July-September 2008

No. 76

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SERVICES & NOTICES

THE FINE PRINT

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Polare is published in Australia by ***The Gender Centre Inc.*** which is funded by the NSW Health Department through the AIDS and Infectious Diseases Branch, and supported by the Department of Community Services under the SAAP program. ***Polare*** provides a forum for discussion and debate on gender issues.
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Unsolicited contributions are welcome, though no guarantee is made by the Editor that they will be published, nor any discussion entered into. The Editor reserves the right to edit such contributions without notification. Any submission which appears in ***Polare***, may be published on our Internet site.

Polare A Magazine for people with gender issues

Editor: Katherine Cummings

DEADLINE

for submissions to the next edition of *Polare* is the eighth of June 2008.

Polare printed in house (text pages) and by WenChai Publications (cover)

Phinn's Report

Celebrating and recognising our partners!

In the huge changes and challenges we experience as transgenders there is often a key person in our lives that we forget - our partners. Whether they decide to stay with us on the journey or decide to leave - they experience just as many life changes as we do.

So this column is dedicated to those partners who support us while we are undergoing the process of change. We forget that this might trigger an identity and sexuality crisis for our partners who also need support. At the gender Cerntre we welcome visits, by partners seeking counselling, support, interaction and welcome them, too, to the drop-ins and social events.

As a transgender person and the head of the Gender Centre I suggest we celebrate and acknowledge the vital and loving role of partners in a healthy and stable life.

Phinn

So THANK YOU to all the partners for being there for us.

Friday Drop Ins for 2008

Jul 4

Social drop-in 10.00am-12.30pm

[note earlier start]

High tea. Everyone welcome

Any questions call Liz on 9569 2366.

PLEASE NOTE:

The email address for Resources and Polare is now:

resources@gendercentre.org.au

It is a good idea to put "Polare" in the subject somewhere as I get a lot of spam, and any message which starts off "Hey dude" or similar will not be given much attention.

The RPA Sexual Health Clinic is sympathetic and well informed on transgender matters. If you want to contact the Clinic to help with their research or to deal with your own issues call 9515 3131

PhD Research on Australian Indigenous Gay, Lesbian and Transgender/Sistagirl experiences.

Aude Chalon (*aud_mmsh@hotmail.com*)

is gathering life stories especially among Sistagirls. If anyone can help, please contact him direct on his email address.

Are you a solicitor? Can you help one of our own, *pro bono*?

Julia Doulman (from the documentary "Becoming Julia") needs help to run an anti-discrimination case against the NSW Police. She is not asking for help for her own benefit alone ... if the case is won the whole transgender community will benefit. The problem relates to the refusal of the NSW Police to recognise name changes. If a police check is made on a person's identity and that person has a previous name which has been changed (by deed poll, by Anglicising a foreign name or by marriage) the police will reveal both the current name and the former name, treating the current name as an alias. The Anti-Discrimination Board has accepted Julia's case as having merit, but she will need legal support and cannot afford to retain a solicitor. If you are legally qualified and interested enough in transgender to be reading this magazine, this is your opportunity to do something for the community. When a transgender changes his or her name and obtains a new birth certificate from the NSW Registry of Births, Deaths and Marriages the former name is sealed and cannot be revealed except by permission of the person concerned or by court order. We believe the NSW Police should be bound by the same rules.

Editorial - Katherine Cummings

One of the most vexatious areas for the transgender is that of identity. We know who we are, usually from a very early age, yet society often refuses to acknowledge our self-definition until we have become legal adults and jumped through hoops and over hurdles to their satisfaction. Of course we all have multiple identities and the definition often depends on who is doing the questioning, and how much power they exert over us and our place in society.

Some aspects of identity do not require written documentation, but many do, and this issue of *Polare* contains a useful set of guidelines compiled by the Inner City Legal Help Centre, which outlines the steps necessary for a transgender in New South Wales to change, or obtain, documentation. Some of these guidelines fall short of the optimum (the issue of passports to preoperative transgenders, for instance) and some of our efforts should be expended in having a more rational and humane solution to the knee-jerk anti-terrorism policy currently in place which steps back from an earlier, more sensible, policy. Until recently transgenders could obtain a passport in the gender role they had adopted in order to travel overseas for gender affirmation treatment in New Zealand, Thailand, the USA or wherever they had chosen. Last year, under the idiotic pretext that terrorism would in some way be thwarted, this right was withdrawn and transgenders were told they must travel on passports showing the gender assigned at birth, or on a 'document of identity' which omits gender. This is mindless and unacceptable harassment of the trangender traveller. Transgenders travelling overseas for surgical reassignment have, by definition, been living in the new gender role for at least a year, and have almost certainly undergone hormonal and possibly surgical intervention which will have changed their appearance in the direction of the gender they are affirming. Yet they are expected to travel on passports which assert their birth gender, and will be unnnecessarily exposed to harassment, bullying and possible "security" sanctions as a result of their apparently inappropriate documentation. To travel on a document of identity is to draw unwanted attention to oneself and, as the Immigration Department itself advises, may result in body searches and other indignities.

For most of us, the first affirmation of identity comes at birth, with the cry of "It's a girl!" or "It's a boy!" based on external genitalia and followed soon after by a confirmatory birth certificate. There are cases of ambiguity and confusion involving birth sex but their recognition and subsequent treatment are part of a more specific problem and deserve detailed discussion in some future editorial.

As the first piece of official documentation, the birth certificate, which should be a simple record of one's arrival in the world, is loaded with a lot of peripheral information, much of which is often considered immutable (one's gender) or changeable only by legal processes. (one's name) and results in legal complications and social difficulties for those who fall outside the narrow parameters that define the "normal" child.

There is an underlying belief that officials cannot err in these classifications, yet some babies are born with Complete Androgen Insensitivity Syndrome (CAIS) which means their bodies cannot take up testosterone, with the result that they look like females and it is often not until puberty that there is any indication that the child is other than female. In most cases they continue to live, quite legally, as female, despite having XY chromosomes, so that one of the primary touchstones of conventional gender identification must be recognised as having exceptions.

As life progresses there is a steady accumulation of official and semi-official documentation all of which attempts to define some aspect of our identities. Baptismal records, school reports, matriculation certificates, degrees, diplomas, military service records, marriage certificates, divorce decrees, drivers' licences, passports, mortgage documents, leases, credit cards ... the list is long.

In contrast to all this documentation is the right of every sentient human to a degree of self-determination. We all have a sense of self which is part of our consciousness virtually from first memories. In most cases this will be congruent with the perceptions held by family and society but in some cases it is at variance with external perceptions and there are those who think they can refuse us recognition in our new gender identities by virtue of

their limited understanding of gender identity.

Some authorities will refuse to change official documents, once issued. Some universities, for instance, will not re-issue degrees and other qualifications in a new name, although most will, on surrender of the original certificate and payment of a fee. Drivers' licences can be obtained with a new image and new name after an official name change, but I understand the former gender is retained in the RTA records. Police files will record one's new name as an alias, and will report it as such to enquirers for record checks, which immediately creates suspicion in the mind of the enquirer.

I served my National Service in the Royal Australian Navy and then served for a number of years in the Naval reserve, yet when I claimed my National Service Medal, with a covering letter explaining my change of name and gender the medal was issued in the name of my predecessor-person.

When I tried to change the name on my Certificate of Australian Citizenship (Naturalisation) I was told that under no circumstances could this be done, as the name in which a naturalisation was recorded was immutable, regardless of people changing their names by Anglicisation or by marriage or for any other reason. Since this would have meant I would have been outing myself every time I showed my citizenship (a requirement for many academic positions) I worked my way through the ranks of the Immigration Department, layer by bureaucratic layer, until I reached the Minister who, after a period of reflection, agreed with my point of view and a procedure was set in place to allow transgenders to change the names on their naturalisation papers.

I changed my legal name, not by Deed Poll but by reputation, and had little trouble with most of my documentation, although a number of official bodies demanded a fee for issuing a new certificate, and the return of the superseded one.

Bodies like Medicare and most of my credit card issuers changed my name in their records on production of my Statutory Declaration asserting my new gender identity. American Express were the exception, demanding a Deed Poll change, but even they saw reason when I held their card aloft and asked for a pair of scissors.

Where am I going with this? I am asserting that only the person most affected by gender role has the right to assert that he or she belongs in a specific role, and the forms of documentation which have been accumulated up to that point should all be changed when the transition from one gender to the other is made. If I have qualified to practise in a certain discipline it is of no importance what name I use in order to do so, as long as the name is registered and traceable. If I wish to live in a gender role other than the one I was assigned at birth I should be allowed to do so without legal impediment.

Those who assume this would open the door to all kinds of perverted or violently inappropriate behaviour are indulging in muddy thinking. The time to act on such matters is *after* an offence has been committed, not on the basis that it *might* be committed. If our actions were continually constrained by the misguided perception of those who think we *might* be up to no good, then not only transgenders but all humanity would suffer from universal social paranoia. If there are people in society who wish to behave anti-socially, and see a masquerade as a necessary part of their transgression, they are not likely to accept the long and bureaucratic constraints currently imposed in order to carry out their wickedness. On the contrary, they will acquire whatever skills they need to pass in society and then slip in and out of role as their schemes demand.

In the final analysis each person should be responsible for her or his identity, the element which is the most vital core of our being. It is who we are, and only we can truly know that truth and assert it in the face of the world.

This issue of *Polare* also includes several comments on the undesirability of Kenneth Zucker and Ray Blanchard having anything to do with the DSM and its definitions of gender identity and gender dysphoria. Zucker believes in 'reparative therapy' or changing a patient's personality. Accounts of the treatment he has accorded children with gender dysphoria are appalling. It verges on the barbarism of aversion therapy which in turn is a version of brainwashing which is simply torture of the mind.

It is important for trangenders to resist the inclusion of Zucker, Blanchard, Bailey and Lawrence and their ilk in the DSM5 revision. The DSM series is used worldwide and can influence our lives in many ways, not least in pathologising transgender.

There is a growing trend to legalise same-sex marriage in various influential parts of the world, recently including Canada and California. This is only of peripheral interest to the transgender world, as we can be heterosexual, gay, lesbian, bisexual or asexual. It is, however, good to see growing acceptance of each person's right to self-define, and the supersession of outmoded social norms whose *raison d'etre* is neither rational nor acceptable in a free society, being based on the one hand on religion and on the other on tradition ("It's always been this way").

It hasn't and it shouldn't.

Katherine

FTM Australia
Information Sheet 2008

FTM Australia is a membership-based network which has offered contact, resources and health information for men identified *female* at birth, their family members (partners, parents, siblings and others), healthcare providers and other professionals, government and policymakers since 2001.

We aim to inform the public of the issues surrounding transsexualism in men (female-to-male transsexuals).

This Australia-wide network is coordinated by Craig Andrews, with the input of members and guided by an Advisory Panel of health and legal specialists.

Membership
Members receive our newsletter *Torque* and access to our e-mail discussion list, *OzGuys*.

Newsletter
Our newsletter – *Torque* is published four times a year for the benefit of members, their families and service providers. *Torque* is posted out to members free of charge throughout Australia and New Zealand.

Discussion List
Our e-mail discussion list is called *OzGuys*. It is open to members of FTM Australia living in Australia and New Zealand.

To find out more please visit our website at
www.ftmaustralia.org

More information about membership is available through
Our website at *www.ftmaustralia.org*
By email *mail@ftmaustralia.org*
By post PO Box 488, Glebe, NSW 2037

We warmly welcome your interest in the network and hope to hear from you soon!

This network is supported entirely by members

The Australian Human Rights Commissioner

would like to meet with people from the sex and gender diverse community

When ?

Monday 21 July 6.00pm - 8.00pm

Where ?

Human Rights Commision ,
Leevel 8, 133 Castlereagh Street, Sydney

RSVP and questions to Sarah Winter, Policy Officer, HREOC (02) 9284 9650 or email *sarah.winter@humanrights.gov.au*

The meeting will be an opportunity to explain the project, for participants to share some personal stories and to discuss human rights issues and possible solutions.

The Human Rights Commissioner is particularly interested in hearing about the difficulties faced by people in changing official documents.

Light refreshments

Counsellor's Page

For this issue of *Polare*, one of the major themes is Self and Identity.

I hope to communicate what I understand of both - from counselling, from interactions, from questioning, observations and insights, from connections made, experience, from thought-provoking resources and from my own reflections - from *my* self.

Do you have the time or inclination to think about *your* self - your values, beliefs, hopes, ideas, experiences and memories, how your self is expressed, perceived and identified? It may be that its not easy to find the opportunity to think about your self. It can take a lifetime, but for a short while, I invite you to spend some time doing so.

It may be that there is no discord between self and identity and no problem with corresponding documentation. Self and identity are so bound up that we fear a loss of existence in society if robbed of our identity or not granted it.

Documentation announces or acknowledges *who we are, what we've done,* and *what we are capable of doing and entitled to do* as deemed by organisations, institutions and government departments, comprised of people functioning as gatekeepers of standards, which are established to protect individuals in society, the society itself, and in some cases the organisations they represent; assessments and decisions are made by people empowered to do so regarding our identity - which document is given to whom.

Our passports show we are citizens of a certain country, our certificates show our achievements in acquiring knowledge and skills and our licences show what we are eligible to do in society. The absence of documentation, of positions to fill and roles to define us - a lack of identity in fact - can have the effect of undermining self-esteem and challenging a person's sense of self; in effect, a person's very existence.

Meaning and purpose in life can be found in occupation; and occupation often goes hand in hand with our life roles (doctor, gardener, carer, mother, father, ...). So much of one's self and experience of life is defined by the roles we lead in family life, community and society: a role can confer an identity on a person by giving that person a title, a certain status, associated responsibilities, rights, security and protection; a person's identity can become synonymous with a particular role ("He's the President!"); and a person's identity and freedom ofmovement and expression can be restricted by a role.

We can strive to obtain and fulfil a role, thrive in a role, inhabit a role, be defined by a role, dislike roles that we find ourselves in or that are forced upon us, try to free ourselves from a role. While some roles we select may feel right for us (like a hand fitting snugly in a glove), others are thrust upon us - and an unwanted identity as well. Our biology and the community and society we are born into can pre-determine our identity and corresponding roles. When we are born our bodies are checked and an announcement is made "It's a boy!" or "It's a girl!". Identification has begun and a role is assigned based on cultural assumptions and/or imperatives. If a baby's genitalia doesn't conform to that of 'boy' or 'girl' this initial and basic assumption of identity is not possible; but for a child, identified easily at birth, but who is later at odds with the 'boy' or 'girl' identification, there can be consternation, confusion and struggle ahead. If someone doesn't fit the existing identification and classification system, new terms can be created, such as 'transgender' or 'transsexual'; but these words lack an associated cultural identity in terms of a range of roles to adopt (as is the case with 'girl/ woman' or 'boy/man'). Although on the surface this may afford a certain freedom, in order to function in society, to take up roles, a dilemma for 'transsexual' people can be whether to disclose this truth about Self.

Assigning identity, wanted or unwanted, can be a simple process; self-actualisation can be so much more complex. The Self may become a good friend of Identity and they may go through life happily together. But if there's unease, disagreement between the two, what then? I someone feels *I am other than me* which state of being wins the argument? Do they communicate and compromise? And what if the argument extends outside and others become involved? It might be that you are banging on the doors of the 'Gatekeepers of Identification and Documentation' for proof of *who you are* or *who you've come to be.* In this situation your best ally may be your informed and self-aware *self* as well as your conviction.

As individuals and as a society our consternation with the *not* usual and *not* expected, if we look into ourselves, may help us to understand and appreciate our own complexity and the complexity of life itself. Throughout a person's life, from the first breath of self with its various expressions, connections, manifestations and even transformations, until the last breath, this unravelling thread, is the nature and fabric of one's self. If the inner life and outer life find concord, harmony in life can be experienced. There may be struggle along the way but there may come a time when one can say, as someone once said, "I have become myself."

Gaye

PLEASE NOTE!

Appointments for counselling should be made directly with Gaye Stubbs, the Gender Centre Counsellor.
Phone 9569 2366 Monday- Thursday.

Letters To the Editor

KENNETH ZUCKER AND THE DSMV

Dear *Polare* editor,

The American Psychiatric Association has announced the members of the work groups who will review scientific advances and research-based information to develop the fifth edition of the APA's Diagnostic and Statistical Manual of Mental Disorders - the DSMV.

The DSM is used as a reference source worldwide by clinicians and researchers as well as insurance companies, pharmaceutical companies and policy makers.

Kenneth Zucker

Named to chair the revisions on sexuality and gender is Kenneth Zucker. Zucker is famous for forcing gender-variant children into reparative therapy in an attempt to 'cure' them.

Zucker has named Ray Blanchard to the work group that will rewrite Gender Identity Disorder. It was Blanchard who coined the term autogynephilia to describe men with an erotic desire to be women and proposed a theory that all trans women could be classified as either autogynephiles or extremely effeminate gay men who needed to become female to express their sexuality.

The DSM is used as a diagnostic tool and therefore has a direct effect on the treatment that clinicians prescribe. The fact that Zucker and Blanchard are even involved in the revisions on sexuality and gender is a scary idea as it could mean that trans people are more likely to be recommended for reparative therapy - which is effectively conversion therapy. It is also likely that Gender Identity Disorder would be diagnosed as some kind of homosexuality rather than have an independent diagnosis - homosexuality would be back in the DSMV and classed as a mental illness.

I would be grateful if you would help by spreading the word about an online petition which can be found at:

www.thepetitionsite.com/2/objection-to-dsm-v-committee-members-on-gender-identity-disorders

and also contact the American Psychiatric Association to put pressure on them to consider removing Zucker and Blanchard from the DSMV work groups.

This really does affect everyone in the LGBT community as the DSM is used worlwide. It is likely that these 'experts' would push to reclassify homosexuality as a mental illness and recommend that LGBT people be prescribed reparative therapy as a 'cure'. I believe that we need to let the APA know what we think.

Thanks,

Kath Murray
redtherock@hiinternet.com

AN ICONIC TRANS-VENUE REBORN

The Taxi Club, in Darlinghurst, has been suffering from rumours that it is headed for the same fate as the Newtown Hotel. It's bad enough when we lose an iconic venue, such as the Newtown through calculated commercial decisions. What can be just as damaging is when rumour has the Taxi Club heading for the same fate. We're here to inform you the rumour has no substance!

As a result of previous management's misdirection, the Taxi Club has suffered a loss of trade over recent years. A lot of the regular members from the club, over these past few years would have no doubt observed the club was losing its feel and character. As a result of this, it certainly was on a gradual slide, and was nearly lost late year through an amalgamation plan.

But, thanks to a forced change by its loyal and supportive members earlier this year, there has been a Change Of The Guard. The club now boasts two transgendered individuals in the roles of President and Secretary Manager, assisted by a new dedicated GLBT team, with a passion to ensure the Taxi Club remains for all of us.

With all of this in mind, the Taxi Club is determined to recapture its position within the Trans Community.

The club has undergone some physical changes internally, to accommodate and provide better facilities/service for any required combination of social fulfilment, during any day/night event. The club is now focussing on being there as a community club, for the benefit and enjoyment of *our* community.

The Taxi Club has been in existence for fifty years. In fact, the club will be celebrating its fiftieth anniversary over the coming months. The Club has always been unique in nature. The new direction and refinements at the club are still primarily focussed on maintaining this unique feeling. There are more changes planned to make it even better. The Taxi Club prides itself on being the most trans-friendly, accepting and tolerant venue in Australia.

Joanne Norman, President
The Taxi Club

Support Services Pages *(in most cases see also the Directory Pages at the back of the magazine for added detail))*

problems?

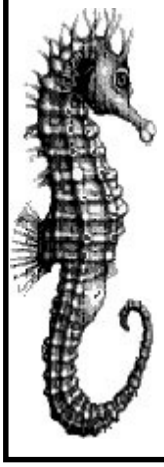
You can write to
The Counsellor
The Gender Centre
PO Box 266
Petersham
NSW 2049

questions?

If you do not wish to be identified, make up a name for yourself or come in and talk confidentially with the Counsellor (by appointment only)

concerns?

Hours
9am - 5pm
Monday and Tuesday only
Email:
counsellortgc@bigpond.com.au
Gaye 9569 2366



THE SEAHORSE SOCIETY is a self help group based in Sydney open to all crossdressers, their relatives and friends. We offer discretion, private monthly social meetings, social outings, contact with other crossdressers, a telephone information service, postal library service and a monthly newsletter.

NSW Seahorse Society

THE SEAHORSE SOCIETY OF NSW INC
PO BOX 203 BOMBONIA PARK, NSW 2111

Call on 0423.125.860 and our **website** is:
www.seahorsesoc.org
Email: *crossdress@seahorsesoc.org*
Membership enquiries, change of details etc. contact
Membership Secretary,
PO Box 6179, West Gosford, NSW, 2250

"crossdress with dignity"

Central Coast Group Forming

A group aimed at networking transgender persons who live/work on the CENTRAL COAST of NSW, AUSTRALIA. Transsexuals, others identifying as transgender, crossdressers and partners who have a connection with the Central Coast are welcome to join. This group is about fostering friendship amongst ts, cd, tg persons and the rest of the trans community. Even if group emails are not your thing please join the contact list (in DATABASE) so that it might act as an email and postcode directory of who's who on the Central Coast. Feel free to email and introduce yourself to the group and any members near your postcode:) Whether you are a crossdresser who prefers their topic to be crossdressing; or a transsexual who prefers to converse on matters of transition please respect and tolerate every member's right to be different. Remember the primary goal is to facilitate contact :)NOT A DATING SITE; SEXUALLY EXPLICIT CONTENT OR CONDUCT WILL NOT BE TOLERATED. [**http://**

Gender Affirmation and Liberation (GAAL)

GAAL is committed to providing a service to: People with the condition of Gender Dysphoria and who are in the process of affirming gender identity by hormonal and/or surgical means or have already done so.

GAAL aims to provide a safe and supportive environment for people in the process of gender affirmation or who have affirmed their true gender to share experiences.

Social Activites. We also have social occasions where we actively encourage the participation of friends, family, partners and other support groups.We hold regular meetings on the third Monday of each month at a venue in South Yarra. GAAL: PO Box 245, Preston, VIC, 3072

Or call our message bank: **(03) 9517 1237** and one of our committee members will contact you as

au.groups.yahoo.com/group/centralcoastts/]

Central Coast Transgender Support

The CCTS was started in the 1990s and is a totally free and unfunded service to all with gender related issues. Its primary function is to offer guidance to all who are contemplating commencement of the Medical and Psychological requirements that are involved in full M to F Transition under the Harry Benjamin Standards of Care.

The Centre also provides access to high quality, subsidised and certified permanent hair removal and offers alternative direction and instruction for the control and managemnent of problem hair or chronic hirsutism within the premises.

The CCTGS operates Monday to Saturday 10am to 10pm
Tel: 0404 054 000
Email: *smh101@exemail.com.au*

QUEENSLAND GENDER CENTRE

The Queensand Gender Centre is run solely by a transsexual here in Brisbane, Queensland, Australia with the aim of assisting those in need of accommodation and assistance.

It is open to all those who identify as transsexuals and who are mentally stable and drug and alcohol free.

The location of the shelter is kept confidential to protect the tenants. The accommodation is in an upmarket suburb on Brisbane's upper north side.

You can stay either up to six months or twelve months and we can house up to six people at a time.

If you want more information or are interested in assisting with the project please telephone, write or e-mail the Queensland Gender Centre (see p.38 for contact details)

OUTER METROPOLITAN AND COUNTRY TRANSEX-INTERSEX SUPPORT (O.M.A.C.T.S.I.S)

Our service provides support for individuals and their families, affected by the issues of transsexualism and/or intersex conditions

We are able to offer social support and out-of-hours counselling services by telephone.

For further information and social support please phone Gina (0247 511 402)

We will soon be in other areas

Zucker: Manipulation of Young Feminine Boys

By Curtis E. Hinkle

Labels define and labels stick. But, what about statistics? Statistics lie so it is said. Or, is it that people lie?

When examining the work of Kenneth J. Zucker, we find labels, statistics, and lies. Although many homosexuals have been described as being masculine in behaviour, an examination of their lives in childhood has found that many were "feminine" in behaviour. (1)

Reports of extreme boyhood "femininity" had also been thought to characterise male to female transsexualism. (2) In fact, there had been disagreement as to whether such extreme femininity dating back to age one or two was a representation of what would become "feminine" male homosexuality (3), or true transsexuality, known also as primary transsexualism or total psychosexual inversion (4). Such extreme boyhood "femininity" had attracted the attention of clinicians and researchers for years. Richard Green of the UCLA Gender Identity Clinic saw them. Bernard Zuger saw them. Their descriptions were almost uniform. They were already stating they wanted to be girls or they were girls, often at the ages of two or three. They were cross-dressing. They were playing with girls exclusively or almost exclusively and were playing with girl's games exclusively or almost exclusively. Their behaviour was overt. It was very observable and it was obvious. So obvious that many would be brought in to a clinician for evaluation and treatment.

However, others (5) rarely ever saw these same boys later as adult men presenting at sex change clinics as transsexuals and desiring sex reassignment surgery. Reports of this extreme "feminine" behavior were conspicuously lacking in those presenting for SRS. The lack of such stories in adult sex change applicants, led Chiland (5) to ask, "Is there such a thing as a transsexual child" (page 55). She had only seen two examples that would fit this description, although her group of adult transsexuals was over 200. Lothstein (see p.c. in ref. 5) had reported three in 1988 and two examples in 1992, and had worked with over 600 transsexuals. Fisk, who coined the term gender dysphoria, saw a wide representation of clinical histories amongst his group's applicants for sex change. (6)

If these applicants who were adults seeking sex reassignment did not report extreme feminine behaviour on any consistent basis (when such reports would have most likely impressed the "gatekeepers" and helped convince them of the "obviousness" of their "femininity"), then what label could adequately describe the majority of the children who did report extreme feminine behavior and if such reports were not substantiated by observations from others close to them as children, would such a label stick when they presented for sex reassignment?

We do get some ideas as to what these individuals were like as children. Chiland (5) described the situation as follows:

"The disorders that may lead to transsexualism in adults may thus be perfectly silent in childhood as far as an observer, parents, or teachers are concerned...the child has no clear idea why he feels bad, and will only give his trouble a name on reaching puberty."

This is far from statements that the child wants to be a girl, or says he is a girl. Chiland (5) writes further:

"An outside observer may notice that something is wrong with the child, but they cannot imagine, any more than the subject himself, that the child is suffering from a disorder of gender identity."

Again, this is far from what would be seen in the other boys described as already cross dressing at the age of two or three, who were playing exclusively or almost exclusively girls' games and with girls. The following is more typical of the childhood of those who present at sex change clinics:

"we see an isolated boy who is ill at ease, does not make friends, and does quite badly at school. But the child has no clear idea why he feels bad, and will only give his trouble a name on reaching puberty." (5)

Furthermore, these adult SRS candidates in adulthood, usually did not show "signs of trouble with their gender identity in childhood that might have attracted attention...very few were taken to clinics" and "still fewer were treated". (5) Remarkably, "some were treated in childhood or early adolescence, with whom the question of gender identity never arose either in evaluation or in treatment;

they were referred and treated for other reasons." (5) When they thought their therapist would be more intuitive and the therapist wasn't, "they became more and more silent and eventually refused to continue the treatment". (5)

Another group (7), when evaluating adult transsexuals, also found that those without extreme "femininity" in boyhood represented a group which had gender identity as the main motivation for seeking sex reassignment and re-labeled these individuals primary transsexuals. They were typically asexual and did not display homosexual behavior nor, as mentioned, were they extremely feminine acting in childhood. They write: "In our series of ten primary transsexuals, nine showed no evidence of effeminacy in childhood… As far as we can make out, they did not engage in girl's activities or play with girls any more than did normal boys... All ten of our primary transsexuals were socially withdrawn and spent most of their time after school by themselves at home... In effect, they were childhood loners..." (7) They further write: "to summarise, then, in childhood, the primary transsexual is not effeminate, but he feels either abhorrence or discomfort in boyish activities." (7) If boys with extreme "feminine" behavior in childhood are not the primary transsexuals, then who are these boys studied by Green (8), Zuger (9), and others? If their behaviour is so effeminate in childhood, yet they do not typically request sex change, what happens to them? It is in the follow-up studies, such as those by Green (8) and Zuger (9), which give us the answer. Green (8) studied forty-four very effeminate boys from childhood into adulthood and found that three quarters of them became homosexual (N=18) or bisexual men (N=14).

Around a quarter of them became heterosexual.

Only one out of forty-four was stated by Green to be transsexual, and Chiland (page 127) notes: "I felt that Green was pushing him further in transsexualism than the subject himself was going." (5) The subject was later reported to have said: "I don't feel like a woman. I want to feel like a woman." (5).
What have others found? Have they also found that these extremely "feminine" boys did not become transsexual, but instead became largely effeminate homosexual adult men? Indeed they have. Zuger (9) studied fifty-five boys, figures of which could only be accurately obtained for forty-five of them in adulthood. Thirty-five to forty-five boys (77.77 %) had a homosexual or bisexual orientation (nearly identitical to Greens' findings), three boys were heterosexual, and seven boys (15.55%) were of uncertain outcome. Of the homosexually oriented boys (N=45), only one was deemed transsexual. Thus, Zuger concluded that effeminate behaviour in childhood is the first stage of homosexuality. (page 63 in ref. 5).

When comparing Green (8) and Zuger's (9) findings, the probability that feminine acting boys will become transsexual is only between two to three per cent. Cohen-Kettenis (10) reported on follow-up of seventy-four children who were claimed to have gender identity problems and found that a higher percentage (twenty-three per cent) had applied for sex reassignment. However, her study did not state the sex of the child. Older reports by several other authors also indicate that "feminine" behaving boys do not turn out to be transsexual, but largely turn out to be adult homosexual men (eleven to thirteen).

What all of these findings point out is that feminine or effeminate type behaviour in childhood represents behaviour – gender role behavior and a higher incidence of homosexuality as the outcome. Indeed, feminine behavior in boyhood does not identify transsexualism or gender identity *per se*. Gender identity may be defined as "the merging of the concept of gender with the intrapsychic concept of identity" (page 120 in ref. 14). Thus, what is observed in these "feminine" behaving boys, is their gender *role*. Identity as a construct is a self-image, a sense of belonging to, an intra-psychic self-concept, which can't be labelled by just observing and categorising behavior. It may only be inferred. It may be inferred from an interpretation of another's behaviour, or from the evaluation of another's self-report. Each is fraught with its own difficulties. First, behaviour need not be in accord with one's sense of self, emotions, or thoughts. Secondly, self-reports need to be believed by others, if one is to claim to be able to accurately gauge them.

In "feminine" behaving boys, the role behaviour is clearly feminine

t o some, although it may be argued that typical young girls do not behave as such, and thus that these boys' behaviour is a caricature (i.e., effeminate and not feminine). That they grow up not to think of themselves as women, and not desire sex reassignment, but instead identify as gay men, indicates that although their gender role behavior may be "feminine", and that although their sexual orientation may be pre-homosexual, that their gender identity, is in fact male.

We may observe their role behavior, (whether it be cross-dressing, attempt at penile removal, a gait, or aggression) and can only infer about its relationship to their identity. And, while we can listen to their self-reports that they are girls, or want to be girls; we do not know what they mean when they say that they are girls or want to be girls. We can only, in error claim that they have a gender identity disorder, when in fact, upon maturity, we see that it is not their gender identity which is affected. Conversely, for the other boys, those who do not behave in a "feminine" way in childhood, but are timid, withdrawn or shy, and who do not self-report that they think of themselves as girls, again, we can only errantly state that they do not have a gender identity disorder, since they struggle and hide silently, and that on maturity we realise their struggles when they appear at sex change clinics.

We have no way to state that they have a gender identity disorder of childhood. It is because of these factors, that we can state that the diagnosis of gender identity of childhood in the Diagnostic and Statistical Manual of Mental Disorders (DSM) is fallacious. It is the misrepresentation by so-called professionals of some very basic tenets of human understanding. When GID of childhood was placed in the DSM in 1980 (15) and in the DSM-R in 1987 (16), the outcome of extreme boyhood "femininity" was not well known. (Green's work (8) and Zuger's (9) work were in progress). Thus, these professionals' misrepresentation of these boys may be justified. However, with subsequent revisions of GID in childhood diagnoses, as found in the 1994 updated DSM IV (17) and the 2000 updated DSM IV TR (18), we still find that boys who are largely pre-homosexual and who have gender *role* behaviour which is highly unusual are mislabeled as having a gender identity disorder, despite no evidence to support that gender identity *per se* is involved and despite evidence to the contrary.

We also see that maintaining this erroneous classification has a unifying thread and that that those who are the most vocal representatives defending this erroneous classification work for the Canadian government, specifically the Province of Ontario – in particular, Kenneth J. Zucker who was on the 1994 subcommittee (with his colleague from Canada, Susan J. Bradley) and was one of only four on the 2002 subcommittee, and who is currently slated as being head of the current subcommittee for DSM V. (19)

When we examine the work of Zucker (20), we find, that he knows well that gender identity disorder of childhood represents largely a pre-homosexual clinical picture, that it does not fit in with what he and his colleagues refer to as gender identity, that it instead relates to what his colleagues know to be sexual orientation and gender role behavior, and that it thus pathologises sexual orientation and gender role behavior. But we also find that it also serves more primary goals. It only pathologises children who fit this category until they become adults and then they do not have a disorder anymore, due to homosexuality being removed from the DSM in 1973. But to have a category of pre-homosexual boys remain in the DSM, under the mis-label of GID, Zucker and his colleagues can make it look as if GID of adulthood is highly inflated due to the logical expectation that a GID of childhood will become a GID of adulthood.

In fact, Zucker's colleague Bailey (21) states: "Zucker thinks that an important goal of treatment is to help the children accept their birth sex and to avoid becoming transsexual. His experience has convinced him that if a boy with GID becomes an adolescent with GID, the chances that he will become an adult with GID and seek a sex change are much higher. And he thinks the kind of therapy he practises helps reduce this risk." (page 30). (It was under Zucker's colleague Susan J. Bradley, that in 1994, transsexualism was omitted from the DSM IV and replaced by GID of adulthood) (17).

Since as we have discussed, transsexualism cannot be identified in childhood, it's abusive that this change of transsexualism in adulthood to GID of adulthood uses homosexual boys to pathologise adult transsexuals. Since it uses GID of childhood which is not about

gender identity, one could be led to believe that transsexuality or even intersex (under gender identity disorder not otherwise specified) is also not about gender identity.

In fact, that is what Zucker's colleagues Ray Blanchard (22) and J Michael Bailey (21) are proposing. In all of their research, as well as the contention by Zucker (20) that gender identity is malleable, there have been no studies which have sought to correlate the effects of hormones on gender identity with the known times of differentiation of sexually dimorphic human brain nuclei or regions, or the exploration that transsexuality is the result of neural growth factors which render the brain even "more female or more male" than is found in typical males and females. These are major limitations of the interpretation of the findings of Zucker's (20, 23) as well as other research involving atypical sexual development (24).

In regard to GID of childhood not being about gender identity, for Zucker, this classification creates additional problems. Although the "inexperienced clinician" may easily be lead to believe that GID of childhood is about gender identity, and that it does progress to a GID of adulthood, every time Zucker gives a diagnosis of GID of childhood on a claim form to the Ontario government, we should be suspicious.

We know that he knows that it is largely pre-homosexuality which he is diagnosing, despite the fact that homosexuality is not considered a mental disease. We know that he knows that adolescent transsexuals which he diagnoses as having GID are likely the same – pre-homosexuals. That would be an incredible amount of billing for diagnoses which he knows fits on paper (to him and his colleagues' DSM efforts), but does not fit in with actual results because they are homosexuals. Thus, we have misdiagnosis in theory, but he is able to bilk the taxpayers, because most won't think that GID is not *about* GID. But, that is only the beginning of the problem for Zucker. As his colleagues are quick to say, the DSM diagnosis, does not in and of itself suggest particular types of treatments. This is a red herring because Zucker has his own treatment and can suggest the same treatment to others.

Zucker further knows himself that extreme feminine boys usually turn out to be adult gay men and not transsexual. Zucker (20) writes: "Follow-up studies of boys who have GID that largely is untreated, indicated that homosexuality is the most common long term psychosexual outcome" (pg. 562). The key word in Zucker's statement here is the word untreated. Zucker acknowledges that GID boys most commonly turn out to be homosexual adult men, not adult transsexuals. This is in striking contrast to his recent documentary statement that "when one engages in psychotherapy" with children and adolescents with gender dysphoria that one may find that many give up the wish for a sex change and come to an alternative to the 'only way I can feel good about myself' is with a sex change." (25). It also contradicts his colleague's description of Zucker's view that, "Zucker thinks that an important goal of treatment is to help the children accept their birth sex and to avoid becoming transsexual". (21)

With this statement, Zucker's colleague, J Michael Bailey, exposes Zucker's "treatment" as fraudulent, since we have already seen that Zucker knows that most of these boys *don't* become transsexual, but instead become non-transsexual adult homosexual men. Thus without Zucker's treatment, they mainly become gay men anyway; and thus, Zucker has no proof of his own fraudulent claims. We are not surprised then, that Bailey again exposes Zucker's "transsexual prevention" treatment of GID boys as fraudulent and baseless, by this following comment, "Zucker believes that most boys who play with girls' things often enough to earn a diagnosis of GID would become girls if they could. Failure to intervene increases the chances of transsexualism in adulthood, which Zucker considers a bad outcome. …Zucker …is the first to acknowledge that no scientific studies currently support the effectiveness of what he does." (21)

We strongly recommend, in the interest of the protection of Canadian taxpayers and the health of Canadian citizens, that investigation into Zucker's and his colleagues' grant applications be carefully evaluated for fraud, that is, to see if Zucker has indeed suggested in grant applications, that any type of treatment he is employing, or requested grant money for, is in fact having an effect on the gender identity outcome of GID boys.

This is from the research side of things. From direct clinical services, we also suggest, that the Canadian government, carefully review all claim forms for

monetary coverage of children with GID and related issues whom Zucker has treated, along with those who have co-treated them, in order to see if their GID diagnosis co-exists with services billed to the government for treatment which Zucker has already indicated is non-scientific and which is not substantiated. Such would be a violation and abuse of such childhood victims as well as fraudulent use of health care dollars, since it is reasonable to expect amongst healthcare systems that a treatment for a condition is indeed meritorious and not fraudulent.

The diagnostic manual (DSM) does not suggest treatment. It is only for diagnostic purposes. Zucker's colleagues are well aware of this. but, any treatment thus taken, must have demonstrated its efficacy, and further must indicate whether it is experimental, along with risks to the patient (in this case the patient's parents). Moreover, even if it were found that Zucker has declared the treatments to be experimental, and even if all risks were carefully "spelled out" to the parents of the children, it would also follow that evidence which is contrary, such as presented here, would need to be told to the parents as well. To not do this, would be to violate certification/licensure regulations and to engage in practice which is unethical and detrimental.

Now that we have shown that Zucker's treatment in fact does not largely prevent adult transsexuality and that Zucker knows that there is no scientific proof for what he does, and that he knows that the vast majority of boys with GID will develop into homosexual men, we will take four further examinations.

(A) Does Zucker's treatment or therapy have an effect on the sexual orientation outcome of boys with GID (does it help prevent or cure homosexuality)?

(B) Does the replacement of adult transsexuality with adult GID and addition of GIDNOS (Gender identity Disorder Not Otherwise Specified) into the DSM IV in 1994 (17), under the direction of CAMH clinician (and Zucker colleague) Susan J. Bradley, use this replacement term of GID and its association with pre-homosexual boys, to pathologise adults with transsexuality and intersexed persons? (Note: pre-homosexual boys are removed from pathology categorisation when they become eighteen, due to homosexuality being removed from the DSM in 1973. (Adult transsexuals and intersexed persons with GID/GIDNOS, are pathologised well into adulthood).

(C) No matter what clinical entity boys with childhood GID represent, is Zucker fudging his data, manipulating statistics, to include more boys in the GID of childhood category, thus fraudulently inflating its numbers?

(D) If Zucker and colleague Blanchard are studying homosexuality, what happens should they try to remove gender identity as a disorder, and do they even believe in gender identity?

Now that we have seen that there really is no solid scientific evidence that Zucker is preventing transsexualism by treating GID boys, the next question is, does Zucker's therapy prevent or change homosexual orientation in these boys?

By Zucker's own admission, as we have seen, the majority of untreated GID boys become adult homosexual men. In Green's (8) study the majority of boys treated became homosexual or bisexual irrespective of whether they were treated or not. Surprisingly, Zucker states that clinical experience (sic) "suggests that psychosocial treatments can be effective in reducing gender dysphoria". (20) Zucker further states, "in considering these various therapeutic approaches, one important sobering fact should be contemplated. With the exception of a series of intrasubject behavior therapy case reports from the 1970's, no randomised controlled treatment can be found in the literature". (20) His only reference to these studies of the 1970's is a publication by him and his colleague, Susan J. Bradley. (26)

However, when we look at behavioural treatments from the 1970's for very feminine type boys, we find reports by Rekers. (27, 28) Perhaps Zucker did not wish to cite these directly, as Rekers' treatments seemed to be harmful and to be largely ineffectual. Zucker doesn't define gender dysphoria, although others indicate that gender dysphoria is related more to gender identity/role than it is to sexual orientation. But, it does not necessarily mean transsexualism. Thus we can't know what Zucker means precisely when he speaks here of gender dysphoria. Certainly gender role behaviour may also be interpreted as part of gender dysphoria. Zucker mentions only one follow-up study of one boy at a one year follow-up (which did not make random assignment to different treatment protocols), in which a child was claimed to

have had *behavioural* change. (20) But behaviour is not synonymous with sexual orientation, and again, Zucker made no direct references to the shortcoming of the treatment by Rekers.

For a discussion of one of Rekers failed attempts at turning a GID boy into a heterosexual, see Zucker's colleague, J Michael Bailey's account, on pages 24-26 in his book. (21) But, more importantly, Zucker's colleague Bailey, again exposes Zucker's belief, that in fact Zucker believes that adult homosexuality in men cannot be prevented or treated by therapy or treatment of GID boys. Bailey demonstrates this as follows about his colleague: "Zucker thinks that kids with GID need to be treated with psychotherapy, and that their families do as well…but Zucker also disagrees with the right's emphasis on preventing homosexuality. Zucker does not consider this an important clinical goal, because he thinks that homosexual people can be as happy as heterosexual people, and regardless, he doubts that therapy to prevent homosexuality works." (page 29 in ref. 21)

Thus, here we have it (A) Zucker's therapy is not preventing child transsexuality. (B) Zucker's treatment is not curing child transsexuality. (C) It is said by his colleague, that Zucker does not believe that his own treatment prevents homosexuality either, and that it is not even an important goal to do so. (21)

In regard to treating "homosexual" or "pre-homosexual" GID boys, Zucker nonetheless states the following: "Others have asserted—without direct empiric documentation—that treatment of GID results in harm to children who are "homosexual" or "pre-homosexual". (pages 562-563 in ref. 20) Again, we have another attempt at conniving by Zucker. In order to accumulate empiric documentation of the efficacy of such treatments for homosexual or pre-homosexual conditions in GID boys, one needs to secure grants or acquire funding for treating homosexuality or sexual orientation. But, one cannot do this readily, since homosexuality is not considered a disorder, and has been removed from such in 1973 by the very Association (American Psychiatric Association) which Zucker is now slated to lead as gender identity disorder subcommittee chair. One can only reasonably expect to study the effect of treatment of pre-homosexuality or homosexuality in boys, by calling it another name; in other words by changing the label and claim that GID in childhood is not about sexual orientation/pre-homosexuality (although we have seen that it is), but falsely claim, as does Zucker, that it is about gender identity. Only when Zucker can pretend to be treating gender identity, by using terminology such as gender *identity* disorder (GID) of childhood, can he secure funding for research and more - to treat children for *sexual orientation*(pre-homosexuality). If he called it what it usually is in fact (but not on paper), that is, gender ROLE and prehomosexual disorder of childhood, it is likely, that he wouldn't be able to deceive the public so easily. On this score, it is interesting, that adult transsexuality as a diagnosis was omitted from the DSM IV when Zucker's colleague - also at CAMH, Susan J Bradley, was in charge of this committee. (17) Removing adult transsexuality is a clever way to deceive people and bilk them for their money, when it is relabelled as GID of adulthood, since the less experienced clinician may think that a childhood GID has a lot in common with an adult GID. Childhood transsexuals largely are not seen (see above) clinically and usually keep their secret hidden and suffer in silence.

They typically didn't get a diagnosis of transsexuality per se, until well after childood. So, when CAHM member Susan J. Bradley as chair of the DSM IV gender identity subcommittee succeeded in removing adult transsexuality as a diagnosis in 1994 (17), the replacement with GID (adulthood) terminology consistently served to pathologise children, adolescents, and adults, all under the same *label*, despite their being separate clinical entities.

As a result, pre-homosexual children/adolescents could be pathologised until adulthood, by falsely suggesting their condition was one of gender *identity*, only to be automatically disorder free at eighteen (adult), when it was usually found (as was expected) that it was about the child's *sexual orientation*.

Since there was no way to identify child transsexuality (and no label of childhood transsexuality per se), which would be a true childhood gender identity "disorder", they would only be *labelled* transsexual *per se*, in adulthood, when it also found (as expected), that they did not have what is generally regarded as a childhood GID.

Yet their numbers would falsely inflate the GID of childhood diagnosis to the less experienced clinician, since it would seem unlikely that a transsexual

cont. p.17

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diagnosis would present or manifest only after childhood.

Thus, the pathologisation of sexual orientation and behaviour by Zucker, under the guise of gender identity (GID disorder of childhood), uses and abuses pre-homosexual boys for a more devious purpose-to pathologise adult transsexuals, and also adults with intersexed conditions who reject their assignment who are also said to have a gender identity disorder not otherwise specified (GIDNOS) in the presence of a physical intersex condition.

But even as GID of childhood is usually not about gender identity *per se*, and even if Zucker has no scientific evidence that he is preventing adult transsexualism, is there any evidence that even more people who should not be diagnosed as having childhood GID, indeed are being diagnosed as such? Indeed, when we and others (29) examine Zucker's writings, we see him including further, without evidence, people who don't meet the diagnostic criteria for inclusion. (30) This suggests that Zucker is manipulating data, fabricating data, and engaging in fraudulent misrepresentation of data in the very publications with which he is receiving grant money to do.

When we examine further some of Zucker's research, we find that in fact, he manipulates data to inflate the numbers of boys who receive a diagnosis of GID of childhood. Again, we have heard that statistics lie. But we think it is not statistics per se which lie, but people who lie. What about Zucker? We suggest that the Canadian government review the following data manipulations by Zucker and decide for themselves.

We will just present the data here, as observed by another group of Zucker's peers from Canada. (29) (We do need to say, that one of the authors (29), Paul Vasey, is being investigated by OII as to whether he was asked by Zucker's colleague, J Michael Bailey, to request Bailey's colleague, Alice Dreger, to write a "tabloid style journalism" article for the publication *Archives of Sexual Behavior*, which is edited by Zucker to defend a controversial book written by Zucker's colleague, J Michael Bailey.)

Bartlett et al. (29) brilliantly point out flagrant errors in data compilation and interpretation in Zucker's research. The fact that there are in fact five conflations of the data lead us to suggest that in fact, Zucker may be fudging his data to inflate the numbers of boys who are diagnosed as having a GID of childhood diagnosis. Consider the following-

"As outlined in the DSM- IV, for a diagnosis of GID in children, there must be a 'strong and persistent cross-gender identification.' In children, one manifestation of this 'disturbance' is the individual's 'repeatedly stated desire to be, or insistence that he or she is, the other sex.' To arrive at the conclusion that the majority (76.1%) of gender-referred children, including those with a diagnosis of GID, expressed cross-sex wishes, Zucker aggregated the categories 'once-in-a-while' and 'very rarely' together with 'frequently/every day'. A more… diagnostically relevant interpretation of Zucker's (2000) Table 36.2 leads to the conclusion that the minority (23.4%) of the boys and girls in his sample expressed what could be considered 'repeated' (i.e., 'frequently/every day') cross-sex wishes indicative of 'strong and persistent' cross-gender identification." Cross-sex wishes that are expressed once-in-a-while' or 'very rarely' are, arguably, not indicative of 'strong and persistent' cross-gender identification." (29)

Zucker cited Green (1987) to support his position/ conclusion that expressing verbally a wish to be the other sex is consistent with Zucker's own data, but again, Zucker did this, "by combining disparate categories, in this case, 'occasionally' and 'frequently'." The authors noted that it is doubtful, that 'occasional' wishes and 'frequent' wishes are 'diagnostically equivalent'. (29)

The authors further state that they are "intended to be conceptually distinct". (29)

Zucker inflated his (2000) data (30) as well as that of Green (8) to compare cross-sex wishes by combining boys who were only gender *referred* with those who were gender *diagnosed*, and by comparing these two clinical groups, with non-feminine boys or control children. (29). Furthermore,

"….such a comparison has limited relevance to a diagnosis of GID *per se*. That either clinical group expressed cross-sex wishes more than control children does not mean that they expressed such wishes to an extent that is of clinical or diagnostic significance." (29)

Zucker (30) also did not define what he meant by his categories "once-in-a-while" and "very rarely" in his

data. Thus, there is no objectivity here. This is also confusing for the informant who provided him information "who may have subjective notions regarding the meaning of the categories 'frequently', 'once in a while', and 'very rarely', based on their own experience and tolerance of cross gender/sex behaviours". (30)

In Zucker's work (30) he further *combined* the categories "frequently" and "every day", but when these categories were presented on the maternal rating scale that he used to gather his data, they were two separate categories. (30)

Finally, Zucker (30), alternately referred to children as "Gender Identity Disorder" group, in his *table*, but as *gender referred* in the text. Zucker (30) responded that not all of the children met *complete* DSM-IV criteria for GID. This of course, limits the value of making specific statements about those children who specifically have GID *per se*. Although Zucker stated "that if only the children who met the DSM-IV diagnostic criteria for GID were included in the analysis, the percentage expressing cross-sex wishes would have been higher. Unfortunately, he presented no data to support this statement." (see page 192 in ref. 29).

We have seen that Zucker has very sloppy usage of statistics and labels in this particular report of his. (30) We encourage others to find comparable examples which may exist in his work and suggest that Zucker has manipulated data. Even if not intentional, this does a great injustice to the samples with which he is studying and to the conclusions which he is drawing, as well as its influence on the clinical and research subjects with whom he is dealing, and also with the professionals who would be adversely affected in their understanding of his data, and in their attempt at dealing professionally with comparable issues.

We do suggest that the government inquire in to how so many errors/manipulations of Zucker's data could occur by Zucker, and if, in fact, it represents intentional "fudging" of data, and if so, what Zucker stands to benefit from this, and at whose expense. By conflating gender identity with pre-homosexuality, Zucker is able to victimise many populations. Transsexuals should be outraged that they should be misrepresented in clinical history and in treatment proposals. "Feminine" homosexuals should also be outraged in the use of one type ("feminine" homosexuality) of homosexuality to pathologise "non-feminine" homosexuals as well as themselves. Transsexual and intersexed groups should also be outraged, that pre-homosexuality further pathologises them by extending a childhood diagnosis (GID of childhood) to include adults (GID of adulthood) or intersexed persons (GIDNOS). All others should be outraged at the role of Zucker in oppressing these groups, with its psycho-emotional toll and with doing this at the expense of the Ontario taxpayers and the Provincial Government.

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ph/sms 0431 979 039 email: nadine.krejci@student.unsw.edu.au

FOREIGN BORN TRANSGENDERS TO BE 'RECOGNISED' IN NSW

A Bill is currently at the second reading stage in the NSW Parliament which will allow post-operative transgenders born overseas to have their gender change recognised in NSW.

The Bill is part of the *Courts and Crimes Legislation Amendment Bill 2008.* If the Bill is passed and becomes an Act, it will be necessary for foreign-born applicants who want a certificarte recognising their gender change to satisfy the same criteria applied to people born in NSW. They must be unmarried and have undergone surgery for the purpose of assisting them to be considered a member of the opposite sex. In addition they will need toshow that they are Australian citizens or permanent residents and that they live, or have lived, in NSW for at least a year. The Bill also amends the "Births, Deaths and Marriages Registration Act to include the phrase "sex affirmation procedure" in place of the earlier form of words that a person has "undergone sexual reassignment surgery". The updated terminology was recently introduced into Victorian legislation. NSW legislation is being brought into closer alignment with other jurisdictions.

MAN WHO ASSAULTED TRANSVESTITE HAS SENTENCE REDUCED

Clinton McCrae, 29, of Pakenham met a person he took to be a woman at a club and spent a couple of hours drinking with her and playing pool. They then went back to her flat where they became intimate. When McCrae realised his companion was a genetic male he assaulted 'her', fracturing an eye socket and vertebrae and cutting the victim's chest, arm and torso. the victim spent four days in hospital and laid a complaint with the police. McCrae said he acted in self-defence. McCrae was sentenced to seven years but Judge Ashley Vincent reduced the sentence on appeal to five years with a non-parole period of two years and nine months. McCrae had put forward ten reasons for his claim that the penalty was too severe, including his guilty plea and that the original sentencing judge had erred in finding that he showed no remorse. Judge Vincent said the sentencing judge also erred when she found that McCrae had shown contempt for his victim.

FTM MINOR CREATES MAJOR MEDIA FUSS

The Family Court in Victoria has given a twelve-year-old FTM permission to delay puberty through the administration of hormonal therapy. The case parallels that of Alex two years ago and the press has had a field day with the situation, referring to the process as a 'sex-change' and virtually accusing the child's mother of brainwashing a little girl into wanting to be a boy.

The processes to delay puberty are reversible and no irreversible steps will be undertaken until the child reaches the age of sixteen, at which point she will make her own decision to proceed with gender reassignment or to withdraw the medication and return to life as a girl.

She can change her name at this point but will continue counselling until she is sixteen.

Families Minister Jennie Macklin supports the court's decision. "Family law and the court are of course set up with the interests of children at its heart," she said.

Medical ethicist Nicholas Tonti-Filippini has entered the fray, predictably toeing the Vatican line and another 'expert', Dr Joe Tucci, who is the CEO of the Australian Childhood Foundation, and a psychologist, has managed to miss the pont completely, saying, "I would have thought that waiting until the kid is older would be amore prudent course of action. Kids can change their minds.Things that seem set in stone when they are twelve will seem very different when they are eighteen or nineteen."

AURORA CONTINUES GOOD WORKS

The Aurora Group has announced its latest round of funding, distributing almost $45,000 to gay, lesbian and transgender community groups and projects.

Phinn Borg, Manager of the NSW Gender Centre accepted a grant which will be used to upgrade the furniture in one of the Centre's refuge houses. The residential program is a low-support, medium-term accommodation service for transgender people and people with gender issues who are homeless or at risk of being homeless.

Other grants were made to help young people in Cessnock and Gosford and Aurora will support workshops and master classes for young and emerging queer film makers.

Aurora's chief fund-raiser is their annual Gala Dinner, to be held this year on 26 July.

Check the Aurora website for details [*www.auroragroup.com.au*].

CROSSDRESSER EJECTED FROM CASINO

And More News Items

Paul Hurst of Coogee, and a friend presented at the Sydney Casino as women and were asked to leave by a security guard for being 'inappropriately' dressed. Hurst, also known to friends as Anne-Maree, said "I have always regarded myself as a woman and lived my life as a woman"and has filed a discrimination action against the casino for refusal to supply services.

Ms Hennessy, who heard the preliminary request for a hearing called for the casino's CCTV of the incident and also stated that the Anti-Discrimination Act protects transsexuals but not transvestites, and stated "Before the tribunal can hear the case what you have to be able to prove to the court is that sexually you are a transsexual." (sic)

There also seems to be some confusion over the 'appropriateness' of Hurst's clothing from the point of view of decency, with claims being made that Hurst's skirt was too brief to be acceptable. Hurst, however, claims to have been wearing a full-length evening gown.

TRANSGENDERS CHAMPION KICKBOXERS

Transgenders Alex Arti and Delilah Slack have distinguished themselves in recent martial arts championships. Arti won in the Open Beginners/Intermediate division of International Sport Kickboxing Association tournament while Slack won the Open Weapons division at the Australian Martial Arts Association tournament. Both were coached by Penny Gulliver, who has offered self-defence courses to transgenders in the past and runs the Gay and Lesbian Martial Arts Club, which offers kickboxing, kung-fu and same-sex-couple salsa dancing in its repertoire of attractions.

Gulliver offers an introductory kickboxing course for $60.00 with some kung-fu thrown in, or salsa classes are offered every Friday night.

CALIFORNIA LEGALISES SAME SEX MARRIAGE

On May 15 2008 the California Supreme Court decided on a 4-3 ruling that restriction of marriage to a man and a woman was unconstitutional and that same sex

SPRING BARBECUE

14 SEPTEMBER NOON-4.00PM

CHRISTMAS BARBECUE

14 DECEMBER NOON-4.00PM

couples could be issued marriage licences after June 17 (because the Court had until June 16 to grant a requested stay of the ruling). No stay was applied and thousands of same-sex couples from all over the United States have flocked to California to be married under the new ruling although many of the newly-weds will not have their marriages recognised in their home states.

It is anticipated that there will be an avalanche of lawsuits from same-sex couples petitioning to have their California marriages recognised throughout the United States.

The only other State to provide same-sex marriage, Massachusetts, has restricted same-sex marriages to residents of Massachusetts.

Californian forms dealing with marriage will no longer include the words 'bride' and 'groom' but will substitute 'Party A' and 'Party B'.

An AAP survey showed 51 per cent of Californians support same-sex marriage, with 42 per cent opposing.

Jan and Ian Hamilton

BRITISH TRANSGENDERED EX-PARATROOPER FIRED BY THE ARMY AND DEMONISED BY THE TABLOIDS [WHAT A SURPRISE]

Jan Hamilton, formerly Captain Ian Hamilton of the Parachute Regiment, had been appointed to an Army media relations manager position in Gibraltar and notified her commanding officer that she was now female, and enclosed the necessary documentation. The Army ordered her to undergo a medical examination as a man and when she refused, revoked the job offer and Jan's army career was terminated.

Jan sued for compensation on the grounds of sex discrimination and won her case. The tabloids then, on the basis of nothing but rumours, suggested that her payout would be of the order of a quarter of a million pounds, and contrasted this with the payouts allocated to severely disabled war heroes. Jan denies that any such sum was ever offered and says she would not have accepted it if it had been.

KIWIS DON'T WANT TO KNOW, JUST LIKE OZ

Following the precedent set by the Australian Bureau of Statistics, the New Zealand Census, scheduled for 2011, will make no attempt to quantify transgender nor intersex in the population. The only genders available to be checked on the census form will be Male and Female.

The 2006 NZ census recorded same-sex and opposite-sex couples living together and civil union couples as well as married couples. These statistics will continue to be sought although the questions are being rephrased to cope with 'poor quality' responses in the 2006 census.

CUBA TO PROVIDE FREE GENDER REASSIGNMENT

In accordance with the general policy of free medical treatment in Cuba (one of Fidel Castro's two promises, the other being free education) gender reassignment has now been added to the list of free therapies.

After years of controversy and negotiation. Mariela Castro Espin, director of Cuba's National Centre for Sex Education, has won her battle to recognise transgender rights.

"We are carrying out a very important study," she said, "and will run educational campaigns to teach society to respect these people and their rights." She also sees the need for legislation to protect these rights.

Cuba is now a world leader on rights for transsexual and gender variant people.

KERRY ELLISON TO START SOCIAL ORGANISATION FOR TRANSGENDERS

Feeling the need for a social organisation for transgenders who are at 'the end of their journey' Kerry Ellison hopes to create a social and support group capable of speaking on behalf of the gender community and able to dispel a few myths.

Kerry feels that the NSW Gender Centre is mainly for people 'who are just starting their journey'.

A spokesperson for the Gender Centre welcomed any new organisation which caters for the social needs of trangenders but suggested that the dismissal of the Gender Centre as having a narrow focus was unrealistic.

"Naturally people starting out need more support and are more visible on the Gender Centre scene but there are many who have long passed the need for social support but still use Gender Centre services such as counselling, employment training and housing and contribute their energy and expertise when specific projects are under way, such as the HREOC hearings or the need for a report on specific aspects of transgender conditions in society.'

ONTARIO TO FUND GRS

The Province of Ontario, Canada, has announced its intention of

funding gender reassignment for transgenders in need of surgery or other therapies. The drawback is that the program will be administered by the CAMH (formerly the Clarke Institute, often referred to as 'Jurassic Clarke', thanks to its primitive views on transgender).

Ray Blanchard and Kenneth Zucker (referred to elsewhere in this issue) are both linked to the CAMH and support reparative therapy. The CAMH recognisesonly transgender women and does not acknowledge the existence of F2M transgenders.

PARIS FASHIONS BLUR GENDER LINES

The Paris Men's Wear collections this year showed what men may be expected to wear in the Spring and Summer of 2009 (sic). It featured examples of the creativity of Bernhard WEillhelm (see

below).

The fashions, overloaded with ruffles, satin, tassel and ruches, are said to 'blur gender boundaries'. . There must surely be better ways to get rid of gender boundaries, if we need to.

VICTORIA MAY REPEAL DISCRIMINATORY EXEMPTIONS

The Brumby government in Victoria is considering dropping exemptions which currently allow religious groups to discriminate against those whose practices they find unacceptable.

The Catholic Church say this might endanger their education, health, welfare and aged care programs.

Some gay rights groups want the exemptions removed, particularly where gay and lesbian teachers are denied teaching positions in schools using public funds.

The move may lead to more power for the Victorian Equal Opportunity and Human Rights

Living with hepatitis C: Narrative of chaos and quest

Magdalena Harris, National Centre in HIV Social Research, UNSW.

Hepatitis C is a highly prevalent disease that, within industrialised countries, is largely confined to people who are current or former drug injectors. In Australia and New Zealand approximately 1% of the population is living with chronic hepatitis C yet both public awareness and political action regarding the disease is scarce. Hepatitis C is a stigmatized condition primarily because of its connection with illicit drug use and secondarily due to public ignorance and fear around transmission. In this article I will provide a brief outline of findings from a research study conducted in Auckland and Sydney that explored individuals' experiences of living with hepatitis C. I use the work of sociologist Arthur Frank (1995) who described three types of illness narratives; restitution, chaos and quest. I found Frank's theory particularly useful as a framework for analysing the way my study participants talked about their illness, and for understanding the narrative differences between participants.


Magdalena Harris

Participants were recruited by a research notice distributed through the NZ Hepatitis C Resource Centre, The Hepatitis C Council of NSW, the Auckland and Sydney Narcotics Anonymous fellowships and the website Hep C Australasia. For recruitment the only criterion was that each participant was to have, or have once had, hepatitis C. Participants comprised twenty-two women and eighteen men who ranged in age from twenty-five to sixty-three years and were diagnosed with hepatitis C from 1989 to 2005. Nineteen participants estimated that they had lived with the virus for over twenty years. Interviews lasted from 60 to 120 minutes and were loosely structured around central themes.

Stigma and disclosure

All of the participants felt hepatitis C to be a stigmatised condition and many were reluctant to disclose. Wariness around disclosure often results from previous bad experiences; over half of the participants reported a negative reaction from others when they informed them of their hepatitis C status.

For those who tend not to disclose their illness, support options can be limited. The majority of participants favoured a strategic mode of disclosure; that is they only disclosed in circumstances where they felt safe or where they predicted a beneficial outcome. Matthew recounts a painful experience of rejection which highlights the advantages of a cautious approach. He cried as he related his experience to me:

It has been extremely difficult…I would come out of my isolation to church on Sunday; it would sort of be my big deal for the week. And I would be excited to meet different men and I would introduce myself …and really be having a good conversation with them and then would turn around to say hello to another mate and they would disappear. And it freaked me out, because I would sort of look at myself, you know, what is going on here, am I too open, am I telling them stuff at the wrong time, or can't they handle it or what's going on, you know.

Interviewer: So had you told them that you had hepatitis C before they disappeared?

I was just open about my situation, of having hepatitis C, being a solo dad, being on the benefit, and just being isolated, and hey I'd like to be your friend sort of thing (he cries). (Matthew, 49)

Matthew's desire to be accepted with his litany of stigmatised positions; solo father, beneficiary, chronic illness, isolation, and loneliness is distressing in its naiveté. In our contemporary success-oriented society to be open in this way is to risk denigration. To gain esteem and human connection one often needs to be guarded and strategic; adept in the ruse of conformity.

Illness Narratives

The restitution narrative

One of the reasons that Matthew was shunned is that his story is the antithesis of that which society desires to hear; the restitution narrative. Frank describes this in the following way: "yesterday I was healthy, today I am sick, but tomorrow I'll be healthy again" (Frank, 1995, 78). The restitution narrative is about the triumph of medicine. While this may fit with the treatment of acute illness, it has little resonance for the chronically ill whose sickness is more long-term. The restitution narrative is akin to Parson's (1951) sick role where illness is a temporary deviance alleviated by medical intervention. It belongs side by side with the liberal ethos of individualism and the primacy of work. Matthew in announcing his vulnerability, his beneficiary status, his long-term illness, and his loneliness, does not draw upon socially validated narratives and therefore has a long history of being shunned by people who cannot cope with his candour.

It was difficult to find an example of the restitution narrative among participants' interview material, which indicated for me its redundancy for people living with hepatitis C. However, one participant framed his illness within a very strong medical framework. Before we met David sent me graphs of his liver function test results from 1981 and used them as a tool in the interview pointing out how different periods in his life coincided with his fluctuating liver levels. David had been on hepatitis C treatment twice unsuccessfully and stated that he would do it again, as:

> At the end of the day what I am doing is I am buying time, I am buying time by concentrating on good health, no alcohol, low fat, high fibre, and exercise in order to buy time so the medicos of the world can come up with the panacea that addresses, resolves and extinguishes my hepatitis C…So in answer to your question, would I go back on treatment, well shit I'd go back on treatment if it is going to buy me time. (David, 55)

David's emphasis on buying time and waiting for treatment evinces a belief in restitution, that ultimately his hepatitis C will be resolvable; he just has to do the right things and wait until "the medicos of the world" come up with a solution.

The chaos narrative

Frank's second narrative type is that of chaos. While the restitution narrative comforts in its possibilities of a happy ending, the chaos narrative threatens: it displays an indiscriminate whirlpool of unsolvable problems, into which anyone may be sucked. The irony of the chaos narrative is that when the chaos is truly being lived it cannot be articulated. The chaos narrative may be seen as an anti-narrative; it indicates troubles so deep they cannot be fully verbalised. Thus, the chaos narrative is hard to hear; it expresses pain and lacks coherence, temporality or narrative order (Frank, 1995). This passage from Laura is an example of a chaos narrative; it is fractured, both in content and form:

> And I can't go home, it is just getting harder and harder, and my health it is just a blow-out, how can I put that in words when I am there, and the lawyer said to me, and I said I am complete, I am content, I can drink every night and it doesn't affect me, and I know if I was drinking every night here I'd be fucked. (Laura, 42)

Laura is a single mother on a benefit with a young son

which was a severe illness. This is relevant in that I found that the strongest predicators of a chaotic narrative were poverty, unemployment and lack of adequate social supports. These were narratives by people who felt marginalised by society, both in having a stigmatised disease and also lacking access to the socially validated narratives of health, career and conspicuous consumption.

I interviewed Sarah while she was in bed, knocked out by her illness. She spoke of a mutually reinforcing combination of fatigue, illness and poverty:

> Well today I am sick. I was going to clean up the house and move, but I am to sick to do it, I can't do it, I don't have the nerve to do it, I don't have enough nervous stamina to get through. The more I think, I think it's your own fault, and then I think back and I have actually got no clothes, I am sitting here with my pajama jacket on and trousers with holes in them, I've got two pairs of socks and an old pair of shoes, a pair of stockings that need replacing. There is no money for clothes or haircuts or anything like that. There is nothing. (Sarah, 54)

While lives punctuated by distress, illness and poverty are common for those marginalised by the restitution narrative, society does not want to know.

Within our neoliberal society a chaotic life is often seen to be the fault of the individual, requiring personal not structural change. However, structural deficiencies can cause chaos. Poverty, lack of adequate support structures, and discriminatory medical systems all add to individuals' feelings of not being able to cope; of being subsumed by their disease.

The quest narrative

Frank's final narrative type is that of the quest. The quest narrative is that of illness as a journey: a voyage of self-discovery where illness is accepted and *used.*

While the hero of the restitution narrative is medicine and the chaos narrative is fractured and hard to hear, the quest narrative looks for a meaning in illness and is thus, a more palatable and positive telling. It is important however, not to overvalue the quest narrative.

It is akin to the restitution narrative in a way in that it is comfortable for others to hear and is not attainable for all. Laura in expressing how hepatitis C has made her a "better person" iterates a narrative of quest:

> Back then when I was using if you had told me I could have got a disease it wouldn't have mattered, I still would have done it, I had no self respect, and today I have learnt, I have become a better person because of it, a sick person, but better person. I've learnt so much about myself because of this. (Laura, 42)

In using the same participant to illustrate both the quest and chaos narratives I wish to show that these narrative types are not exclusionary; they can all exist in one person's story, with different narratives dominating on different occasions.

Quest and Narcotics Anonymous

Frank's narrative types, especially those of quest and chaos, provided a way to understand the disparity in how participants recruited through different networks articulated their experience. I found the quest narrative arose predominantly in participants who were recruited through Narcotic Anonymous (NA). Although some respondents in this group were economically disadvantaged, they belonged to a strong social network; one which encouraged talking about vulnerabilities and in which many people had hepatitis C. It appeared that a number of these respondents had through their association with NA developed a quest narrative in which illness is accepted and seen as a journey, often one of self-discovery. This excerpt from the NA *Basic Text* articulates a quest narrative. Here, addiction is premised as an ongoing disease;

1283-1289.

13) Davenport, CW. A follow-up study of 10 feminine boys. *Archives Sexual Behavior* 1986, 15: 511-517.

14) Money, J. *Sin, Science, and the Sex Police.* Prometheus Books, Amherst, New York, 1998.

15) *Diagnostic and Statistical Manual of Mental Disorders, (3rd edition)*, American Psychiatric association, Washington, D.C.

16) *Diagnostic and Statistical Manual of Mental Disorders, (3rd edition-revised)*, American Psychiatric Association, Washington, D.C.

17) *Diagnostic and Statistical Manual of Mental Disorders,(4th edition)*, American Psychiatric Association, Washington, D.C.

18) *Diagnostic and Statistical Manual of Mental Disorders, (4th edition-Text Revision)*, American Psychiatric Association, Washington, D.C.

19) *Diagnostic and Statistical Manual of Mental Disorders, (5th edition*- forthcoming), Washington, D.C.

20) Zucker, KJ. Gender identity development and issues. *Child Adolescent Psychiatric Clinics North America* 2004, 13:551-568.

21) Bailey, JM. *The Man Who Would Be Queen: The Science of Gender-Bending and Transsexualism.* Joseph Henry Press, Washington, D.C., 2003.

22) Blanchard, R. *Deconstructing the Feminine Essence Narrative*. Archives of Sexual Behavior 2008, (in press).

23) Bradley, S., et al. Experiment of nurture: Ablatio penis at 2 months, sex reassignment at 7 months, and a psychosexual follow-up in young adulthood. *Pediatrics* 1998, 102: E91 (Available on the World Wide Web at http://www.pediatrics.org/cgi/content/full/102/1/e9)

24) (For review of psychosexual outcomes in various intersex conditions, see *Archives of Sexual Behavior* 2005, 34, August.)

25) *Trapped*. Discovery Health Documentary, 2004Public Broadcasting Service, U.S.A.

26) Zucker, KJ & Bradley, SJ. Gender identity disorder and psychosexual problems in children and adolescents. New York, Guilford, 1995.

27) Rekers, GA. Sex-role behavior change: intra subject studies of boyhood gender disturbance. *J Psychology* 1979, 103: 255-269.

28) Rekers, GA., et al. Assessment of childhood

however, with the help of the fellowship, addicts can achieve a life "beyond their wildest dreams":

> We realise that we are never cured, and that we carry the disease within us for the rest of our lives. We have a disease, but we do recover. Each day we are given another chance…The program works a miracle in our lives. We become different people. (NA 1988:8)

Kate felt that belonging to NA had improved her illness experience. "Working the steps" had helped her to alleviate anger which she connected with the health of her liver:

> What else has helped me is, this is going to sound silly, just getting rid of my resentments, 'cause that is kind of from your liver, shitty liver you know, so doing that Step Four was really healthy for getting rid of all that crap and anger. (Kate, 41)

Narcotics Anonymous operates on the 'disease concept': that addiction is a disease, and therefore, not a moral or criminal issue. The participants who belong to NA are cognisant of a quest narrative in relation to growing and learning from their addiction; thus it is easier for them to adopt this outlook in relation to their hepatitis C. While NA does not normally provide support for hepatitis C, the makeup of membership means that many members have the disease due to past intravenous drug use. For these people, NA also provides the opportunity to meet and talk with others who have hepatitis C thus alleviating the silence and stigma associated with the disease.

Conclusion

Frank does not connect his narrative types to contextual factors such as economic position and social supports whereas I found that social and economic marginalisation often correlated with a more chaotic narrative. The stigma of hepatitis C meant that many participants felt obliged to silence their narrative of illness, so that when it did emerge in interviews it burst forth, often with a great deal of emotion, with temporal jumps and tangential diversions. The effect of being able to regularly share with others the impact and experience of an illness such as hepatitis C was seen in the participants from NA who, accustomed to voicing an illness narrative, were calmer and spoke of the value of a supportive peer network. Mutual help groups such as Narcotics Anonymous are interesting in that they provide not only a social network of peers but a framework within which illness can be framed as a quest.

Restitution, the dominant and socially acceptable narrative, was rarely found in the tales of my participants. The redundancy of this narrative for the chronically ill meant that, following Franks theory, the narratives that were predominantly utilised were those of chaos and quest. These narratives are not exclusionary; both were present in most interviews. However, quest occupies a more socially acceptable format and those participants who belonged to the Narcotics Anonymous fellowship were familiar with its articulation. Common, particularly amongst former dependant drug users, was a framing of their former life as chaotic, looked back upon through a narrative of quest. For those, however, who lacked such support frameworks, chaos was often ongoing, and this was the narrative that dominated. Chaos is uncomfortable for a society primed to the restitution narrative and the ideal of autonomous liberal subjectivity. The primacy of work and the negation of ongoing sickness meant that many participants chose to silence their narrative

Sex and Gender Diverse People and Documents of Identity: Factsheets compiled by the Inner City Legal Centre

For transgender and intersex people, there can be a range of identity documents that you may want to change so that they properly reflect your gender and name. Here are some of the most common areas where people may want to amend their documents.

Note: A number of the agencies will only change your records if you have had gender reassignment surgery. In other cases, however, it may be possible to change your identity documents if you haven't had surgery.

These factsheets apply to adults who want to change their identity documents. This means people aged eighteen years or over. If a child wants to change any of his/her documents he or she should seek legal advice.

Birth Certificates

Amending your Birth Certificate

If you were born in NSW and have had gender reassignment surgery, you can apply to have your Birth Certificate amended to reflect your correct gender. The new birth certificate will not show that you have changed your gender, but there will be a note on your new certificate that says your birth was 'previously registered in another name'.

Access to your old birth certificate is limited by legislation. Other than you, only the following people can apply for your original birth certificate:

- Your child
- The executor or administrator of your estate
- Your parent
- Your spouse of former spouse ;

or

- An officer from the following law enforcement agencies:
- The NSW Police Force
- Police Forces of other Australian States or Territories
- The Australian Federal Police
- The NSW Crime Commission
- The Australian Crime Commission
- The Office of the Director of Public Prosecutions of NSW, or another Australian State or Territory, or the Commonwealth
- The Independent Commission Against Corruption.

To apply, you must:

be over 18 years old; and
not be married (either never married, or widowed or divorced); and
have undergone gender reassignment surgery.

'Gender Reassignment Surgery' is defined as:

A surgical procedure involving the alteration of a person's reproductive organs carried out:(for the purposes of assisting a person to be considered to be a member of the opposite sex, or to correct or eliminate ambiguities relating to the sex of the person.

Your application must include statutory declarations from two medical practitioners, confirming that gender reassignment surgery has occurred.

The cost for registering a change of sex with the NSW Registry of Births, Deaths and Marriages (BDM) is $95.00, plus a $5.00 postageand handling fee. An application will take fifteen working days to process. You will also need to provide some current identification. A list of the identification documents you need is at: *http://www.bdm.nsw.gov.au/amend/proofofIdentification.htm*

Your new birth certificate can be used anywhere in Australia. In countries where a change of gender is not legally recognised, you cannot use your new birth certificate. In those jurisdictions, you must tell them that your gender has been changed or use the old birth certificate.

The Application form to change your birth certificate is at: *http://www.bdm.nsw.gov.au/amend/Approved%20-%20Register%20Change%20of%20Sex.pdf*

Official Change of Name

You can apply to the NSW Registry of Births, Deaths and Marriages to change your name if you

are over eighteen years old and:
- you were born in NSW or your birth was registered in NSW;
or
- you are an Australian Citizen or permanent resident who is ordinarily a resident of NSW.

You should know that it is an offence to change your name with the intention to deceive someone. You are not allowed to change your name to:

something that is obscene or offensive;
something that could not practically be used;
something that resembles an official title;
something that is against the public interest.

The cost for registering a change of name is $128.00, plus a $5.00 postage and handling fee. An application will take five working days to process. You will also need to provide some current identification. A list of the identification documents you need is at: *http://www.bdm.nsw.gov.au/changeName/proofOfIdentification.htm#AdultChangeName*

The Application form to change your name is at: *http://www.bdm.nsw.gov.au/PDF%20forms/changenameadult2007.pdf*

Change of name by repute or usage

You can also change your name without taking any formal steps. Once you have used, and become known by, the new name, the law will recognise it. But you should be aware that it may be harder to change your other identity documents if you don't have documents to prove that you have changed

Passports

Getting a Passport when you haven't had Gender Reassignment Surgery

If you want to travel overseas and you haven't had gender reassignment surgery, the Department of Foreign Affairs and Trade (DFAT) can only issueone of the following travel documents:

- A full passport with your birth sex;

or

- A limited validity passport (for up to twelve months) with your birth sex;

or

- A Document of Identity, which has a maximum validity of twelve months, and the gender field is left blank.

DFAT will not issue an interim passport in your correct gender for the purposes of overseas travel for gender reassignment surgery.

If you decide to apply for a Document of Identity, DFAT will write and tell you that:

- ❑ Some countries will not accept Document of Identity as a valid travel document.
- ❑ Some countries might view a Document of Identity as suspicious, and might delay or harass you; and
- ❑ A body search might be embarrassing.

DFAT will want you to write back to them, and say that you have received the letter from them, and that you agree to getting a Document of Identity.

If you have been given a limited validity passport or a Document of Identity, you can only get another travel document with your correct gender after you have had gender reassignment surgery.

Getting a passport when you have had Gender Reassignment Surgery

If you were born in Australia:

To get a new passport, you will need to provide DFAT with evidence of your identity.

The Australian Manual of Passport Issue says that you need to provide DFAT with your birth certificate showing that your gender has been changed. You can get this from the NSW Registry of Births Deaths and Marriages, or the equivalent body in the State or Territory of your birth.

If you have had gender reassignment surgery, and cannot get a new birth certificate because you are married, the Passport office can issue you a passport in your correct gender. You will need to provide evidence to the passport office confirming:

1.That you are an Australian citizen;

2.Your gender; and

3.Your identity.

If you were born overseas:

To get a new passport, you will need to provide DFAT with a revised Citizenship Certificate that records your correct gender, or some other formal evidence from the Department of Immigration and Citizenship that recognises that your gender has been changed.

Contacts:

The Gender Centre (02) 9569 2366
http://www.gendercentre.org.au
Inner City Legal Centre (02) 9332 1966
http://www.iclc.org.au
Australian Passport Information Service 131 232
http://www.passports.gov.au

RTA

To change your name on your driver's licence, you need to submit an 'Adjustment to Records' form, and take it to an RTA office. You can get this form from an RTA office, or download it from:
http://www.rta.nsw.gov.au/publicationsstatisticsforms/downloads/45070212.pdf
You will need to provide original identity documents to the RTA. This could mean:

A Change of Name Certificate issued by the Registry of Births, Deaths and Marriages;

or

A birth certificate showing your name at birth and your new name.

You also need to provide the RTA with other documents to prove your identity. A list of these documents can be found at *http://www.rta.nsw.gov.au/licensing/proofidentity/proof_list12.html*

You should be aware that the RTA will keep a record of your old name on their system as an alias.

Centrelink

If you have not had gender reassignment surgery, you can request that Centrelink record your name change by giving them evidence of the change.

For example, you could give them a copy of a new driver's licence or your change of name certificate.

If you have had gender reassignment surgery, you can request Centrelink to record your changed name and gender by providing your new birth certificate or a document from your surgeon certifying that you have undergone gender reassignment surgery.

Medicare

To change your name with Medicare, you must have legally changed it with the Registry of Births, Deaths and Marriages. This means you will need either an amended birth certificate, or a change of name certificate.

If you have not had gender reassignment surgery, then you can either:
- go to a Medicare branch with your change of name certificate and one other piece of identification; or
- send a letter to Medicare stating that you want to change your details with them. You will need to get your change of name certificate and one other piece of identification certified by a JP, solicitor or other qualified person

This means that Medicare will change your name in their records, but they will not change the gender they have you recorded as.

If you have had gender reassignment surgery, then you can either:
- go into a Medicare branch with your amended birth certificate and one other piece of identification;

or
- send a letter to Medicare stating that you want to change your details with them. You will need to get your amended birth certificate and one other piece of identification certified.

To change your recorded gender with Medicare, you will need to provide a letter from a doctor, stating that:
surgery has taken place;
and you are undergoing hormone therapy;
and you have been living in this gender for at least two years.

You should be aware that Medicare divides treatments according to gender.

If you change your records to your new gender, then you may be denied Medicare reimbursement for treatment that is allocated only for people of

your birth gender.

Amending your records held with Government Departments - NSW

You can apply to amend your records held with NSW Government Departments, including the Police, Department of Community Services, Department of Housing You have the right to amend your records held with a NSW government department if:

The document contains information about your personal affairs;

The information is used by the government agency;
You believe the information is incomplete, incorrect, out of date or misleading.

If you want to amend your records, your application should:

- Be in writing
- Say that it is an Application under the Freedom of Information Act 1989 (NSW)
- Contain enough information so that the agency can identify the document;
- State the reasons why you believe the document is incomplete, incorrect, out of date or misleading
- If you claim it is out of date, give them updated information
- Give them an address where they can send letters to you

If your records have been amended, you should still be aware that the NSW Police may list your old name as an alias. This means that this name will come up if a criminal record search is conducted.

Amending your records held with Government Departments - Commonwealth

You can apply to amend your records held with Commonwealth Government agencies, including the Police, Department of Community Services, Department of Housing.

You have the right to apply to amend or add an annotation to your records held with a Commonwealth government department if:

- The document contains personal information about you;
- The information is incomplete, incorrect, out of date or misleading;
- The information is available for use by the government agency.

If you want to amend your records, your application should be in writing, and should include a return address. It should be sent to the agency whose records you want to change. Your letter should include:

Which document needs to be amended;
What information is incomplete, incorrect, out of date or misleading, and why; and
What amendment you would like.

Note: Commonwealth agencies usually will not entirely get rid of the old records that they have.

Land ownership - Certificate of Title

To change your name on the Certificate of Title to any land you own in NSW, you need to complete a Notice of Change of Name Form, and a Notice of Sale Form. These forms will change the recorded name on the title, and will inform the local council and the water supply authority that the name on the title has changed. Both these forms are available from the Department of Lands.

Leases

If you are renting a property and have an existing lease, then the lease will continue if you change your name. If you want to change your name on your lease, here are some options for doing this:

Send your landlord or real estate agent some proof of your change of name and ask them to consent to change your name as it appears on the residential tenancy agreement.

Send your landlord or real estate agent proof of your change of name, and ask them to annex it to your residential tenancy agreement. You can also request that any future correspondence be sent to you in your correct name.

It would probably be best to discuss either of these approaches with the landlord or real estate agent before you send the letter.

If the landlord or real estate agent refuses to do either of these, you may be able to apply to the Consumer, Trader and Tenancy Tribunal to have your name changed on the lease. If you wish to do this, you should seek legal advice.

Citizenship

If you were born outside Australia, you may want to get a new certificate of citizenship. You will need to complete the following forms:
Application for Evidence of Australian Citizenship - Form 119 (available at *http://www.immi.gov.au/allforms/pdf/119.pdf*

The fee for this application is $55.00; and a Request for amendment or annotation to personal records -
Form 424C is available at:
http://www.immi.gov.au/allforms/pdf/424c.pdf

You will also need to provide supporting documents, such as a change of name certificate, or evidence of gender reassignment surgery.

Department of Housing

If you are in Department of Housing accommodation, you can change your records with them by filling in an Advice of Tenant Name Change form. This form will ask for your details, and the reason why you are changing your name. You will need to give them evidence that your name has changed. This could include:

- Centrelink documentation
- Drivers licence
- Bank account statements

The form is available at:
http://www.housing.nsw.gov.au/NR/rdonlyres/03B2387D-6532-4F3A-A379-B23DE1FA82A1/0/DH1034_Advice_of_tenant_name_change.pdf

Foreign documentation

Any documentation from an overseas country will be subject to the laws of that country. If you wish to change these, you should contact the relevant Embassy or get legal advice.

Wills, Enduring Guardianships or Enduring Powers of Attorney

If you have a will, an enduring power of attorney or an enduring guardianship document, you should make changes to these if you change your name.

Australian Electoral Commission

The Electoral Commission can change your name and gender on your registered details. You do not need to have had sex reassignment surgery to change your records. You can change your records by filling in an
Electoral Enrolment form, available at:
http://www.aec.gov.au/pdf/enrolment/forms/ER016w_NSW_0208_F.pdf

Other identity documents

There are a number of other documents that you might want to change when you change the official record of your name and gender. These can include:

- University, TAFE and School qualifications
- Insurance policies
- Professional or skills based licences
- Banks
- Electricity, Gas and Phone Companies
- Credit cards

Many of these organisations will have different policies for changing your records. If you have any records or identity documents from them, it is best to call the organisation and ask them about the process for changing your records held with them.

Contacts

The Gender Centre
(02) 9569 2366
http://www.gendercentre.org.au

Inner City Legal Centre
(02) 9332 1966
http://www.iclc.org.au

NSW Registry of Births, Deaths and Marriages
1300 655 236
http://www.bdm.nsw.gov.au

RTA

132 213
http://www.rta.nsw.gov.au

Codgers
a play by Don Reid

Directed by Wayne Harrison,

Featuring Ronald Falk, Ron Haddrick, Edwin Hodgeman, Jon Lam, Gragham Rouse and Henry Szeps

Eavesdrop on six senior Aussie men who meet regularly in a gym for exercise, coffee and conversation. The play deals with ageing, racism, gender role diversity, inclusion and acceptance ... all wrapped up in people's secrets. And the deepest secret of all for one of the men ... just who is the mysterious Rose? Her revelation is a great challenge to the bonds of mateship for the group. Eventually the men learn that 'difference' is a matter of point of view and that 'you wouldn't be dead for quids', and, no matter what, you gotta laugh!

Dignity and humour sit side by side in the play's treatment of all its issues.

Riverside Theatre, Parramatta
July 30 - August 9, (02) 8839 3399
www.riversideparramatta.com.au

Hothouse Theatre, Albury/Wodonga
August 12 - 16, (02) 6961 8388
www.hothousetheatre.com.au

Griffith Regional Theatre
August 19- 20, (02) 6961 8388
www.griffith.nsw.gov.au

Manning Entertainment Centre, Taree
August 26, (02) 6552 5699
www.gtcc.nsw.gov.au

Jetty Memorial Theatre, Coffs Harbour
August 28 - 30, (02) 6652 8088
www.coffsharbour.nsw.gove.au

NORPA. Starcouirt Theatre
September 2 - 3, 1300 066 772
www.norpa.org.au

Glen Street Theatre, Belrose
September 9 - 20, (02) 9975 1455
www.glenstreet.com.au

Laycock Street Theatre, Gosford
September 22 - 23, (02) 4323 3233
www.laycockstreet.com