P.F.L.A.G. Frequently Asked Questions

<http://www.critpath.org/pflag-talk/tgsfaq.html>

Webpage associated with the T.G.S. – P.F.L.A.G. mailing list, a list "for support of parents, family, spouses and friends of transgendered people and transgenders who wish to discuss family or other personal relationships."

TransFamily

<http://www.transfamily.org/>

"TransFamily is a support group for transgendered and transsexual people, their parents, partners, children, other family members, friends, and supportive others. We provide referrals, literature, and over-the-phone information on all transgender issues "

A Parent's Dilemma, the Transgender Child

<http://www.firelily.com/gender/gianna/dilemma.html>

Well-written article by counselor and gender specialist Gianna E. Israel.

A Lover's Leap of Faith

<http://www.tsfaq.info/flgc-speech.html>

A Speech Given at the Friends (Quakers) for Lesbian and Gay Concerns Midwinter Gathering, February, 1999. The lesbian lover of an F.T.M. writes from a faith-based perspective about her partner's gender transition and its effects on her.

Human Rights Campaign's Transgenderism and Transition in the Workplace

<http://www.hrc.org/issues/4854.htm>

"A guide that examines transgender workplace issues, including a discussion of the law and strategies for dealing with transitioning on the job." For both workers and employers.

Transsexualism: Notes for Employers

<http://www.looking-glass.greenend.org.uk/work.htm>

"This document is intended to provide guidance to Managers and Employers of persons diagnosed with Transsexualism. It details the current legal position [in the U.K.] regarding such persons' employment rights, and makes recommendations for "best practice" ways of dealing with transsexualism in the workplace."

Books

Most of these books can be ordered from the I.F.G.E. bookstore.

Boenke, Mary (ed.) *Trans Forming Families: Real Stories About Transgendered Loved Ones.* Waterford Press, 1999.

Brown, Mildred L. *True Selves: Understanding Transsexualism—For Families, Friends, Coworkers, and Helping Professionals.* San Francisco: Jossey-Bass Publishers, 1996.

- Burke, Phyllis. *Gender Shock: Exploding the Myths of Male and Female*. Anchor Books, 1996.
- Cameron, Loren. *Body Alchemy: Transsexual Portraits*. Pittsburgh, Pa U.S.A.: Cleis Press, 1996.
- Cole, Dana. *The Employer's Guide to Gender Transition*. Waltham, Ma U.S.A.: I.F.G.E., 1992.
- Devor, Holly. *F.T.M.: Female to Male Transsexuals in Society*. Bloomington: Indiana University Press, 1997.
- Israel, Gianna E., et al. *Transgender Care: Recommended Guidelines, Practical Information, and Personal Accounts*. Philadelphia: Temple University Press, 1997.
- Kirk, Sheila M.D. *Feminizing Hormonal Therapy for the Transgendered*. Blawnox, Pa U.S.A.: Together Lifeworks, 1996.
- Kirk, Sheila M.D. *Masculinizing Hormonal Therapy for the Transgendered*. Blawnox, Pa U.S.A.: Together Lifeworks, 1996.
- Kirk, Sheila Pa U.S.A. and Martine Rothblatt, J.D. *Medical, Legal & Workplace Issues for the Transsexual*. Blawnox, Pa U.S.A.: Together Lifeworks, 1995.
- Bornstein, Kate. *Gender Outlaw: On Men, Women and the Rest of Us*. New York: Routledge, 1994.
- Califia, Pat. *Sex Changes: The Politics of Transgenderism*. San Francisco, California: Cleis Press, 1997.
- Feinberg, Leslie. *Transgender Warriors: Making History from Joan of Arc to Rupaul*. Boston: Beacon Press, 1996. Also see Leslie's website.
- Wilchins, Riki Anne. *Read My Lips: Sexual Subversion and the End of Gender*. Ithaca, N.Y. U.S.A.: Firebrand, 1997.

Send us your feedback.

Last modified: 20th July 2003

This document may be copied and distributed in print as long as the entire document is included and the copyright notice is not removed. Please also include the U.R.L. for this webpage <http://www.tsfaq.info/>. Please do not copy the web pages for posting elsewhere on the web; link to this site instead.

© Copyright 1998–2003 Su Penn. All rights reserved.

Please Note:

The Gender Centre is listing these links for information regarding specific areas of transgender life and transition, and other resources where appropriate. Please note, while information on these websites have been found useful to some, the Gender Centre takes no responsibility for information appearing in these websites.

Many of the websites are American and British owned and operated. While general support information may be similar to here in Australia, web surfers are encouraged to contact the Gender Centre for information regarding most medical and legal issues.

The Gender Centre also possesses an extensive referral manual in the areas of legal, medical, accommodation, employment, H.I.V./AIDS, Psychiatric, Youth, Aboriginal and Corrective Services. Some of this information cannot appear on our webpage for legal reasons, and again, interested parties are encouraged to contact the Gender Centre directly.

Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only. The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au



The Gender Centre Inc. Fact Sheet
Intersexuality 101
Courtesy the Intersex Society of North America

Reviewed July 1st 2008

What is Intersexuality (Hermaphroditism)?

Our culture conceives sex anatomy as a dichotomy: humans come in two sexes, conceived of as so different as to be nearly different species. However, developmental embryology, as well as the existence of intersexuals, proves this to be a cultural construction. Anatomic sex differentiation occurs on a male/female continuum, and there are several dimensions.

Genetic sex, or the organisation of the "sex chromosomes," is commonly thought to be isomorphic to some idea of "true sex." However, something like 1/500 of the population have a karyotype other than XX or XY. Since genetic testing was instituted for women in the Olympic Games, a number of women have been disqualified as "not women," after winning. However, none of the disqualified women is a man; all have atypical karyotypes, and one gave birth to a healthy child after having been disqualified.

The sex chromosomes determine the differentiation of the gonads into ovaries, testes, ovo-testes, or non-functioning streaks. The hormones produced by the foetal gonads determine the differentiation of the external genitalia into male, female, or intermediate (intersexual) morphology. Genitals develop from a common precursor, and therefore intermediate morphology is common, but the popular idea of "two sets" of genitals (male and female) is not possible. Intersexual genitals may look nearly female, with a large clitoris, or with some degree of posterior labial fusion. They may look nearly male, with a small penis, or with hypospadias. They may be truly "right in the middle," with a phallus that can be considered either a large clitoris or a small penis, with a structure that might be a split, empty scrotum, or outer labia, and with a small vagina that opens into the urethra rather than into the perineum.

What are the frequencies of Intersex conditions?

The frequency of inherited genetic conditions, such as congenital adrenal hyperplasia, differs for different populations. It has been estimated that as many as 4% (although it is more likely to be around 1%) of the population could be affected by some form of intersexuality. This includes men or women with abnormal hormonal levels.

Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only. The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au

Recommendations for Infants and Children

With regard to Intersexuality

Reviewed July 1st 2008

Why this document?

The current model of treatment for intersexual infants and children, established in the 1950's, asserts that since the human species is sexually dimorphic, all humans must appear to be either exclusively male or female, and that children with visibly intersexual anatomy cannot develop into healthy adults. The model therefore recommends emergency sex assignment and reinforcement in the sex of assignment with early genital surgery. It also encourages care providers to be less than honest with parents and with intersexuals about their true status.

As a growing number of us who are intersexual have shared our experiences with each other, we have reached the conclusion that, for most of us, this management model has led to profoundly harmful sorts of medical intervention and to neglect of badly needed emotional support. Our intersexuality—our status as individuals who are neither typical males nor typical females is not beneficially altered by such treatment. Instead, it is pushed out of the view of parents and care providers. This "conspiracy of silence" – the policy of pretending that our intersexuality has been medically eliminated – in fact simply exacerbates the predicament of the intersexual adolescent or young adult who knows that s/he is different, whose genitals have often been mutilated by "reconstructive" surgery, whose sexual functioning has been severely impaired, and whose treatment history has made clear that acknowledgment or discussion of our intersexuality violates a cultural and a family taboo.

A new model of treatment

Based on discussions with dozens of adult intersexuals, we are prepared to recommend a new paradigm for the management of intersexual children. Our model is based upon avoidance of harmful or unnecessary surgery, qualified professional mental health care for the intersexual child and his/her family, and empowering the intersexual to understand his/her own status and to choose (or reject) any medical intervention.

Avoid Surgery

First and foremost, we recommend avoidance of harmful or unnecessary genital surgery on infants and children. No surgery should be performed unless it is absolutely necessary for the physical health and comfort of the intersexual child. We believe any surgery that does not meet these criteria to be essentially elective cosmetic surgery which should be deferred until the intersexual child is able to understand the risks and benefits of the proposed surgery and is able to provide appropriately informed consent.

Examples of such cosmetic surgery to be avoided are plastic repair of first degree epispadias or hypospadias (minor displacement of urethral meatus), vaginoplasty, clitoral reduction or recession, and clitorrectomy. Examples of conditions which would appear to justify early surgery

are severe second or third degree hypospadias (with extensive exposed mucosal tissue vulnerable to infection), chordee (extensive enough to cause pain), bladder exstrophy, and imperforate anus.

Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only. The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au



The Gender Centre Inc. Fact Sheet
Transsexualism
The Current Medical Viewpoint

Reviewed July 1st 2008

Produced for the Parliamentary Forum on Transsexualism.

Chair: Lynne Jones, M.P.

by: Dr. R Reid, Hillingdon Hospital (Medical Sub–Group Convenor), Dr. Domenico di Ceglie, Tavistock Clinic, Mr. James Dalrymple, London Bridge Hospital, Professor Louis Gooren, University of Amsterdam, Professor Richard Green, Charing Cross Hospital, Professor John Money, Johns Hopkins Hospital, U.S.A.

Second Edition, 18th January 1996

Summary

Purpose

This document provides an overview of current best practice in providing effective health care for persons with the transsexual syndrome. It describes the nature of the syndrome, its diagnosis, treatment and outcomes; recognises its biological aetiology; and makes recommendations for the legal status of people experiencing transsexualism. It updates a similar document produced for the Forum on 14 February 1995.

The syndrome

Transsexualism is a Gender Identity Disorder in which there is a strong and on–going cross–gender identification, i.e. a desire to live and be accepted as a member of the opposite sex. There is a persistent discomfort with his or her anatomical sex and a sense of inappropriateness in the gender role of that sex. There is a wish to have hormonal treatment and surgery to make one's body as congruent as possible with one's psychological sex.

Treatment

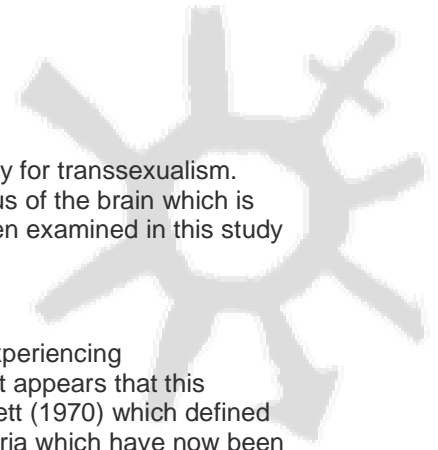
The currently accepted and effective model of treatment utilises hormone therapy and surgical reconstruction and may include counselling and other psychotherapeutic approaches; electrolysis; and speech therapy. In all cases, the length and kind of treatment provided will depend on the individual needs of the patient and will be subject to negotiation between the Consultants involved, the patient's General Practitioner and the patient.

Outcomes

Studies which have been carried out into long–term outcomes indicate that a treatment model using the principles described above is highly successful, with some suggesting up to a 97% success rate. This compares extremely favourably with the outcomes of treatment for other chronic conditions.

Aetiology

Dr. Harry Benjamin, who introduced the syndrome to the general medical community in the early 1950s, favoured a biological explanation of the syndrome, believing that the genetic and endocrine systems must provide a "fertile soil" for environmental influences. The weight of current



scientific evidence suggests a biologically-based, multi-factorial aetiology for transsexualism. Most recently, for example, a study identified a region in the hypothalamus of the brain which is markedly smaller in women than in men. The brains of transsexual women examined in this study show a similar brain development to that of other women.

Legal position

The present legal position is that people who have been diagnosed as experiencing transsexualism immediately lose a substantial part of their civil liberties. It appears that this situation was decided by the decision in the case of *Corbett versus Corbett* (1970) which defined the legal sex of the plaintiff as male, using genital and chromosomal criteria which have now been superseded. Medically, there is no reason why people receiving treatment for transsexualism and who have permanently changed gender role should be given any lesser legal status than that of any other person.

1. Aims and Objectives of this Document

1.1 The aim of this document is to provide an overview of current best practice in providing effective health care for persons with the transsexual syndrome.

1.2 Its objectives are to:

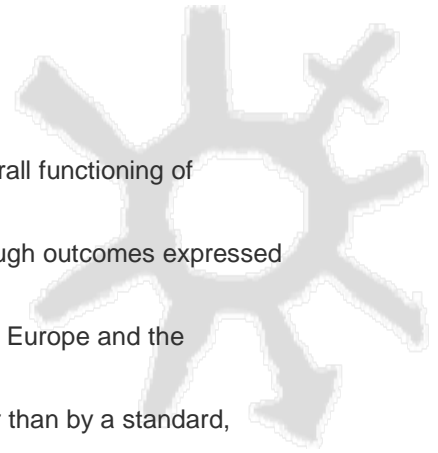
- describe the nature of the medical evidence;
- identify appropriate diagnostic criteria for transsexualism;
- indicate the main features of appropriate models of treatment;
- identify outcomes and measures in terms of improved quality of life;
- describe the case for a biological aetiology; and
- make recommendations for the legal status of people experiencing transsexualism.

2. The Nature of the Medical Evidence

2.1 Following the general move away from a mechanistic base of thought by the scientific community at large, new views of medicine, health and disease have arisen¹. In the United Kingdom (U.K.), these have been accompanied by a government policy which identifies patient care as the main expected outcome of medical research and development². An important response of the medical profession to these changes has been its growing recognition that the application of quantitative, empirically-based methodologies to the social phenomenon of health does not necessarily produce results which can usefully inform the practice of medicine in its lived social and cultural contexts³. Instead, there has been an increasing emphasis on the quality of life for patients as the measure of the effectiveness of healthcare⁴.

2.2 One result of this has been that in the process model of aetiology – diagnosis – treatment – outcome, expectations of proving causality are now less significant. Instead, interest in aetiology has focused increasingly on its usefulness in informing treatment and contributing to successful outcomes. This trend reflects the fact that the aetiology of many of the chronic conditions for which medicine provides treatment is unknown. It also recognises that the growing complexity of scientific and social theories and their interrelationship makes causality increasingly difficult to define.

2.3 Thus, in the case of transsexualism, current medical practice considers it from the viewpoints of:



its socio–biological context, that is, its relationship to the overall functioning of individuals in their social contexts;

- measuring the effectiveness of diagnosis and treatment through outcomes expressed as improvements in the patient's quality of life;
- relating U.K. practices to comparative practices elsewhere in Europe and the developed western world;
- treating each patient according to their individual need rather than by a standard, prescriptive regimen of healthcare;
- having an aetiology which is unproven and which does not, therefore, provide appropriate evidence for an adversarial court–room setting; and
- increasing concern that an inappropriate focus on aetiology rather than an appropriate focus on the outcomes of treatment could operate to the disadvantage of patients.

3. Diagnostic Criteria

3.1 Two main diagnostic systems for transsexualism are in operation, International Classification of Diseases 10th Edition (I.C.D. 10)⁵ and Diagnostic and Statistical Manual of Mental Disorders 4th Edition (D.S.M. IV)⁶. Diagnostic criteria which combine features of both systems are as follows:

- Transsexualism is a Gender Identity Disorder in which there is a strong and ongoing cross–gender identification, and a desire to live and be accepted as a member of the opposite sex. There is a persistent discomfort with his or her anatomical sex and a sense of inappropriateness in the gender role of that sex. There is a wish to have hormonal treatment and surgery to make one's body as congruent as possible with one's psychological sex;
- The diagnosis of transsexualism is confirmed when gender dysphoria has been present for at least two years and has been alleviated by cross–gender identification; and
- Transsexualism is linked with, but distinct from:
 - Intersex conditions (e.g. androgen insensitivity syndrome or congenital adrenal hyperplasia) and accompanying gender dysphoria;
 - Transient, stress related cross–dressing behaviour; and
 - Persistent pre–occupation with castration or penectomy without a desire to acquire the sex characteristics of the other sex.

4. Treatment

4.1 There is no single model of treatment: rather, variety in approach is both supported and sought as part of the continuing professional discussion of the syndrome. Typically, however, an effective model of treatment will utilise hormone therapy and surgical reconstruction, and also include:⁷

- counselling;



psychotherapeutic approaches;

- electrolysis; and
- speech therapy.

4.2 Assessment of the patient's progress is likely to take place at approximately three monthly intervals and at the appropriate point surgery will be used. Depending on the physicality and the overall health of the patient, surgery may include, for male to female transsexuals:

- vaginoplasty (construction of a vagina);
- penectomy (removal of penis);
- orchidectomy (removal of testes);
- clitoroplasty (construction of a clitoris);
- and possibly breast augmentation (enlargement of the breasts);
- rhinoplasty (reshaping the nose);
- cosmetic surgery such as hair transplants or facial remodelling;
- thyroid chondroplasty (shaving of the Adam's apple); and
- crico–thyroid approximation and anterior commisure advancement (for raising the pitch of the voice),

and for female to male transsexuals:

- hysterectomy & oophorectomy (removal of uterus and ovaries);
- bilateral mastectomy (breast removal); and
- possibly phalloplasty (construction of a penis).

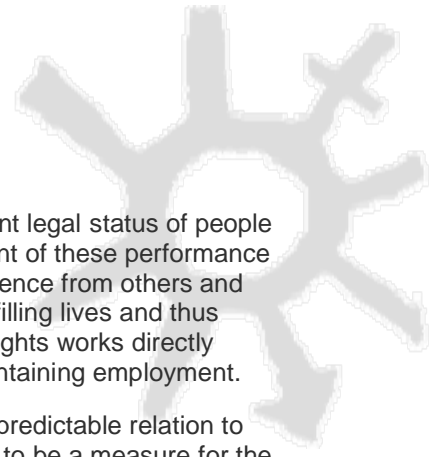
4.3 As medical and surgical techniques and knowledge increases, other or additional treatments may be used. In all cases, the length and kind of treatment provided will depend upon the individual needs of the patient and will be subject to negotiation between the Consultants involved, the patient's General Practitioner, and the patient. Involving the patient (and, in the case of minors, the parents or guardians of patients) in the management of their own programme of care is considered to be extremely important.

5. Outcomes and measures

5.1 There is a paucity of research into the long–term outcomes of treatment for transsexualism. However, the studies which have been carried out indicate that a treatment model using the principles described above is highly successful, with some suggesting up to a 97% success rate⁸. This compares extremely favourably with the outcomes of treatment for other chronic conditions.

5.2 Using a "Quality of Life" model for measuring the effectiveness of patient care, outcomes of this kind may be measured in terms of expressed patient satisfaction with their ability to:

- find employment;
- make relationships;
- integrate with the larger community; and



live fulfilling lives.

5.3 It is a matter of concern to the U.K. medical community that the current legal status of people who have been treated for Transsexualism works against the achievement of these performance indicators. That status marginalises individuals who have no visible difference from others and prevents them from being able to integrate, make relationships or live fulfilling lives and thus impairs quality of life⁹. In particular, the lack of substantive employment rights works directly against the important economic performance indicator of finding and maintaining employment.

5.4 The heterosexual or homosexual partnership of the patient bears no predictable relation to outcomes of treatment for Transsexualism and should not be considered to be a measure for the effectiveness of treatment.

6. Aetiology

6.1 Dr. Harry Benjamin introduced the syndrome to the general medical community in the early 1950s and advocated the compassionate treatment of it¹⁰. Benjamin favoured a biological explanation to the syndrome, believing that the genetic and endocrine systems must provide a "fertile soil" for environmental influences¹¹.

6.2 In their work on plastic surgery techniques four years later, Gillies and Millard echoed Benjamin's point of view and suggested that transsexualism should be classified as an intersex condition¹².

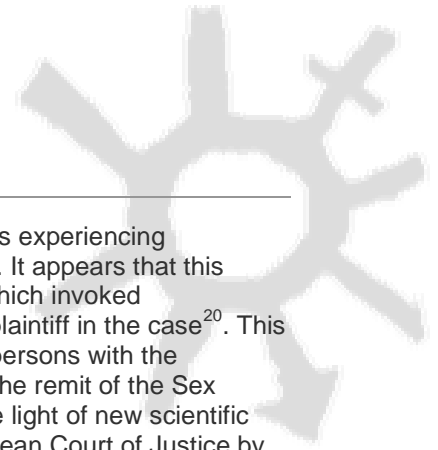
6.3 In an authoritative review of research in this field in 1985, Hoenig follows Benjamin in ultimately depending on a biological force or forces to account for transsexualism¹³. Summarising and commenting on this and other medical viewpoints three years later, in 1988, Doctor indicates that the overall weight of evidence is that there is "the formation of some kind of gender system within the brain that is fundamental to ultimate gender identity and gender–role development"¹⁴.

6.4 It is a viewpoint of this kind that Money suggests in an authoritative paper "The Concept of Gender Identity Disorder in Childhood and Adolescence after 37 years" where he states "causality with respect to gender identity disorder is divisible into genetic, prenatal hormonal, postnatal social, and post–pubertal hormonal determinants" and suggests "there is no one cause of a gender role ... Nature alone is not responsible, nor is nurture, alone. They work together, hand in glove."¹⁵

6.5 More recently, in a paper given to the Council of Europe's XXIII Colloquy on European Law, Gooren has suggested that "there is now evidence to believe that in transsexuals the differentiation process of the brain taking place in the first years after birth has not followed the course anticipated of the preceding criteria of sex (chromosomal, gonadal, and genital)"¹⁶. Thus, although sex assignment at birth by the criterion of the external genitalia is statistically reliable, in people experiencing transsexualism it is not: they are exceptions to the statistical rule.

6.6 Most recently, a study has been carried out of a region in the hypothalamus of the brain which is smaller in women than in men. Strikingly, the region was of female size or smaller in six male–to–female transsexuals, regardless of hormone treatment. This result supports the hypothesis that gender identity stems from an interaction between the developing brain and sex hormones¹⁷.

6.7 This view that the weight of current scientific evidence suggests a biologically–based, multi–factorial aetiology¹⁸ for transsexualism is supported by articles in journals, the press and popular scientific works.



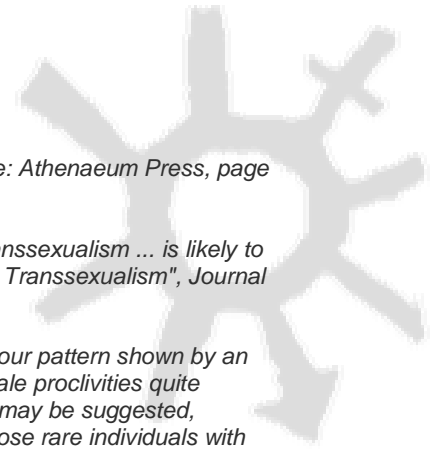
7. Recommendations for Legal Status

7.1 The present legal position is that people who have been diagnosed as experiencing transsexualism immediately lose a substantial part of their civil liberties¹⁹. It appears that this situation was decided by the decision in *Corbett versus Corbett* (1970) which invoked "chromosomal, gonadal, and genital" tests to define the legal sex of the plaintiff in the case²⁰. This definition has since been applied to employment to the disadvantage of persons with the transsexual syndrome, for example, by placing them apparently outside the remit of the Sex Discrimination Act²¹. These tests must be considered obsolete now in the light of new scientific information and the legal view has recently been challenged in the European Court of Justice by the case of *P versus S and Cornwall County Council* where the Advocate General has declared that the Equal Treatment Directive "must be interpreted as precluding the dismissal of a transsexual on account of a change of sex".²²

7.2 Current medical knowledge recognises that an absolute aetiology for transsexualism is not available although the present weight of evidence is in favour of a biologically-based, multi-factorial causality. It is considered, therefore, that scientific knowledge of transsexualism has progressed considerably since *Corbett versus Corbett* and that the evidence presented there is no longer reliable. From the point of view of medical ethics, the imperatives of respect for autonomy, beneficence, non-maleficence and justice²³ mean that medicine would not support any legal interpretation of its research into transsexualism that would operate against the health, well-being or advantage of patients. Medically, there is no reason why people receiving treatment for transsexualism and who have permanently changed gender role²⁴ should be given any lesser legal status than that of any other person.

References

1. 1 More general works such as Lupton, D. (1992) *Medicine and Culture*, London: Sage and Seedhouse, D. (1991) *Liberating Medicine*, Chichester: Wiley, provide a useful overview and synthesis of the major work in this field, including that of, for example, Illich; Foucault; and Ian Kennedy.
2. See, for example, NHS (1994) *Supporting Research and Development in the N.H.S.*, London: H.M.S.O., *Working for Patients, Managing the New, the Calman Report*.
3. See, for example, Colquhoun, D. and Kelleher, A., eds. (1993) *Health Research in Practice: Political, Ethical and Methodological Issues*, (London, Chapman and Hall).
4. See, for example, Fallowfield, L. (1990) *The Quality of Life: The Missing Measurement in Health Care*, London, Souvenir Press.
5. World Health Organisation (1992) *International Classification of Disorders*, Geneva, W.H.O.
6. American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* Washington: A.P.A.
7. See, for example, Reid, R. (1992) "Working with Gender Dysphoria", *Counselling Gender Dysphoria*, Ed. Z.J. Playdon, Devon: ATC.
8. Green, R. and Fleming D.T. (1990) "Transsexual Surgery Follow-Up: Status in the 1990s", *Annual Review of Sex Research*, Ed. J. Bancroft, volume 1, 1990, pages 163 – 174. Of the 130 F.T.M.'s reported in the study, 97% of the outcomes were considered to be satisfactory; of the 220 M.T.F.'s 87% of the outcomes were considered to be satisfactory. See also Pfafflin, F. & Junge, A. (1992) *Geschlechtumwandlung Schattauer, Stuttgart/New York for an extensive survey on outcome*.
9. For a general discussion of the medical effects of social stigmatisation see Scambler, G. (1991) "Deviance, sick role and stigma", *Sociology As Applied to Medicine*, Ed. G. Scambler, 3rd edition, London: Balliere Tindall, pages 185 – 196.



10. King, D. (1993) *The Transvestite and the Transsexual*, Newcastle upon Tyne: Athenaeum Press, page 46.
11. Benjamin stated the "if the soma is healthy and normal no severe case of transsexualism ... is likely to develop in spite of all provocations". Benjamin, H. (1953) "Transvestism and Transsexualism", *Journal of Sex Research*, 5:2, page 13.
12. "The physical sex picture does not always bear a fixed relation to the behaviour pattern shown by an individual. One or other hormone may determine an individual's male or female proclivities quite independently of the absence of some of the appropriate physical organs. It may be suggested, therefore, that the definition of hermaphroditism should not be confined to those rare individuals with proved testes and ovaries but extended to include all those with indefinite sex attitudes." Gillies, H. and Millard D.R. (1957) *The Principles and Art of Plastic Surgery*, Volume 1, London, Butterworth, page 370–1.
13. Hoenig, J. (1985) "The Origin of Gender Identity" *Gender Dysphoria*, Ed. Steiner, B.W., New York: Plenum Press.
14. Docter, R.F. (1988) *Transvestites and Transsexuals, Towards a Theory of Cross-Gender Behaviour*, New York: Plenum Press, page 63.
15. Money, J. (1994) "The Concept of Gender Identity Disorder in Childhood and Adolescence After 39 Years", *Journal of Sex and Marital Therapy*, 20 (3: 163–177).
16. Gooren L.G.J. (1993) "Biological Aspects of Transsexualism and their relevance to its legal aspects", *Proceedings of the XXIII Colloquy on European Law: Transsexualism, Medicine and the Law*, Strasbourg; Council of Europe.
17. J.N. Zhou, M.A. Hoffman, L. Gooren and D.F. Swaab, "A sex difference in the human brain and its relation to transsexuality", *Nature*, 2 November 1995, volume 378:6552, pages 68–70
18. For example, Moir, A. and Jessel, D. (1989) *Brainsex* London: Michael Joseph; Gorman, C. (1992) "Sizing up the Sexes", *Time*, 20 January 1992, pages 38–45; "Sex is all in the Brain", *Times* 12 September 1992.
19. McMullen, M. & Whittle, S. (1994) *Transvestism, Transsexualism and the Law*, (London, Gender Trust).
20. *All England Law Reports* (1970) Volume 2 pages 32 – 51 *Corbett v Corbett otherwise Ashley*.
21. *Industrial Tribunal Case No. 16132/93* (1993) *Interim Decision of the Industrial Tribunal P v S and Cornwall County Council*.
22. *Court of Justice of the European Communities, Opinion of the Advocate General in the case of P v S and Cornwall County Council* (1995) case C–13/94, paragraph 25.
23. Gillon, R. (1994) "Medical Ethics; four principles plus attention to scope" *British Medical Journal*, volume 309 (16 July 1994) pages 184–188.
24. *The point of permanent change of gender role is decided by the consultant psychiatrist in negotiation with the patient and is usually the commencement of the "life test"*.

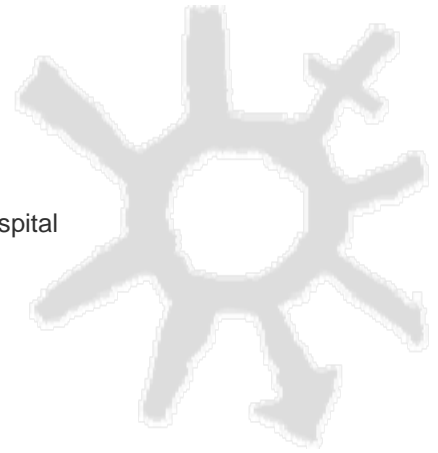
Authors

This document was produced as part of the work of the U.K. Parliamentary Forum on Transsexualism chaired by Dr. Lynne Jones M.P. Its authorship was led by Dr. Russell Reid, Hillingdon Hospital, London, in collaboration with:

- Dr. Domenico di Ceglie, Tavistock Clinic
- Mr. James Dalrymple, London Bridge Hospital

Professor Louis Gooren, University of Amsterdam

- Dr. Richard Green, Gender Identity Clinic, Charing Cross Hospital
- Professor John Money, Johns Hopkins Hospital, U.S.A.



Gender Centre publications provide neither medical nor legal advice. The content of Gender Centre publications, including text, graphics, images, information obtained from other sources, and any material ("Content") contained within these publications are intended for informational and educational purposes only. The Content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health care provider with any questions you may have regarding your medical condition. Never disregard professional medical advice or delay seeking it because of something you've read. Always seek professional legal advice on matters concerning the law. Do not rely on unqualified advice nor informational literature.

The Gender Centre Inc. 7 Bent Street (P.O. Box 266) Petersham N.S.W. 2049 Ph: (02) 9569 2366 Fax: (02) 9569 1176

Web: www.gendercentre.org.au Email: reception@gendercentre.org.au