Polare

MAGAZINE OF THE NEW SOUTH WASLES GENDER CENTRE

Edition 82
January-March 2010

the Gender Centre Service Magazine

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

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

We offer a wide range of services to people with gender issues, their partners, families and organisations, and service providers.

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

the Gender Centre

The place to go for confidential, free services for people with gender issues.

7 Bent Street
PO Box 266
Petersham
NSW 2049
Tel:(02) 9569 2366
Fax: (02) 9569 1176
Email:
reception@gendercentre.org.au
Website:
www.gendercentre.org.au

The Gender Centre is staffed 10am-5.30pm Monday to Friday

DROP-INS

Wednesday 6pm - 8pm

All other times by appointment only

Our Services

- ☐ **Support and education**
- ☐ **Social and support groups**
- ☐ **Drug and alcohol counselling**
- ☐ **Quarterly magazine *Polare***
- ☐ **HIV/AIDS information**
- ☐ **Condoms and lube**
- ☐ **Needle exchange**
- ☐ **Accommodation**
- ☐ **Referrals to specialist counselling, medical, HIV/AIDS, education, training, employment, legal welfare, housing and other community services**
- ☐ **Outreach - street, home, hospital and jail**
- ☐ **Counselling and support groups for partners and family**

Residential Service

For all enquiries relating to the residential service, please contact us.

Cover: Kim Petras completed her gender reassignment surgery in November 2008, at the age of sixteen and is generally regarded as the youngest recorded person to have done so. Kim struggled to be recognised as female from the age of two and won the support of her parents and later that of Dr Bernd Meyenburg, head of a Frankfurt children's clinic. She gave interviews describing her 'gender transition' and by the time she was fourteen had come to the notice of print and TV media world-wide. She is making a career for herself as a pop-singer and is a popular role model for her peer group.

January-March 2010

No. 82

CONTRIBUTORS

phinn borg, katherine cummings, helen ward, rachael wallbank, annie richards

REGULAR

FEATURES

THE FINE PRINT

Polare
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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.

SERVICES & NOTICES

DEADLINE

for submissions to the next edition of *Polare* is the eighth of March 2010

Polare A Magazine for people with gender issues

Editor: Katherine Cummings

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The Manager's Report

The past months have been very busy with the AGM, reports, meetings and research projects with other organisations, as well as organising events for the coming year and so on.

This year a significantly higher numberof service providers and employers requested training from the Gender Centre, and there was an increase in student visits from TAFE and private colleges. Our drop ins are also increasing in size so that soon there will be a lack of space available for these functions.

Then there has been organisation of an event for the 2010 Mardi Gras. The Gender Centre, in partnership with the Inner City Legal Centre, will be presenting the 2010 Transgender Film Festival at the Sydney Mechanics' School of Arts (see ad. on p. 14). The festival will start at 11.00am and finish at 9.30pm. A long day, but worth it.

All the films are documentaries. One is in French, with subtitles ... "L'ordre des Mots" ["Binding Words"]. This film addresses gender identity issues head on by questioning often unchallenged societal norms and by analysing the nature of oppression and repression faced by the trans- and intersex communities of France.

"Screaming Queens" tells of the riots at Compton's cafeteria. This award-wining documentary deals with the little known story of transgenders and transvestites fighting police harassment at Compton's Cafeteria in San Francisco in 1966, three years before the famous riot at Stonewall Inn Bar in New York.

"Still Black" is an alternative feature documentary on the lives of six black transmen.

"She's a Boy I Knew" is guaranteed to be the most compelling DIY, gender bending, feel-good film directed by a transsexual lesbian you've seen all year,

"Unravelling Michelle" delves head first into the gender-bending highs and lows of Michelle's male-to-female metamorphosis through the eyes of Michelle and those closest to her during the process.

"Trained in the Ways of Men". In 2002, transgendered Alameda County teenager, Gwen Araujo, was severely beaten, tied up and strangled to death by four men who had been with her at a party. This eye-opening documentary combines interviews with Araujo family members and legal experts, with footage from both trials (the first resulted in a hung jury).

There will also be two short fillers around the eight minute mark.

We are calling for volunteers from the community to help out on the day and to help on Fair Day. If you would like to donate some time to help, please contact me at the Centre (9569 2366).

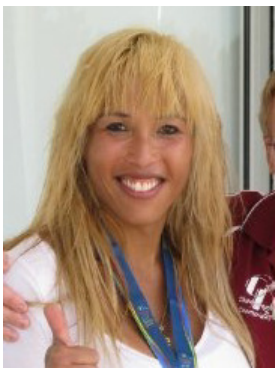
And now it is that time of year when I take my leave and spend some quality time with my partner and our now almost-grownup teenagers. I hope you all had a wonderful Christmas and will have a Happy New Year. Stay safe and I look forward to seeing you in 2010.

Phinn

More information on the Transgender Film Festival is to be found in this issue on pp.6 and 14.

STOP PRESS

Linda Montana wins silver and bronze at Masters' Games



Linda Montana

I'd never heard of the Masters' Games until a trainer at City Gym casually informed me of then, so I checked them out, registered and then hesitated because I've never participated in an international event ... ever ... and Caster Semenya was all over the media.

"Nevertheless I promised myself I would do something extraordinary. I trained hard and enlisted a lawyer (Yasmin hunter from ICLC) and my endocrinologist, Professor Alfred Steinbeck to contact the Australian Masters' Games Committee to let them know my situation. In short, I entered women's events as a transgender, with full endocrinology results in hand.

My Cinderella story ended with a silver medal in women's doubles and a bronze in the mixed doubles. I may have made Australian tennis history and even world history as the first pre-op transgender to successfully compete in an international sporting event. I was proud to be the flag bearer for the transgender community. It was certainly one of the most courageous things I have ever done.

My next goal is the 2010 Gay Games in Cologne.

Linda Montana

Editorial - Katherine Cummings

In my last editorial (*Polare 81*) I devoted some space to young transgenders who have been receiving more sympathetic publicity than has been the case in past years. Some of this interest was created by the case of Kim Petras, a young German pop-singer, who may be, at sixteen years of age, the youngest publicised transgender to receive full reassignment surgery with the approval of her parents and the relevant government bodies. We are using an image of Kim on the cover of this issue with her kind permission.

In the editorial mentioned above I talked of other transgenders here and overseas who have been allowed to transition while still minors, and the desirability of campaigning for this to happen in the hope that, sooner or later, it becomes the norm rather than the exception.

Phinn Borg, Manager of the Gender Centre, asked me to devote this issue to the "young transgender" which is why so much of the issue concerns that segment of our transgender community. In my 81 editorial I cited the long piece on the Internet by Annie Richards and I have now obtained her permission to include an edited version of her essay in this issue. It starts on p.20.

It is proving more difficult to find information about female-to-males who have transitioned early. There are a number of reasons for this. For a long time we were told that there were many more male-to-female transgenders than female-to-male, but as the phenomenon is studied it is becoming clear that the incidence of mtf and ftm are probably at parity (one-to-one).

Nevertheless ftms are often harder to detect as they have some natural physiological advantages in the hormonal therapy masculinisation process, such as the growth of facial hair, the natural deepening of the voice and the onset of male-pattern baldness, all of which help those ftms who choose to blend in with society.

We know, of course, about the well-publicised cases such as that of Alex, who was allowed by the Family Court to start the affirmtion process at the age of thirteen. A less desirable side-effect of the case was the ruling that all similar cases must be referred to the Family Court for decision.

In other words, it was no longer legal for the child's legal guardians (usually his/her perents) to authorise legal, social and medical gender affirmation procedures,except, of course, (regrettably) in the first year of the child's life, in cases of indeterminate or "unsatisfactory" genitalia.

As a matter of courtesy I contacted an FTM support group to see if there was a source of information on "young FTM transgenders" i.e. those who had transitioned before they turn eighteen. To my surprise I was informed that there was no such thing as a young transgender and that young transsexuals did not need to transition, but would simply grow up in their affirmed gender. I was also enjoined to contact Rachael Wallbank (the highly talented and committed lawyer who ran the Kevin and Alex cases, among others) who would put me straight on my misunderstanding of the situation with regard to "young MTFs or FTMs".

This farrago of misunderstanding and muddy thinking stemmed from an assumption that I was referring to very young children whereas I had made it clear that I was talking about anyone who transitioned before the age of eighteen. I apologise that material on young FTMs will need to appear in a later issue as I do not wish to delay this issue any further.

Of course in an ideal world children **would** be treated sympathetically and assessed for transgender status at an early age, but in the real world most children are forced to conceal their status until later, when their views may be more respected. If they are fortunate they may then achieve hormonal therapy before puberty, deferring puberty until later assessment, which, one hopes, would be based largely on their ongoing self-assessment. Regrettably many transgenders go through puberty before they reach the age of majority and are forced to suffer the pain, indignity and expense of undoing as much of the damage caused by puberty as they can.

I intended to devote half of this editorial to sorting out some of the confusions over the terms used to define aspects of transgender, but Rachael contributed an excellent article for this issue in which she touches on gender terms. I wrote a short piece as a contributor (i.e. without the glory, power and presumed infallibility of my editorial status) on my view of language in the area of transgender, taking issue with some of Rachael's views, but revisions to Rachael's piece have forced me to defer mine until the next issue.

I am grateful to Kim Petras for allowing the use of her image on the cover of this issue, to Rachael Wallbank for her essay on young people with transsexualism and to Annie Richards for her piece on young MTFs. There is a lot to consider and weigh in this issue of *Polare* and there has been so much contributed material that I have had to add extra pages.

If you have opinions you would like to share, remember that we are always looking for contributions from the readership and welcome your input.

Katherine

An Open Letter to the Editor

It is encouraging to see authorities agreeing to requests with respect to gender reassignment at a young age. I take this to mean they, at long last, are starting to listen to what we have to say and what we think should be done rather than prescribing a solution based on misconceptions drawn from the available, but often misguided, expert literature.

Many of the oldies, like me, had to battle with a very structured and a sometimes well meaning if misguided system. We also learned to be somewhat cynical of most experts. '*A drip under pressure*' is often not far from the truth.

It is not so long ago that 'Justice Omrod' a supposedly knowledgeable Englishman with both medical and legal qualifications made recommendations that were acted on by the establishment following the "*Corbett v. Corbett"* case. His judgement showed a total lack understanding that could only result from proscribing rather than researching, listening and diagnosing.

Nearly all the advice that affected my actions positively came from my peers, not the establishment.

One of these days there may be a solution other than surgical intervention but I'm not going to hold my breath waiting for it to arrive. Without that intervention I would be either living as a man and an emotional cripple driven by compulsions that I could not control or living as a parody of a woman on the fringe of society. In either case almost certainly alienated from my family.

I have never been in doubt as to the efficacy of my gender related surgery any more than I have with respect to a hip, and shoulder replacement. Given that these latter are to correct what is really worn cartilage suggests that a much less intrusive intervention is not too far away.

Again, however, it is not what may one day be available, but what is available now, that needs to be acted on. I could survive much more easily without my joint replacements than I could without reassignment surgery. I would much prefer to be a physical cripple than an emotional one.

I was fifty before my then wife handed me a book by the current *Polare* editor and said "I think you should read this". On reading Kate's book it became crystal clear to me what my problem was.

It was not that I did not have an inkling of what was wrong before or that I had not read as much literature as was available over some forty years ... it was just that until that point I had doubts and had thought that the brain could control the rest of the body.

With better information earlier I probably could have arrived at the same conclusion while still in Primary School.

In a compassionate and informed environment, this understanding could, and should, be reached at a much earlier age. What age this should be is determined by the individual concerned (hopefully with the aid of a sympathetic family) and not at some preconceived age such as fifteen or eighteen. The earlier the better should be the rule as this results in fewer problems and lower costs for the person concerned and consequently avoids a string of problems and costs for society as well. There will be the occasional person who makes and later regrets such a decision. However people have to accept responsibility for their own mistakes and these should not stand in the way of the majority. Any protocol should be aimed at identifying these few mistaken cases, if possible.

To get where I am I had to follow a protocol that I found both demeaning and mostly irrelevant. But 'hey' if it was the only way to get what I wanted, so be it. However when you and a group of friends, who are in the same position as you are, and cover a wide spectrum of society including academics who are highly credentialed in their own field are all agreeing that it is unnecessary, you do wonder at the misguided logic that created the protocol in the first place.

I think of the confusion my forays into my mother's and sister's clothes from almost the beginnings of my memory caused both me and my family, and the added confusion during puberty when it appeared to be related to ejaculation, the early years of university when fear of going into department stores resulted in my stealing from clotheslines and eventually from houses. This last activity finally resulted in my facing court, being made subject to probation, and undergoing counselling that was irrelevant to my true situation. I still cringe when I remember the times when I tried to sew up my own genitals with a needle and thread as well as a number of other stupid practices that would add little to thrust of this article.

Then came the erroneous thinking that a marriage which was more successful than most would put an end to my problems, Finally, when I had no doubt as to the nature and solution to my problems, my marriage, like many others, foundered on the gender perceptions of my partner. Fortunately for me the parting was less acrimonious that most. However my ex-partner did suffer a not inconsiderable degree of angst and was of the opinion (which is hard to contest) that I should have known myself better.

As I had reached a mature age the cost of transition was considerable. First there was a separation, then divorce and splitting of assets. Breaking the news to two adult children, one at university and one returned from a year overseas; breaking the news to close friends including a business partner and then the decision that if I was going to go ahead it would not be in my own backyard.

I did not believe that I would be very successful in what I was attempting so I did not want to be a further embarrassment to those I loved. I used to think I would wind up destitute, living in an attic on Flinders Street (Sydney) and be an object of amusement for small children. To my surprise, however, my transition has gone relatively smoothly. I do envy the younger generation who will not have to endure hours of painful and costly electrolysis, hours of costly psychiatric counseling (in my case mitigated by a sympathetic and humorous psychiatrist who realized that there was nothing that he could do to help me.)

And a few minor cosmetic operations (which in hindsight were probably unnecessary). The only intervention for which I was grateful was speech pathology at RPA but again for a younger person before puberty this would not be necessary.

I do not consider that my life would necessarily have been better if I had had gender reassignment at an earlier age but I do know that if I had had better information available to me I probably would have wanted to have the change before I started high school..

The misguided logic that has led to many following a path such as mine is now hopefully largely in the past.

Helen Ward

Do You Believe You Are Intersexed?

If so and you would like to know more and meet others like yourself then contact: OII Australia [Organisation Intersexe Internationale] at PO Box 1553, Auburn, NSW, 1835 or at: oiiaustralia@bigpond.com or visit our website at www.oiiaustralia.com

Sex and Gender Education (SAGE) Needs You!

SAGE is a grassroots organisation that educates, campaigns and lobbies for the rights of **all sex and gender diverse people in Australia:** transsexual, transgender, intersex, androgynous, without sex and gender identity **Membership is FREE!**

SAGE no longer sends out printed newsletters - instead we send out occasional news and updates via email, and also post news items, articles and documents on the SAGE website.

To join SAGE, and receive occasional news updates, go to

http://lists.cat.org.au/mailman/lisinfo/sage

and sign up to our low-volume mailing list
For more information visit our website
www.sageaustralia.org

SAGE - campaigning for your rights!

Health in Difference Conference 2010

From the 29th of April, to the 1st of May, 2010 Sydney is hosting the *Health in Difference* Conference, Australia's premier conference on the health and wellbeing of lesbian, gay, bisexual, transgender, intersex, queer and other sexuality, sex and gender diverse (LGBTI*) Australians. This year the conference has a specific focus on diversity and inclusion, looking in particular at the following five themes:

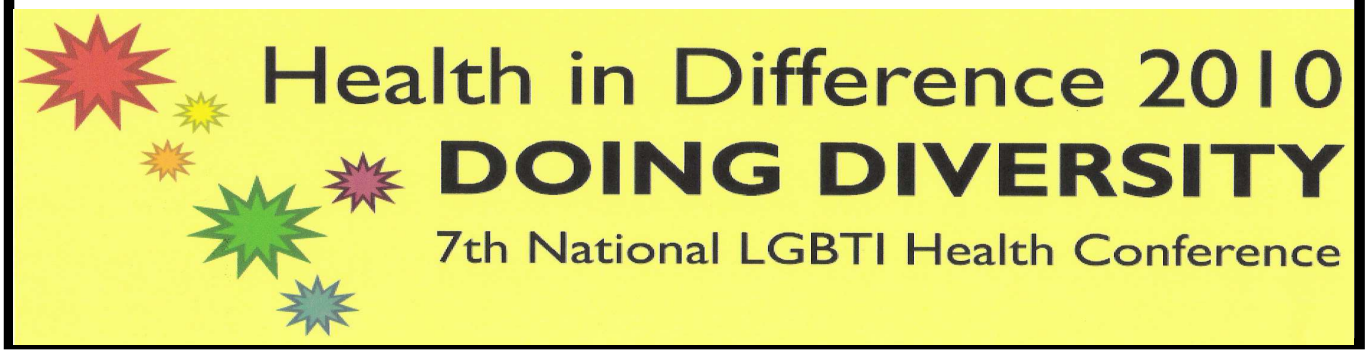
- Social Inclusion, Exclusion and Resilience: A Social View of Health
- Indigenous Health and Wellbeing: Culture, Context and Colonisation
- Sex and Gender Diversity: Differences within Diversity
- Community: The Changing Natures of Our Relationships
- Politics, Evidence and Practice: Creating Change

The *Health in Difference* organisers are committed to making the conference as accessible and inclusive as possible to transgendered and other sex and gender diverse people and organisations. There are a couple of trans folk in the working group, and the National LGBT Health Alliance have been consulting widely with a variety of communities around Australia to ensure that the event is as welcoming as possible to a whole range of identities.

With that in mind, we'd like to encourage as many people from the sex and gender diverse community as possible to contribute to the conference, and come along. There is a call for papers open until the 29th of January, seeking presentations and workshops from a wide variety of people and perspectives, especially regarding the inclusion of sex and gender diversity in the mainstream LGBT health and wellbeing agenda, and about the specific health needs of sex and gender diverse individuals.

We encourage you to check out the National LGBT Health Alliance's website for submission guidelines and registration details. (www.lgbthealth.org.au/Health-in-Difference-2010)

* *Health in Difference* uses "LGBTI" as a recognisable acronym to refer to a group of identities that includes but is not limited to lesbian, gay, bisexual, trans/transgender and intersex people. We also use it as an invitation to think across identity labels and consider sexuality, sex and gender diversity in all their facets and communities. We call on queers, queens, straights, sistergirls, brotherboys, transsexuals, takatapui, fa'afafine, femmes, bois, bears, and toms, all those with an interest in sexual orientation, sex and gender identity and how these relate to health and wellbeing to be part of *Health in Difference 2010*.



Australian Passport Office Apologises to Stefanie Imbruglia

The Department of Foreign Affairs and Trade (DFAT) has agreed to issue appropriate passports to sex and gender diverse people and change offensive terminology in its training material, to be more inclusive of diversity.

In July 2007 Stefanie Imbruglia, a forty-two-year-old transsexual woman, applied to the Australian passport office (run by DFAT) to obtain a female passport in order to travel to Thailand for legal gender reassignment or affirmation surgery. She had been registered at birth as male but she had been living as a female for two years. To her amazement she was told that she would only be allowed to travel on a male passport despite having letters from her medical specialists confirm-ing that she had been undergoing treatment for sex and gender dysphoria.

Stefanie Imbruglia

For twenty years the Australian goernment had issued one-year limited passports to people who were going abroad for affirmation surgery. Under the Howard government the Minister for Trade and Foreign Affairs rescinded that right in 2007 without consulting specialists in the field, service providers or any members of the sex and gender diverse community. Had Stefanie applied for a female pasport a few days earlier there would have been no problem. She had, in fact, inquired by telephone a week earlier and had been told there would be no problem.

It is dangerous for transsexual women to travel abroad on male passports, and vice versa, as they can be subjected to searches, intimidation, arrest, violence and embarrassment.

Twenhty years ago there was the case of an Australian transwoman named Estelle Asmodelle, who was arrested in Singapore after she had been forced to travel on a male passport. It was this case that forced the Australian passport office to start issuing limited one-year passports to transwomen travelling overseas for surgery. It also commenced the practice of issuing passports in the new gender for those who were post-operative and single.

Stefanie, standing in the passport office, was extremely upset and afraid as a very rude passport officer kept calling her "Sir" even though she was wearing a skirt and jacket and presenting as female.

When Stefanie arrived in Thailand she was stopped by a passport control officer in front of the other passengers and called to account for the discrepancy between her female appearance and male passport. This was highly embarrassing for her and forced her to disclose her medical history in public and against her will. What she had warned the Australian SFAT might happen, did happen.

On her return to Australia after surgery, Stefanie, as a member of SAGE (Sex and Gender Education, a lobbying group for sex and gender diverse people) decided to bring an action against DFAT through the Australian Human Rights and Equal Opportunity Commission (HREOC), now the Australian Human Rights Commssion (AHRC).

The case asserted that DFAT had knowingly placed Stefanie in danger by refusing her a passport that reflected her identity. DFAT was in breach of Article 12 of the Internatonal Covenant of Civil and Political Rights (ICCPR) under the Australian Human Rights Commission Act 1986. The United Nations' Conventionon Human Rights requires countries to issue citizens with documents for safe travel in and out of their countries.

Stefanie also filed a complaint that DFAT had been guilty of sex discrimination under the Sex Discrimination Act 1984. Since it had issued her with a female passport on her return from Thailand but had refused her one before she went, it had discriminated against her because she presented as the same person on both

occasions. The complaint also encompassed the way she had been mistreated by the passport officer. Genitals do not define a person's sex or gender. Approximately one in a hundred children are born with some form of sex or gender diversity.

Over the following two years the AHRC sought conciliation between the parties. In the interim the AHRC had published its 2008 project that looked into the human rights difficulties faced by people who were sex and gender diverse and concluded that many government departments needed to adopt a more positive and accommodating attitude to all sex and gender diverse people. For far too long this group has been excluded from fully taking part in society as bureaucracy has failed to keep up with scientific progress and human rights. In mid 2009 conciliation between the parties was finally reached.

DFAT agreed to:

1. A complete unreserved written apology to Stefanie for the way she had been treated.

2. The restoration of the right for people going abroad for sex realignment surgery to be given a passport in their appropriate sex and/or gender.

3. The recognition that some people who are intersex, transexed, transsexual, transgendered or any of the other sex and gender diverse identities may not be candidates for genital surgery. They may, however, live in their preferred sex and/or gender roles.

4. That such people upon presentation of a letter from a medical professional would be able to obtain a permanent passport in the appropriate sex and/or gender. Not all people are able to change their birth certificates or cardinal documents to reflect their identity. Each case would be considered on a cases by case basis.

5. That the phrase "medical professional" would be interpreted as meaning a general practitioner, gynaecologist, endocrinologist, urologist, psychiatrist, psychotherapist, counsellor, sexologist or social worker; in accordance with international standards of care for helping sex and gender diverse people.

6. An alteration to DFAT's training material for employees that lumped all sex and gender diverse people under the umbrella term "transgender", whichis offensive to many sex and gender diverse people. They were to change their terminology to address sex and gender diverse people's needs and allow those people to identify as they needed under the Sex and Gender Diverse label without discrimination.

7. The removal of an offensive training handout to DFAT employees that gave wrong and misleading information about sex, gender and sexually diverse people.

8. That people presenting with no sex or gender on their cardinal documents may be considered for a passport that does not state sex or gender. This clears the way for parents of intersex children who do not want to be forced into registering their children as male or female when that child may be neither or both. Some adults identify as neuter and wish their documents to reflect that status.

Stefanie wishes to thank AHRC for its part in brokering the conciliation, DFAT for adjusting its position to afford equal human rights and appropriate passports to all sex and gender diverse people, and to SAGE for its assistance in bringing the case before AHRC, and Dr Tracie O'Keefe DCH, ND, for her assistance in helping Stefanie bring the case.

This article has been reprinted with permission from the web page of SAGE (www.sageaustralia.org). We thank them for allowing its reproduction. It has been lightly edited. KC

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

Aude Chalon

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

aud_mmsh@hotmail.com

Support Services Pages

(and some ads)

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:
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Gaye 9569 2366

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 management of problem hair or chronic hirsutism

The CCTGS operates Monday to Saturday 10am to 10pm

Tel: 0404 054 000 **Email: *smh101@exemail.com.au***

Katherine's Diary; the story of a transsexual, revamped, updated, uncut.

Originally published in 1992, this new edition has been updated to December 2007 and includes a lot of added material from the earlier years. 428pp., (32pp in colour). A$35.00 +$10.00 post.

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Faculty of Health Sciences

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Are you a professional who works with transgender clients?

If so, would you like to take part in an important research study on the needs of variant children and their parents?

Elizabeth Anne Riley, in conjunction with the Universityof Sydney, is doing her PhD and conducting the research titled:

Gender Variant Children: Views of Professionals, Parents and Transgender Adults [Ref.no. 11203]

If you would liketo take part, or would like more information about this survey, visit

www.fhs.usyd.au/sexual health

This is an international survey, please pass it on to anyone who may be interested.

Sex, Gender & Sexuality Clinic

Director: Dr Tracie O'Keefe DCH, ND

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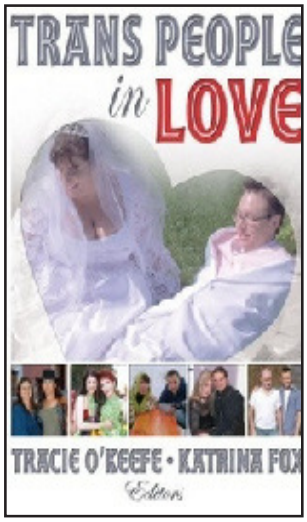

"Compelling in freshness."
- Del LaGrace Volcano

"The genius of the editors is in capturing these different visions."
- Christine Burns, VP of Press for Change, UK

"A rich and varied array of informative and provocative stories of relationships."
- Jamision Green

"Do not neglect this book."
- Professor A.W. Steinbeck

An anthology of real-life stories by trans people of their experiences of being in love

Contributors include Sydney legend 'Carmen' and a foreword by Kate Bornstein & Barbara Carrellas

Published by Routledge, 2008
(In stock at The Bookshop and the Feminist Bookshop in Sydney, and at Hares & Hyenas in Melbourne).

Still available: *Finding the Real Me: True Tales of Sex & Gender Diversity*, eds: Tracie O'Keefe & Katrina Fox

TRAINING!

Training courses have been offered throughout 2007-09 including Makeup, Hotel Worker, Workplace Hygiene Certificate and Senior First Aid Certificate.

Little interest has been shown and these courses have been poorly attended.

What courses **would** you like to see offered in 2010?

Please contact Liz on 9569 2366 or email

casemanagement@gendercentre.org.au

Gender Centre Library

To borrow books you will need to become a member of the Library. You will need to supply personal details (phone number, address etc.) You can make an appointment to join and see the Library by phoning 9569 2366 on Monday or Wednesday. Ask for the Resource Worker.

Video tapes are not for loan but can be viewed, by appointment, in the Gender Centre.

The Library is now housed in the Reception Area of the Gender Centre.

Books may be borrowed for 3 weeks

If you are isolated for any reason and would like to have material mailed to you, please let the Resource Worker know. Don't forget to include your mailing address!

Change of mailing list?

different **Gender**?
different **Address**?
different **Name**?
no more *Polares* thanks?

Mail to:

Polare - The Editor
The Gender Centre Inc
PO Box 266
Petersham
NSW 2049

All **my OLD details**

_____
_____
_____
_____
_____

All my NEW details

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Young and Transgender? 20-35 years?

Whether you're a verified gender outlaw or just gender questioning and want to find some like-minded travellers ... why not come along, trade questions, answers, thoughts and support.....

A discussion group will be forming soon, but we need people to sign up in advance so that the programme can be properly planned. For more information call Dash on 9569 2366.

IAAF WILL PAY MEDICAL BILLS FOR CASTER SEMENYA

The International Association of Athletics Federations has offered to pay for any remedial surgery Caster Semenya may decide to undertake, if the tests carried out indicate that such a course would be to her benefit, and possibly lessen the risk of testicular cancer. They are also reported to have decided that whatever the outcome of her tests, Semenya will be allowed to keep the goldmedal she won in the 800 metres race at the recent world championships in Berlin


Caster Semenya

SEX-CHANGE LESBIAN ALLOWED TO BE LEGAL FATHER OF HER BIOLOGICAL CHILD

A woman who is living in a lesbian relationship following sex affirmation has been recognised as legal father of the couple's child. Brigitte was born Bernd and deposited sperm before undergoing sex affirmation surgery. The sperm was used to impregnate her lesbian partner. Brigitte has been identified on the birth certificate as Bernd to avoid speculation and prevent the possibility of revealing that one of the parents is transgendered.

MTF SPORTSWRITER MIKE PENNER COMMITS SUICIDE

Sportswriter Mike Penner, for a time known as Christine Daniels, apparently committed suicide in November 2009.

She announced her revised status from male to female in the North American Spring of 2007.


Christine Daniels

She wrote at the time, " I am a transsexual sports-writer. It has taken more than forty years, a million tears and hundreds of hours of soul-wrenching therapy for me to work up the courage to type those words. I realise many readers and colleagues and friends will be shocked to read them." Late in 2008 she made a decision to de-transition back to being Mike Penner. There has been an outpouring of sympathy and empathy for the well-liked sportswriter but it is not known why he committed suicide and it is not certain that the act was transgender-related.

THAI STUDENTS MAY CROSS-DRESS, EXCEOPT FOR GRADUATION

Katoey students at the Thai Rajabhat Institutes, will not be allowed to wear dresses or female uniform to their Commencement (Graduation) ceremonies. Although the rector of the Thai Chamber of Commerce University said that dress regulations at many universities permitted cross-dressing he felt that it was inappropriate for Commencement, whtihc is royally sponsored at State-run universities. Siroj Polpanthin, rector of Suan Dusit Rajabhat University said that if the request had been granted, female students might want to wear male clothing.

MORE THAN 700 SWEDISH TRANSGENDERS ON RECORD

Sixty people applied in 2009 to change their sex in Sweden, bringing the known total to around 700. Most have changed from male to female. A study of post-operative transgenders showed that nearly all had a better life five years after affirmation surgery than they had had before.

MELBOURNE PHOTOGRAPHER WINS AWARD FOR STUDY OF SISTAGIRL

Bindi Cole, Melbourne photographer, has won the $25,000 Deadly Art Award for her portrait of Ajay, a Tiwi Island sistagirl (an indigenous term roughly translated as transgender).

GENDER GENE IDENTIFIED

A gene labelled FOXL1 has been identified as potentially holding a key to easier gender reassignment. When the gene was turned off in laboratory mice the ovaries of emale mice developed into testes. Scientists are now tring to find the MTF equivalent gene. Ovary cells began changing within forty-eight hours of the gene being switched off.Although the end result would be a change in hormonal supplies, it is likely that the subjects will be infertile.

The New South Wales Gender Centre

Presents

The 2010 SydneyTransgender Film Festival

Trans on Film

At the Sydney Mechanics' School of Arts
280 Pitt Street, Sydney
Saturday, February 20, 2010, starting at 11.15 am

L'ORDRE DES MOTS/BINDING WORDS. Documentary. 75 minutes. Self-produced by Cynthia Arra and Melissa Arra. Subtitled in English.
This film addresses gender identity issues by questioning our societal norms and analysing the nature of the oppression and repression faced by the Trans and Intersex communities

11.15 am to 12.30 pm

12.45 pm to 1.45 pm

SCREAMING QUEENS; the riot at Compton's Cafeteria. Documentary. 57 minutes.
Directed by Victor Silverman and Susan Stryker. Award-winning film tells the little-known story of transgenders and transvestites fighting police harassment at Compton's Cafeteria in SanFrancisco in 1966, three years before the famous riot at the Stonewall Inn in NYC.

STILL BLACK; a portrait of black transmen

Documentary. 77 minutes. The stories of six thoughtful, eloquent and diverse transmen.

3.00 pm to 4.20 pm

4.35 pm to 5.45 pm

SHE'S A BOY I KNEW. Documentary 70 minutes.

Guaranteed to be the most compelling DIY, feel-good film, directed by a transsexual lesbian you've seen all year.

UNRAVELLING MICHELLE. Documentary. 83 minutes. Directed by Dan Shaffer. This is a feature-length diocumentary that delves headfirst into the highs and lows of Michelle's male-to-female metamorphosis, through the eyes of Michelle and those who've been closest to her during the process.

6.00 pm to 7.30 pm

7.45 pm to 9.22 pm

[End of day]

TRAINED IN THE WAYS OF MEN. Documentary. 97 minutes. Directed by Shelley Prevost.

In 2002, transgendered teenager, Gwen Araujo was severely beaten and strangled to death by four males. This eye-opening film uses interviews with Araujo family members and legal experts with footage from both trials (the first resulted in a hung jury).

Young People with Transsexualism – The Contemporary Australian Experience by Rachael Wallbank

Introduction and a Discussion about Language

When Katherine Cummings and I began discussing an article for this issue of *Polare*, Kate casually used the term "young transgenders"- which resulted in a lively discussion about language and terminology. Craig Andrews and I currently mentor and represent *True Colours (www.truecolours.org.au),* a group of young Australians who experience transsexualism, their parents, loved ones and supporters. So while Kate has her own opinions on language and terminology, our shared interest in language and the human rights of young people with transsexualism meant that she was happy for me to make a contribution to this issue which includes a critique of what I contend to be the vague and misleading term "transgender".

Conducting and appearing in the *Re Kevin* cases (circa 2000 - 2003)[1] had a number of impacts on me. Those cases introduced me to expert evidence concerning the sexual differentiation of the brain and hence the innate intersexual nature of both sexual identity and transsexualism. The explanation for transsexualism that posits that the predicament is an intersexual condition derived from the brain and balance of the individual's sexually differentiated features conflicting as to sexual identification still has no real competition and is now being supplemented and reinforced by genetic and other research.

The old saying "You are what you think" turns out to be true and there are certain things we think we are that we cannot change our minds about - including our sexual identity. This experience also resulted in a personal re-evaluation as I have since identified as a person who has experienced transsexualism as an "I" for intersex rather than "T" for Transgender.

I know that this reality upsets some people, particularly some in the political Intersex lobby, but the fact is that it is the only credible explanation medical science has to offer for transsexualism. The psychological disorder model explanation has never been credibly evidenced notwithstanding its support in the DSM IV.

But what does this discussion about language and terminology have to do with young people and, in particular, young people who experience transsexualism and their contemporary Australian experience? Well, as I hope to explain, just about everything - from their ability to have their affirmation of their innate sex recognised as legitimate to their access to timely treatment.

Why am I so critical of the widely accepted terms "male to female transsexual" and "female to male transsexual"? I fundamentally object to the assertion that when someone experiencing transexualism affirms his or her innate sex, they change or transition their sex or sexual identity. On the contrary, they affirm their innate sex or sexual identity. With the benefit of the finer potential of 'non-trans' language I can say, however, that such people in the act of such sex affirmation will most often change their gender expression or cultural expression of sex to bring it into conformity with their affirmed or innate sex. Note the need to distinguish biological from cultural matters here. If I conflate the different terms 'sex' and 'gender' I lose the ability to express fully the difference between innate biologically derived sex or sexual identity and the culturally and expected expression of that identity; gender. I deal with this issue in just about every case concerning transsexualism I have conducted in an effort to wrestle expert and other evidence into an understandable and unprejudiced terminology that will be consistent and understandable to judges.

Rachael Wallbank

It seems to me that out of both linguistic habit and as a result of a misplaced aversion to the word "sex", many people push the word "gender" too far; confusingly giving "gender", "gender identity". "assigned gender" and "innate gender" fundamentally different meanings notwithstanding the same root word.

If we go back to dictionary basics, we find that the primary definitions of "sex" indicate the biologically determined sexual dichotomy referred to as "male" and "female", while "gender" means a form of culturally interpreted classification relating to, but different from, sex. Properly construed, the 'sex terms' are "male".female" and "intersex". 'gender terms' are "masculine", "feminine" and "neuter".

The need 'trans-language' has to replace the 'gender terms' - "masculine/feminine" with the sex terms "male/female" shows that in trying to stretch and distort the word "gender" to do the linguistic work of both the words "sex" and "gender", it actually robs both "sex" and "gender" of their full traditional meanings and linguistic potential to describe respectively and distinctly the phenomena biological diversity and diversity in gender expression. "MtF/FtM" terminology has nothing to do with gender or gender meaning words such as "masculine", "feminine" and "neuter". "MtF/Ftm" terminology was established in order to refer to a "change of a person's sex through genital reassignment surgery". Way back when, when scientists and clinicians first employed the terms "male to female transsexual" and "female to male transsexual" they were making a quasi-biological

1. Full case references and a detailed discussion for this case can be found in the author's paper "Re Kevin in Perspective" published by Deakin University and accessible at *www.truecolour.org.au*.

statement based upon the now acknowledged fallacy that genital formation, and especially external genital formation, determines an individual's sex.

The hypothesis espoused by Dr Money, exposed as false by Professor Diamond and others in what came to be known as the "Joan/John" case, was that a person's sexual identity was malleable rather than innate and fixed. Accordingly, if one surgically revised the genitalia of a person from more or less one sex to the other and had the person live in accord with his or her culture's gender expectations of people who possessed the sex usually associated the revised genitalia, the person's sexual identity would eventually change to become that sex. Countless numbers of infants born with intersexually formed genitalia have suffered terribly, and been obliged to experience a form of transsexualism, as a result of receiving medical treatment in infancy based on this erroneous hypothesis.

So the term "MtF", for example, is founded upon the proposition that a person so described was male and has been more or less changed to female. The medical or scientific basis relied upon for that proposition is that "male" should be assigned to those with a clearly male genital formation, "female" to those with a clearly female genital formation and "intersex" to a sexually mixed or unclear genital formation . No other biological sex indicators are taken into account, and no consideration is given to intersexual diversity other than that genitally indicated.

In communicating how people who experience the predicament of transsexualism actually experience Sex Affirmation Treatment - as an affirmation of an unchanged innate sex or sexual identity and **not** a change of sex (and that therefore Sex Affirmation Treatment, including in adolescence, is therapeutic and essential) - I rely upon a huge amount of contemporary medical science and expert evidence that confirms that, of all the sexually differentiated parts of a human being, the only one that can't be changed, and which dominates a person's life, is the person's sexual identity or "brain-sex".

In this understanding of sex and sexual diversity, while genitalia are recognised as playing an extremely important role in a person's ability to live in accord with their sex or sexual identity, they do not determine a person's sex. The brain does.

Hence I say that "MtF/FtM" is prejudiced, inaccurate and genitocentric[2], focussed on the genitals as being the only or primary indicators of a person's sex - thus ignoring or devaluing chromosomal, hormonal and neurological brain sex insignia; because this is what is meant when a medical scientist or clinician uses these terms.

2. Meaning focused upon the genitals as being the only or primary indicators of a person's sex - thus ignoring or devaluing chromosomal, hormonal and neurological/brain sex insignia.

This is another indicator of the need for conscious consideration of the language used to refer to people who experience transsexualism and to people who express gender differently. I'm sure that in using "MtF/FtM" many have not been consciously seeking to reinforce the genitocentric prejudice inherent in such terminology; but that is the effect. Language is a powerful force for good and ill.

I coined and encourage the use of the terms "Affirmed Male/boy/son" and their female equivalents when referring to young people who experience transsexualism and who have affirmed their innate sex, in order to establish an alternative to the equivalent terms used by medical science and colloquially. Whereas some would say "Female to Male Transsexual/Transgender Person" or just "Girl or daughter" (solely based upon original genitalia) to describe a young person who had affirmed the male sex, I call that person an "Affirmed Male", "Affirmed Boy" or simply "son".

The old genitocentric terms such as "MtF" actually attack and subvert the proposition that transsexualism is an example of natural biological diversity in sexual formation and undermines the legitimacy of the sex affirmed by the person with transsexualism.

As reported by Dr Eric Vilain, paediatrician, Chief of Medical Genetics at the University of California USA in the ABC Radio National "The Health Report" broadcast on 14 March 2005:

> *Recent advances in the field of the genetics of sexual development have shown the extreme complexity of defining males and females from a biological standpoint. There is no one biological parameter that clearly defines sex. The second point is that there are differences between male and female brains very early in development. This suggests that the sexualization of the brain happens very early during embryonic life. The last point is that significant minorities of individuals are left out of simple civil rights because they don't fit established categories of sex.*

In their medico/legal article entitled "Ethical Concerns Related To Treating Gender Nonconformity In Childhood And Adolescence: Lessons From The Family Court Of Australia", learned authors Milton Diamond, Ph.D., University of Hawaii, John A. Burns School of Medicine and Hazel Beh, Ph.D., J.D., University of Hawaii, William S. Richardson School of Law, indicate just how far science has now outstripped our common cultural sense or awareness of the determination of an individual's sex:

> *Most commonly a person's sex is evaluated based on chromosomes, gonads, hormonal levels, internal genitalia, external genital appearance, and social lifestyle. With increasing*

> *sophistication and knowledge, however, more factors are being identified so that a final resolution on a person's "sex" can also involve different gene constellations as well as brain sex.*[3]

The *Re Kevin* cases required that I answer the challenge of trying to communicate my client husband's personal experience of being a male experiencing transsexualism and the broader experience of that phenomenon to the judges (and later the media) involved in the face of the cultural and expert mystification of that experience. Barrister Teresa Anderson and I came to believe early in the case that our client husband and his wife had very little chance of overcoming the powerful UK *Corbett*[4] case authority (which basically said that transsexualism was a kind of mental illness and that the derived claimed sexual identity was not a legitimate one) and being declared to be a man for the purposes of the Common Law of Australia and entitled to legally marry as such, if we permitted our client to be referred to as a "Female to Male Transsexual (Person)", "a transsexual" or "a trans-man" or allowed his state of being to be confused with those people who are fundamentally comfortable with their sexually differentiated bodies (and their sexual identity) but who use dress and minor bodily alterations to express gender in a culturally surprising or diverse way.

In answer to this challenge, and as "Kevin" had undergone sufficient internal genital surgery to be accepted at the time as having undergone Genital Reassignment Surgery ("GRS"), I came up with "Man of Transsexual Background" on the basis of the expectation that, at worst, this ungainly term was educational and, at best, the parties and the court would, over time and with the impetus of evidence and argument, just call him "a man" and let him get married as such. Fortunately, this is what took place.

This appreciation of the power of language to overcome expert and cultural prejudice led to the creation of a new language, which I called Affirmative Language[5], to describe the experience of diversity in sexual formation.

My first attempt to publish a short dictionary of Affirmative Language was in my paper with the ungainly title *The Legal Environment Following Re Kevin: New Perceptions And Strategies For Effective Law Reform In Respect Of The Legal Rights Of People Who Experience Variation In Human Sexual Formation And Expression*[6] delivered at the NSW Anti-Discrimination Board's March 2003 Neglected Communities Forum event. From the start, people living with transsexualism, as well as people who experienced other forms of diversity in sexual formation, welcomed this new terminology that honoured their reality and spoke of their experience with some clarity. I am pleased to say that that the use of Affirmative Language has continued to grow exponentially since then. It was extensively used by the Australian Human Rights Commission in its recently (and regrettably titled) *Sex Files*[7] report as well as by the Chief Justice of the Family Court of Australia, Diana Bryant, in her 2009 Costello Lecture entitled "It's My Body Isn't It? Children, Medical Treatment and Human Rights"[8].

Issues of sexual formation and gender expression are fundamentally different and have clearly different medico-legal interests and needs; especially for the young.

Adapting the World Health Organisation definition, I define "transsexualism" as:

> *The experience of knowing oneself as being of the sex (the "affirmed sex")* [9] *opposite to the sex to which one has been assigned, accompanied by a pervasive and sustained discomfort with one's anatomical sex causing distress and a need to live and be accepted as a member of the affirmed sex accompanied by a need to have surgery and hormonal treatment to make one's body as congruent as medically possible, having due regard to the practicality and safety of available medical treatment, with one's affirmed sex.*

In other words, the person experiencing transsexualism experiences him/herself as being of one sex, while his/her body functions and classifies him/her as if he/she is of the other sex, experiences critical discomfort as a result and would undergo every reasonably safe medical procedure financially within his or her means in order to attain full personal physical function and social interaction consistent with that experienced sex.

While it may once have been effective and even necessary for people who experience diversity in sexual formation and those who experience diversity in gender expression to express themselves culturally as one united 'community' (including forming a loose form of community with the Gay, Lesbian and Bisexual community as in "GLBT" and "GLBTI"), in order to get a cultural voice and be culturally heard, there was always a discomfort to these ungainly

3. (2005) Diamond and Beh, "Ethical Concerns Related to Treating Gender Nonconformity in Childhood and Adolescence: Lessons from the Family Court of Australia. *Case School of Law Journal of Law-Medicine. 15.2.240 footnote 2*

4. *Ibid.*

5. An up-to-date version of Affirmative Language with a critique of 'trans-language' can be accessed at *www.truecolours.org.au*

6. At *www. wallbanks.com*

7. At *www.humanrights.gove.au/genderdiversity/sex_files2009.html*

8. Both the text and and audio version of this lecture can be accessed at *www.truecolours.org.au*

9. "affirmed sex", where "sex" indicates a person's "innate sexual identity" (also sometimes called gender identity) and not a person's sexuality or object of sexual attraction.

associations and a considerable price to be paid in terms of the mystification of the truth of the disparate predicaments, needs and interests of these diverse groups.

As I argued at last year's Gender Centre Debate, the cultural evolution of transsexualism (and pan/trans-gender expression for that matter) is at a point of maturity when these phenomena need separate voices as the need for cultural clarity has outgrown the need for numbers. This issue deserves a paper of its own.

It's time that the human right to express gender in a diverse way was expressed with clarity, incorporating such voluntary body changes and other personal art as the individual shall choose from time to time, without the need to prove any particular medical condition and without the need to fit into any cultural 'box' or category.

It is difficult to advocate for the right of people generally to express gender in a diverse way (including trans-gender expression) without the need for any medical diagnosis or classification while confusing the subject of the advocacy with people who have the condition of transsexualism. Worse still is the sometimes horrific harm done when a person who merely seeks to express queer, pan or trans-gender, perhaps through a need to seek some kind of legitimacy in a medical diagnosis through the mimicking of symptoms, or through misunderstanding, receives Sex Affirmation Treatment when he/she should not.

Thankfully, this error has been virtually eliminated in the accepted medical protocol (the "Dutch Protocol" - to be discussed later) approved by WPATH and almost universally applied to the treatment of young people with transsexualism where a number of strategies are in place to make sure that young people who are truly pan or transgender, or who are merely unsure or confused as to their sexual identity, do not receive treatment. A similar protocol should apply to adults, but with both treatment protocols administered by endocrinologists as the primary treating physician.

It is also much harder, for example, to convince the Commonwealth and State Governments of the critical need people who experience transsexualism, and especially those on the verge of adolescence, have to receive publicly funded Sex Affirmation Treatment when such people are confused with those with gender expression issues. This is a critical human rights issue as, in the absence of receiving Sex Affirmation Treatment, many such young people who experience transsexualism self-harm or self-destruct.

The fact is that people who experience transsexualism are not likely to be recognised by government in Australia and receive publicly funded Sex Affirmation Treatment (as they do in the United Kingdom) when such people are referred to as "Transgender" while another group of people, also referred to and referring to themselves as "Transgender" say to the media and at public forums that, for them, such treatment is wholly or partly unnecessary or optional. Witness the Australian Human Rights Commission recently prioritising documentary/identity issues above medical treatment issues for the Australians they identified as being "Sex and Gender Diverse".

This situation also creates a mistaken perception that young people who experience transsexualism are an extreme example on some kind of misconceived continuum of "transgender youth"; who can perhaps be moderated with psychiatric 'treatment'.

I note that it also suits a number of clinicians to be able to 'treat' a greater number of people (including young people) under the imprecise GID[10] differential diagnosis and under the umbrella "Transgender" label than they would be legally permitted to do if they were obliged to differentially diagnose and distinguish transsexualism. Under the terms of the present misleading and broad DSM IV *GID* malaise those clinicians concerned to make a proper differential diagnosis of adolescent transsexualism are obliged to make up their own confusingly hybrid terms such as "Extreme GID" and "GID Transsexual Type."[11]

Once upon a time, as soon as I raised issues such as these, I could almost hear the howls of accusations of transsexual superiority/separateness and the lynching mob in motion! This is understandable in a country like Australia where Sex Affirmation Treatment, and especially quality GRS, is hard to obtain and only available to those who can afford it. It is also understandable amongst professionals in the sociological and psychiatric communities who have established their reputations and practices on sexual identity through the nurture/flexible (feminist) "Gender Theory" approach to this field and/or the mental illness model for transsexualism and diverse gender expression.

Now, with more sophistication in both research and discussion being introduced to the field, a much more mature approach is possible. "Cross-Dressing" and other forms of pan/trans-gender expression are no longer vilified so much by the culture so that the original term 'transgender', with its specific meaning relating to diversity in gender expression, can be reinvigorated and culturally distinguished from transsexualism. So too, mature and intelligent advocacy can be undertaken for public funding/subsidy of Sex Affirmation Treatment (including GRS) through Medicare for people who experience transsexualism of as an essential therapeutic medical treatment; free of the implication that

10. "Gender Identity Disorder" (GID) in the *Diagnostic and Statistical Manual of Mental Disorders. 4th ed. (DSM-IV)* published by the American Psychiatric Association.

11. Vigorous representation are being made through the World Professional Association for Transgender Health (WPATH) and directly to the American Psychiatric Association to have GID removed from the DSM-V, or at least, transsexualism and pan/transgender expression removed fromthe DSM-V. The more support the better - so make your contribution to the debate.

such treatment is optional and an over-reaction to a psychological illness.

Numbers/Prevalence

While each individual is precious, numbers are important to politicians and dictate health policy.

It is difficult to estimate the number of people living with transsexualism in Australia; let alone those under eighteen years of age whom I will term "young". The Australian Bureau of Statistics (ABS) says that there were 21,875,000 Australians as of 30 June 2009. Based upon an extrapolation and a rounding up of the ABS figures and those of the United Nations it is reasonable to estimate the current number of Australians eighteen years or younger at approximately 5,400,000.

I use eighteen years of age as the benchmark for the term "young" as that is in accord with the use made of that word in the Family Court of Australia and as it is a turning point for civil and human rights. Prior to attaining eighteen years of age, Australians with transsexualism cannot legally access GRS and are consequently unable to alter their legal sex and are denied a congruent and accurate legal identity post sex affirmation; with all the contemporary dangerous implications entailed. Until they turn eighteen, neither these young Australians, nor their parents on their behalf, can access the essential and reversible Adolescent Sex Affirmation Treatment without an Order of the Family Court of Australia or, in some circumstances, a State Supreme Court, as a result of the well-meaning, but in my view incorrectly decided, decision in the 2004 Family Court case called *Re Alex*[12] - with all the stress, expense, dangerous delay and opportunity for error that process of delay involves.

Typical cited prevalence numbers for transsexualism as published by Bakker and Others in 1993[13] and adopted by WPATH are 1 in 11,900 for Affirmed Females [AF][14] and 1 in 30,400 for Affirmed Males [AM].

Since about 2001, these statistics have been challenged by a number of researchers; but most stridently by Lyn Conway. I am indebted to the 6 September 2007 paper entitled *On the Calculation of the Prevalence of Transsexualism*[15] published and presented by Lynn Conway and Femke Olyslager for a detailed and rather complex discussion of the prevalence of transsexualism and how it has been, and perhaps should be, assessed. In a nutshell, Conway and Olyslager argue that the fact that prevalence assessment has been producing a greater rate of prevalence year by year has to be explained. The fact is that throughout the world, including even developed countries, many people with transsexualism experience severe psychological suffering in shamed silence without anyone (sometimes including the sufferer) ever knowing that they experience transsexualism and a successful treatment is available. Some die that way.

Even if a person publicly affirms his/her innate sex and is able to seek help and obtain a diagnosis, such a person is often unable for legal, religious, personal or financial reasons to access full Sex Affirmation Treatment; including GRS. Thus, the traditionally widely accepted statistics, based upon the number of GRS procedures performed in a given population, do not actually report the prevalence of transsexualism at all. Conway and Olyslager, applying the results of more contemporary methods of assessment conclude:

> "*…the lower-bounds on the prevalence of the underlying condition of transsexualism to be between 1:1000* [AF] *and 1:2000* [AM]*, using those reports' own data.*"

Moreover, these authors postulate that by using

> "*… recent incidence data and alternative methods for estimating the prevalence of transsexualism, all of which indicate that the lower bound on the prevalence of transsexualism is at least 1:500* [for both affirmed sexes]*, and possibly higher.*"

While I have not evaluated their calculations and resultant statistics, I agree with Conway and Olyslager that the accepted incidence statistics are simply wrong and fail to account for observable facts. For example, *True Colours* has new parents joining regularly from all States of Australia.

As transsexualism is innate and you can't catch it or acquire it, the actual numbers and the steady and significant increase in the number of young people with transsexualism in Australia as compared to prior generations, I postulate that it is best understood in terms of its being the result of greater cultural and parental understanding and support for difference and diversity generally; and diversity in sexual formation in particular. Fewer children are trying to live in stealth.

Thus, if one applied Conway and Olyslager's more conservative prevalence rate for transsexualism based upon past data methods applicable for affirmed females (1:1,000) to the Australian population and applied it to both sexes, the result is that as at 30 June 2009 out of a population

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12. *Re Alex - Hormonal Treatment for Gender Identity Dysphoria* 2004 31 Fam LR 503

13. (1993) A. Bakker, P.J.M. van Kesteren, L.J. G. Gooren and P.D. Bezemer. "The prevalence of transsexualism in the Netherlands" *Acta Psychiatrica Scandinavica, v. 87, pp 237-238.*

14. Square brackets show material has been inserted by the author of this article.

15. Presented at the WPATH 20th International Symposium, Chicago, Illinois, September 5-8, 2007.

of 21,875,000 Australians of all ages there are likely to be 21,875 Australians who are currently experiencing transsexualism. I note that Conway and Olyslager postulate that about double the number of people who experience transsexualism in any population are likely to exhibit a preference for pan/trans-gender expression. If the current number of Australians eighteen years or younger is approximately 5,400,000, that is approximately 25% of the total population, then this rate of prevalence indicates that there are likely to be approximately 5,469 Australians eighteen years and younger who are experiencing transsexualism at this time.

Time will tell. I expect that we will continue to see the number of unexplained self-harming events and suicides (especially amongst the young) shrink as the number reporting the experience of transsexualism and accessing timely Sex Affirmation Treatment increases.

Adolescent Sex Affirmation Treatment

So what is Sex Affirmation Treatment in adolescence?

The medical protocol accepted and applied in Australia for the medical treatment of adolescents with transsexualism is the internationally accepted and adopted treatment guidelines of WPATH *Standards of Care for Gender Identity Disorders*[16] which reflects the protocol established by the Dutch clinicians, Professor Doctors P.T. Cohen-Kettenis and H. Delemarre-van de Waal at the VU University Medical Centre, Amsterdam, the Netherlands. This treatment protocol consists of two Phases of Treatment during adolescence. The First (diagnostic) Phase of treatment, commences at approximately Tanner Stage 2 (the onset) of physical puberty, during which physical puberty is postponed using hormonal medication while supportive counselling and confirmatory diagnosis takes place ("Phase One Treatment").

The Second Phase of treatment, commencing after the ultimate diagnosis is completed at about mid-adolescence (or by about sixteen years of age) continues Phase One Treatment (including psychological support) while introducing other hormonal medication for the purpose of inducing the development of age-appropriate secondary sexual characteristics consistent with the treated adolescent's Affirmed Sex ("Phase 2 Treatment"); collectively ("medical treatment for adolescent transsexualism").

The Deplorable Impact of the Family Law Act and *Re Alex* On Access to Therapeutic Medical Treatment

I was fortunate to appear for the parents of the first young Australian to receive full (both Phase 1 and 2) Adolescent Sex Affirmation Treatment.

Although the circumstances of a pending decision, as well as the already well-stretched constraints of this essay, prevent me from fully exploring the current Australian legal issues concerning that medical treatment, I can relate that the expert evidence currently available to Australian courts can be summarised as follows:

- Ø The adolescent diagnosis of GID indicates the condition of transsexualism in adolescence and adulthood;
- Ø The differential diagnosis of adolescent transsexualism is reliably made; with other phenomena such as mental illness, confusion and/or discomfort as to gender or sexual identity (called "gender dysphoria" to distinguish it from GID/transsexualism), homosexuality and gender non-conformity easily diagnostically distinguished applying the DSMIV criteria for GID and the WPATH Standards of Care.
- Ø The reliable differential diagnosis of adolescent transsexualism is not primarily dependent upon the individual circumstances, maturity or decision-making capacity of the individual adolescent, but rather the clarity, consistency and longevity of an adolescent's affirmation of a sex opposite to the adolescent's first assigned sex;
- Ø The experts agree with the findings of Chisholm J in *Re Kevin* concerning the aetiology or causation of transsexualism; with the most likely explanation for the phenomenon of transsexualism being that it is a biological or physiological phenomenon whereby a human being experiences an intersexual brain/body sexual differentiation resulting in the experience of discontinuity of sexual identity between an individual's mind and body;
- Ø The only appropriate and effective treatment for adolescent transsexualism is to bring the individual's body into sexual harmony with the individual's mind by way of medical treatment for adolescent transsexualism incorporating Phase 1 and Phase 2 Sex Affirmation Treatment.

16. The World Professional Association for Transgender Health (WPATH). *www.wpath.org/publications_standards.cfm*

- Ø Both Phases 1 and 2 of Sex Affirmation Treatment are properly characterised as directly and personally therapeutic and administered for the purpose of treating a malfunction or ameliorating the dysfunction in and of the person of the patient. In circumstances where diagnostic Phase 1 of that treatment is professionally administered, there is no possibility of parent/guardian/child conflict of interest or intent.
- Ø Phase 1 and Phase 2 Sex Affirmation Treatment are different and separate non–invasive and non-surgical medical treatments administered for different specific purposes with different consequences and cannot be conceptually conflated;
- Ø All of the known consequences of Phase 1 and Phase 2 Sex Affirmation Treatment are reversible; naturally on the cessation of treatment as to Phase 1 Treatment and naturally and surgically as to Phase 2 Treatment;
- Ø Permanent irreversible infertility is not a known or expected result of the administration of either of Phase 1 or Phase 2 Sex Affirmation Treatment - or both treatments in combination from mid-adolescence until early adulthood;
- Ø The denial of Phase 1 and Phase 2 Sex Affirmation Treatment to adolescents with transsexualism has certain dire personal, family and cultural consequences – including a significant risk of the self-harm and/or death of adolescents by suicide;
- Ø All adolescents living with transsexualism around the world share the same condition and experience the same effects from the provision or denial of Sex Affirmation Treatment;
- Ø The Dutch clinicians, Professor Doctors P.T. Cohen-Kettenis and H. Delemarre-van de Waal at the VU University Medical Centre, Amsterdam, The Netherlands, have now carried out a Longitudinal Study of almost 100 consecutive adolescent patients who have received Sex Affirmation Treatment and there is yet to be a case of misdiagnosis or regret as a result of their conservative yet complete treatment protocol.

Then how could a decision like *Re Alex* come about? In my view, the error in the decision in *Re Alex,* which classified Adolescent Sex Affirmation Treatment as a "special medical procedure" requiring court approval, came about for the following main reasons:

1. The state of local medical expertise given as evidence at the time failed adequately to distinguish transsexualism in childhood and adolescence from conditions of mental disorder, illness, confusion or transgender expression combined with a failure to adduce the best international expert advice available;
2. There was an utter absence of adequate legal submission since the parties to the case seemed simply to acquiesce to the Applicant Government Department's desire to divest itself of its responsibilities for Alex and his medical treatment by transferring that responsibility to the Family Court;
3. Factors 1 and 2 were combined with the use by both experts and lawyers of a blend of 'trans' and genicentric language to produce new words and terms such as "Gender Identity Dysphoria" and a perception of adolescent transsexualim as a mental illness - where treatment was seen only as a panacea for the worst affected individuals - and not an essential therapeutic medical treatment to be accessed as a right.
4. In these circumstances an incorrect application of the High Court's opinion in *Marion's Case*[17] resulting in Adolescent Sex Affirmation Treatment being classified as a "*special medical procedure*", like the non-therapeutic sterilisation of a mentally disabled adolescent - when it is, in fact, a singularly therapeutic, conservative and comparatively safely administered medical treatment. When it is denied to a young person with transsexualism on the verge of puberty there are both short and long term risks of permanent psychological damage, self harm and diminution of life.

The wrong of the *Re Alex* decision is demonstrated by the fact that every day throughout Australia adolescents with intersexual conditions (other than transsexualism) receive precisely the same hormonal medications for precisely the same therapeutic purposes as in Sex Affirmation Treatment without that treatment being classified as a "special medical procedure". And those young Australians receive that crucial, time-developmentally-critical medical treatment without their parents having to first undertake the huge task of obtaining an Order of the Family Court of Australia.

Until it is formally recognised as error and set aside by government legislative action or court decision, it seems

17. *SMB and JWB; Secretary, Department of Health and Community Services [sic] (Re Marion) (1992) 175.CLR 218/*

to me the direct and natural continuing consequence of the *Re Alex* decision is that young Australians who experience the life-threatening and disabling condition of transsexualism and who, as they enter adolescence, should be receiving the clearly safe, successful and therapeutic medical treatment that is Sex Affirmation Treatment, will not, and they will suffer needlessly as a result.

Against this tragic legal background, however, there are decisions pending that may cut short the terrible ongoing implications of the *Re Alex* decision and anyone reading the 2009 Costello Lecture delivered by the current Chief Justice of the Family Court of Australia, Diana Bryant, entitled "It's My Body Isn't It? Children, Medical Treatment and Human Rights."[18] has to be optimistic that, whatever the result of any one case, humane reform to avert the worst ongoing affects of the *Re Alex* decision will come sooner rather than later. In the meantime, I know of no other country in the world that has made the access of young people with transsexualism subject to a system of court authorisation similar to that now existing in Australia after *Re Alex*.

The Contemporary Australian Scene

Young people with transsexualism in contemporary Australia face huge challenges accessing medical treatment.

Those who are blessed with a secure enough environment and supportive parents, simply announce to the world their innate sex beginning as soon as they are cognitively able to grasp and express the difference between the sexes; usually between four and ten years of age.

And as reported by Dr. William Reiner, child psychiatrist, University of Oklahoma Health Sciences Center in the ABC Radio National "The Health Report" broadcast on 14 March 2005:

> *And what I began to realise very early on is that in order to discover who or what a child is or for that matter who or what an adult is you have to ask them...I have a six year old [patient] , two seven year olds, (and) two eight year olds who spontaneously declare it*. [a sex different from that assigned based upon genitalia]. *They say "I'm a boy and I don't know how you could not know that..." and sometimes they'll start just saying "My name is Bob..."*

Unfortunately, if that trusting revelation of fundamental innate identity is met with dismissal, ridicule or other form of emotional or physical violence, then dissociation and stealth, with all their long lasting harmful side-effects, become the only survival tools available for young ones in this predicament.

There is also the predicament of young people with transsexualism whose affirmation of sexual identity is supported by their parents, but who then find it hard to gain medical help and/or acceptance for their child within school environments. While this situation is improving rapidly - due to the number of parents doggedly pursuing the rights of their children to live according to their affirmed sex - given prevalence numbers there are many more young people who have not been prepared or able to risk seeking parental help and support and who live their affirmed sex in secrecy if not shame.

Saddest of all to me, however, is the case of those young people with transsexualism and their families who end up in the care of support groups, local doctors, counselling centres, psychologists and psychiatrists who, while genuinely believing they are competent to help, are not even competent to advise these young people and their parents/carers of the existence and availability of Sex Affirmation Treatment.

I do not look forward to the next conversation I am obliged to have with a good loving parent who found out about the Phase 1 puberty-suspending aspect of Sex Affirmation Treatment when it was too late for their child to benefit from it. These parents grieve with their adolescent child as he or she struggles to live with that missed opportunity and with the life-long disability of a body that has already undergone a physical puberty utterly at odds with the adolescent's sexual identity. Such conversations are often characterised by the suffering, social isolation and self-harming of the children and the distress of the parents who are full of a remorse, guilt and that special anger reserved for misplaced trust.

As with almost everyone of my generation, my affirmation of my femaleness to my parents in childhood turned out, even with a referral to a psychiatrist, to be futile. I went underground and survived in a world without the Internet, in shame and secrecy and utter dissociation. I, along with many others, can only imagine how things might have been if I had been able to receive Adolescent Sex Affirmation Treatment. Such is life - as they say.

Ultimately, I have found that thinking about young people with transsexualism and considering their contemporary reactions to Sex Affirmation, family and the provision or denial of Sex Affirmation Treatment, helps me to better discover who I am and where I've been.

At *True Colours* [See the Directory p.42. Ed.] we can provide referral to expert medical practitioners for Adolescent Sex Affirmation Treatment. We hope to encourage more medical practitioners and psychologists to fully investigate and gain a thorough expertise this field of practice and to provide for the education of medicine, law and culture in Australia concerning the reality and needs of young people with transsexualism as well as their parents/carers and families.❑

18. Op cit; footnote 8.

QUEENSLAND GENDER CENTRE

The Queensland Gender Centre is run solely by a transsexual 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 email the Queensland Gender Centre (see p.40 for contact details).

PLEASE READ THIS!

If you are moving, please tell us your new address. Undeliverable issues of *Polare* waste money that could be used for other services.

The Gender Centre has joined Twitter!!!

For those who don't know, Twitter is an Internet text-based social networking system a bit like SMS. Messages are restricted to 140 characters but if you want to keep up to date daily (or more frequently) with what is going on at the Gender Centre, you can do so on Twitter.

Go to the Internet, and type in *www.twitter.com/thegendercentre* to see the latest Twitter news. Note that this is one-way information. You can't respond or ask questions on Twitter. If you need further information you will need to phone (02) 9569 2366

or email *reception@gendercentre.org.au*

or *resources@gendercentre.org.au*.

LEGAL PROBLEMS?

The Inner City Legal Centre will be providing advice sessions for clients of the Gender Centre.

The ICLC can advise in the following areas:

family law | criminal matters | fines | AVOs | victim's compensation | employment | identity documents | police complaints | discrimination | domestic violence | sexual assault | complaints against government | powers of attorney | enduring guardianship | wills | driving offenses | credit and debt | neighbourhood disputes

Dates for 2010 have not been set but sessions will be held monthly. You can phone or email and ask to be given an appointment as early as possible. See below...

To make an appointment please contact a staff member of the Gender Centre on 9569 2366. Bookings are essential.

NEEDLE EXCHANGE

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PETERSHAM
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10am-5.30pm
Monday to Friday

A confidential free service for people with gender issues *(Ask for the Outreach Worker)*

Sharps Containers

Pill Filters
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Spoons
Water
Fit Packs
Swabs
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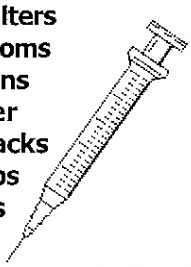

Syringes
1ml, 2.5ml, 5ml

Needles
21g, 23g, 25g, 26g

or phone the Alcohol and Drug Information 24 hr advice, information and referral service. Sydney
02 9331 2111
Country 009.42.2599

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6 - 8pm
Yummy food - New friends
- Free -
Friends/Family all welcome

7 Bent Street, Petersham

FTM Australia

2010

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.

This Australia-wide network is coordinated by Craig Andrews, with the input of members and guided by an ad-hoc Advisory Panel of health and legal specialists. We aim to inform the public of the issues surrounding transsexualism in men (*female-to-male*).

Newsletter

Our newsletter - Torque is published four times a year for the benefit of members, their families and service providers. Torque is available as a pdf document which is emailed to you or available on our website. All the information about Torque is on the website at www.ftmaustralia.org/resources/torque.html

OzGuys Discussion List

Our e-mail discussion list is called OzGuys.

OzGuys - is open to FTM Australia members living in Australia and New Zealand.

Goals of the discussion list include:

- To encourage friendships and information sharing amongst members
- To empower members and their families in understanding transsexualism
- To encourage members to adopt positive images of being men in society and achieve anything and everything they dream of.

For more information please visit
http://groups.yahoo.com/group/ozguys/
To find out more or read our resources please visit our website at www.ftmaustralia.org
We warmly welcome your interest in the network and hope to hear from you soon!

Australian Centre For Photography

Artist Talk

Rebecca Swan

Talking Shop

"There is a fine line between a powerful image and a sensational image; between honouring your subject and exploiting them for the shock factor."

Shane 1998 image by Rebecca Swan

New Zealand photographer Rebecca Swan discusses her powerful portraits of alternative gendered people.

6—8pm Thursday 4 March 2010

Tickets can be purchased at the door.

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The Young MTF Transsexual

by Annie Richards

This article discusses the treatment of transsexual boy-to-girl children. When allowed to, such children are almost always able to rapidly and successfully assimilate themselves into society as females. This alone is enough to differentiate them from transsexual women who transition when adult.

It is necessary to distinguish between *intersexed* infants, who in some cases are assigned a gender contrary to their genetic sex, and gender identity dysphoric (GID, aka transsexual) children. While very young intersexed infants have no say in their sex assignment or reassignment (which is usually done before they are twenty-four months old), transsexual children consciously reject the gender in which they are being brought up at some point between two years old and puberty.

Since the 1960's - when Dr John Money, a physician at Johns Hopkins University, made the medical community at least recognise transsexuality - there has been an ever increasing incidence of male-to-female (MTF) reported GID cases and requests for treatment across all age groups. However in recent years the growth in reported cases among teenagers, particularly boys, has been extraordinary. No one compiles official statistics on transgender youths, but everyone agrees that their numbers are rising very quickly. Undoubtedly this is partly the result of increased access to information. A child today with 'gender dysphoria' - the catch-all term for disconnect between body and gender identity, will almost certainly have heard about transsexuals by the time they reach the critical point of puberty. Many children with GID problems learn about transsexualism from TV shows and documentaries and then go on-line, looking up anything and everything they can find out about transsexuality, and start to chat and email with other transsexuals.

With the increasing awareness and more favourable publicity given to transsexualism, MTF children who in the past would have suppressed their female gender, or at least deferred dealing with it openly until reaching adulthood, are now coming forward while still children. In most cases their families respond positively and supportively, but occasions of outraged parents and internal family battles about how to deal with a would-be daughter will never cease completely.

Unfortunately there continues to be a reluctance in the medical profession to pro-actively treat gender identity disordered children, even when they are diagnosed as "core" or "true" transsexuals. However even the famous/notorious "*Standards of Care for Gender Identity Disorders*" (which very few medical professionals dare to defy) has now advanced slightly as regards young transsexuals as it reached it's sixth edition in 2001.

While recent trends are somewhat encouraging, young transsexuals (under twenty) seeking and obtaining medical help and treatment are still vastly outnumbered (ten or twenty to one?) by their older counterparts - most of whom bitterly regret their years of delay. Also, young transgirls tend to immediately go stealth after transition, and the girls referred to in this article are exceptionally brave about their transsexuality - or had little choice as they were outed by the media.

Sex Assignment

A person's sex can be determined or judged by many factors, including:

1. *Legal Sex:* In the UK the infamous ruling by Justice Ormrod, determined that this was the sex stated on the original birth certificate - although since 2004 the *Gender Recognition Bill* has overturned many aspects of this ruling.
2. *Hormonal Sex:* Based largely upon male type testosterone plasma levels, or female type oestrogen and progesterone plasma levels.
3. *Chromosomal Sex:* Male "XY" or female "XX" genes as determined by a karyotypic study (there are many other combinations).
4. *Internal Sexual and Accessory Organs:* The presence of male (testes) or female (ovaries) gonads, and male (e.g. vasa deferens, ejaculatory ducts and prostate gland) or female (e.g. uterus, vagina, fallopian tubes) accessory organs.
5. *External Sexual Characteristics:* Male (e.g. penis, scrotum) or female (e.g. clitoris, labia majora) appearing external genitalia, and other male (e.g. beard) or female (e.g. breasts) appearing secondary sexual characteristics.
6. *Gender Role:* The sexual role a person lives in, and the sex they are perceived as being. It has been defined as "A social status usually based on the convincing performance of femininity or masculinity".
7. *Gender Identity:* The gender a person identifies with and believes they are.

Factors 6 and 7 are commonly and unfortunately combined under the term "gender-role", but I prefer to keep them separate when possible. A particularly confusing but frequent use of the word "gender" is in the phrase "gender reassignment surgery (GRS)". It's essential to differentiate between a person's physiological sex (factors 4 and 5), and a person's social and mental gender (factors 6 and 7). Surgerycan't ever change the latter and the phrase "sex reassignment surgery (SRS)" is a better, although still seriously exagerating, description of what surgery can achieve.

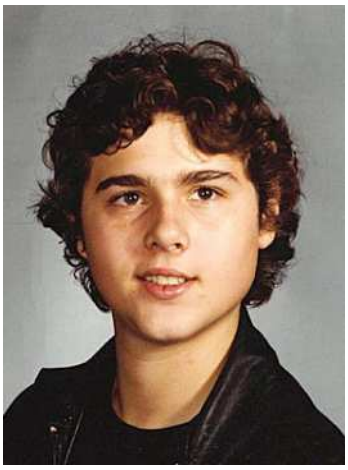
Gender

For most children their legal, chromosomal and physical sex agree with their mental gender and preferred gender role.... but not always. As already mentioned, children with gender identity problems are described as having gender dysphoria.

Establishing a gender identity is a process that most people take for granted, but that no one completely understands.

Scientists and sociologists agree that traditional gender roles are in many ways socially constructed, e.g. girls learn to wear dresses and boys learn to wear trousers. But no one seems to understand what makes a transsexual child raised in a male gender role embrace the female role as her own and vice versa. Nor can anyone explain why many intersexed children raised as one sex eventually migrate back to the gender that their genetics or their prenatal hormonal environment would have predicted.

Bill Summers, a professor of medical history at Yale who studied the science behind gender and sexuality says "You have to learn somehow what it means to be a boy or a girl. You don't come born with the idea. But enough people say, 'I always knew I was a boy but I was raised as a girl' that I can't doubt they have these feelings."



David Reimer, brought up as Brenda after a botched circumcision, but returned to life as a man when he discovered the truth.

Summers points to the work of Dr John Money who became famous in the 1960s for recommending and surgically facilitating the transition of a young boy [an identical twin] with a botched circumcision into living as a girl - the so called "John/Joan" case. Money initially declared the gender re-assignment to be a success, but his work was later undermined when the girl grew up with a masculine gender identity anyway. Summers notes that "the whole idea [was] that given hormone treatment and the right social environment, you can determine gender identity. It's not really quite so simple."

The bottom line seems to be that sociologists and psychologists still don't know where gender identity comes from or why - but it is unlikely that either biology or society operates totally independently from the other. The only current certainty seems to be that when young children decide that they are a boy or a girl and this decision contradicts their supposed physiological sex, the result is much anguish and cost to the child, the parents and the medical profession.

Young boy-to-girl transsexuals have few doubts about their sex - they know that they are really female and unlike older transsexuals can usually easily pass as such.

Sexual Identification of Transsexual Children

It is important to note that many boy-to-girl "transsexuals" do not consider themselves to be transsexual - indeed they often actively dislike being called such - they just consider themselves to be girls. The reality is that young transgirls often associate the word "transsexual" with TV documentaries featuring strange balding middle-aged men, married, with children, who at the end of the programme still look, sound and behave like men wearing wigs, dresses and too much makeup to their very discriminating eyes and standards. Young transgirls simply cannot relate themselves with these examples of transsexuality - their problems are totally different, and passing is rarely one of them.

A key, if obvious, differentiator between transsexuality emerging in children and the far more numerous instances of it emerging in an adult is the pre-puberty age at which noticeable cross-gender behaviour appears in the former group. According to one study, two thirds of transsexual boys are aware that they belong to the opposite sex and exhibit such behaviour" by age five, and 77% by age ten. Another study of 137 MTF transsexuals confirms these figures, finding 70% exhibited cross-gender behaviour before age ten, and another 20% before age fifteen.

For example Richard ('Richie') always wanted to wear dresses like his sister, when age two and a half his mother caught him trying to cut his penis off with nail clippers, saying "this doesn't go here". At age seven he was finally diagnosed as having Gender Identity Disorder, his parents changed her name to Riley Elizabeth and let her go to school as a girl - where she blossomed from a "sad confused little boy into a happy young girl". The financial burden of Riley's medical care had been crippling, but her parents had no doubts - "seeing Riley's happy face now, it's worth every penny"

It seems that at least three-quarters of gender dysphoric children will eventually have sex re-assignment surgery (SRS).

If clinical testing finds that the following conditions apply:

i. onset of a desire to belong to the opposite sex before puberty

ii. cross gender behaviour and social role without sexual arousal

iii. dislike for one's own secondary sexual characteristics

then core transsexuality, commonly known as "true" or "primary" transsexuality, is likely to be confirmed and appropriate sex-reassignment treatment should be started. However there still remains considerable reluctance by the

medical profession to supportively treat a physically normal boy with gender identity problems - a boy who's adamantly insistent that he's really a girl. The sex re-assignment of babies and very young boys became medically acceptable in the 1970's and 1980's (indeed, perhaps too common) - but has since become discredited and unfortunately there has been a carry over affecting young transsexuals. It seems to often require courageous and forceful parents before doctors will medically facilitate the transition of a minor.

Parents

An understandable reluctance to "come out" to one's parents remains probably the greatest single obstacle to the early and successful treatment of many transgirls. On the other hand, things do seem to be improving, and television and the Internet are playing a key role in this - these days most transsexual children first learn about "transsexuality" from TV programmes. Relating positively to this condition they - and often their parents - seek further information via the Internet and from books.

Model and actress Pascal Ourbih, transitioned at 18, and had surgery soon after.

It is impossible to underestimate how important the understanding and support of parents is for a young transsexual's eventual success in life. It is also difficult to underestimate how much emotional strain having a transsexual child can impose on parents.

Many parents become a pillar of support and understanding, indeed there are many instances of parents going to extraordinary lengths and expense to aid their new daughter - for example moving house so she can go to a different school and avoid anyone who knew her as a boy.

In another positive example, Jamie never felt herself to be a boy, and when at age eleven she finally told her parents "You think that I am a boy, but I am a little girl!", they accepted her choice and she is now living very happily and confidently as their daughter.

On the other hand, there are also instances where the child tells the parents and the result is a nightmare of arguments and pressure. Rachel (formerly Daniel) describes how when she told her parents at age seventeen: "They didn't shout at me but the conversation was very heated. Mum got upset - although she said she'd guessed a while ago - and Dad was annoyed. They both said they didn't want me to dress up in the house and that I'd always be Daniel to them. ... My parents have been good to me, but they'll always see me as their son." Rachel is actually luckier than many girls. Enforced visits to a suitable psychiatrist (suitable for the parents at least) to treat the child's gender disorder are common. Perhaps in a few cases a "cure" is achieved, but more commonly the child suppresses his/her transsexuality, and if he/she persists then an eventual total rejection by one (usually the father) or even both parents may well occur. For example, Brazilian, Roberta Close, was disowned by her father, and only reconciled years later. While now a successful model and actress, for several years in her teens Roberta descended in to the seedier side of life that all too many transsexual women go through in order to earn a living.

Often transsexual children feel unable to tell their parents about their feelings and needs. This usually means that a public admission of their transsexuality is deferred to adulthood - and the delay is always much regretted. But the resourcefulness of children should not be underestimated. For example, one text book (*Man and Woman, Boy and Girl*) describes how a woman secretly obtained and took hormones while still a young teenage boy. Her concerned parents eventually took her to a hospital for tests to help determine the cause of the resulting physical changes, but she had had enough warning to stop and let her system clear. The doctors concluded that the changes were spontaneous and natural (some degree of gynaecomastia - male breast development - is quite normal in mid-puberty boys), and told the parents not to worry.

Medical Guidelines for the Treatment of Transexual Children

The widely followed *WPATH Standards of Care for Gender Identity Disorders,* a document which has previously (and increasingly controversially) been against the hormonal treatment of under-sixteens, has relaxed its rules slightly in the latest (2001) Version 6. It now states that:

> "Adolescents may be eligible for puberty-delaying hormones as soon as pubertal changes have begun. In order for the adolescent and his or her parents to make an informed decision about pubertal delay, it is recommended that the adolescent experience the onset of puberty in his or her biologic sex, at least to Tanner Stage Two." *[on average this means about age 11 for biologic females, age 12 for biologic males] .....*
>
> "Adolescents may be eligible to begin masculinising or feminising hormone therapy as early as age sixteen, preferably with parental consent. In many countries sixteen-year olds are legal adults for medical decision making, and do not require parental consent. ....
>
> "Any surgical intervention should not be carried out prior to adulthood, or prior to a real-life experience of at least two years in the gender

role of the sex with which the adolescent identifies. The threshold of eighteen should be seen as an eligibility criterion and not an indication in itself for active intervention."

Although still not coming out in favour of starting feminising hormone treatment at a normal puberty age and delaying any sex-change surgery until at least age eighteen, the standards do at least now allow the treatment of very young adolescents with puberty-delaying hormones and thus help prevent the socially and mentally disastrous development of normal male [secondary] sexual characteristics and appearance in an under-sixteen MTF girl.

In its defence, the *Standards of Care* are clearly and understandably concerned about some instances of unsuccessful boy-to-girl gender re-assignment of intersexed babies, such as the highly publicised failure of the gender re-assignment of David Reimer (aka the "John/Joan" case), and want to avoid any future repetition.

If a boy is diagnosed as a transsexual then a failure to immediately start treatment is not only deferring the inevitable in the vast majority of cases, but is doing so at a considerable cost to the child's future as a girl and woman. It is indisputable that the earliest possible transition and pre-puberty hormonal and surgical treatment will offer most MTFs massive psychological and physical benefits.

Maite Schneider started hormones at eighteen.

Early transition and commencement of treatment and transition will permit the transsexual boy-to-girl a female childhood, a normal puberty (excluding menstruation) and allow her to enjoy her teenage years as a young woman. It is an absolutely priceless experience if a transsexual girl goes through her adolescence as a female, with a circle of same-sex girl friends. It's a period of time when her personality, identity and attitudes are forming, and the stage for the rest of her life is being set. She will have irreplaceable girlish memories and social adjustments that a transition later in life can never give her. Her life experience will be much more like that of other women, she will be able to talk more easily about parts of her past, her school days, and even have photos to show her future boyfriends. For many girls, denying these experiences to her and enforcing an unwanted male gender is simply disastrous.

One successful transsexual woman 'Anna Taylor' describes her early experiences: "It never occurred to me that I was a boy. I just wondered why I had something extra. I had sessions with a child psychologist and my parents were told to bring me up neutrally. My mother tried, but my dad would slap me if he caught me playing with dolls. My mother says that if it had been up to her she would have banged on every door to let me become a girl, but my dad wouldn't stand for it."

Anna ran away from home several times until, aged eight, she went to live with her grandparents who were prepared to bring her up as a girl. At age eleven she started at a new school where the headmaster was very sympathetic and agreed to let her register as a girl. "For the first time no one was laughing at me. From being very withdrawn, I became very bubbly and outgoing. The only allowance they made was that I had to change in a separate cubicle for games and use the teachers' toilets. The school was afraid of another girl seeing something they shouldn't. [But] I got very depressed when the other girls started wearing bras. My own doctor wouldn't prescribe hormones for me at thirteen, so my grandmother took me to Amsterdam to find a doctor who would. Within a few months I'd grown very small breasts. Doctors agreed that I should have had gender reassignment surgery when I was younger but now that I was an adolescent, I would have to wait until I was eighteen."

A recent follow-up study of sex-reassignment in twenty-two adolescent transsexuals (ten started hormones under age sixteen, twelve under eighteen) found that after surgery in all cases all signs of gender dysphoria had disappeared, they scored normally in psychological tests and they were socially functioning well. Not a single girl/boy expressed feelings of regret concerning their decisions to undergo sex reassignment. The study concluded that with careful preliminary screening, starting sex reassignment procedures before adulthood results in favourable post-operative functioning.

Puberty

Puberty can be defined as the biological developments which change boys and girls from physical immaturity to biological maturity. For a transsexual child an inappropriate puberty sets a mountain that can never be full conquered, while an appropriate puberty offers a greatly eased path to gender reassignment, both physically and psychologically.

Puberty is often a nightmare for 'gender dysphoria' children according to Cohen Kettenis, Professor of Psychology at the Medical Centre of the Free University in Amsterdam, "They develop an enormous dislike for their body." Most children seen by Professor Cohen react with horror to the changes that occur in their bodies at puberty. It appears that their so-called "transsexual" feelings become much stronger and they do not feel at home in the body that they now developing. Margaret Griffiths of the Mermaids support group says very similar things, "Some girls and

boys go through Hell at puberty, they have few friends, they are bad in school, because they can concentrate on nothing, and some have suicidal thoughts."

When Riley (who had been living as a girl since age seven, after threatening to kill himself) was warned by her mother when age ten that in a few years time nature would start turning you in to a man. Her reaction was horrified "Please don't let that happen ... please!".

Although the child may not admit to his transsexual desires at this stage, the parents will often start to have some concerns about their son. The onset of puberty is a critical point as the child is faced with his own undesired physical masculinisation, often combined with a great jealousy of. girls and their physical changes.

By age fifteen some 90% are exhibiting feminine behaviour. This is the point where many transsexual children finally admit to their wish to be a girl and they, or their parents, seek help.

One now happily post-SRS girl described how she felt at puberty: "That was the hardest. My own body was staging a mutiny, even." At sixteen she finally confessed to her secret to her parents who took her to several doctors but they wouldn't help, "I knew I couldn't be happy letting my body masculinise on and on. And so at seventeen I graduated from high school and found hormones on the street."

Now twenty-one, Zoe concurs about puberty: "When puberty arrived I was repelled by my erections and deepening voice. At times I felt suicidal." Jamie Cooper was twelve when she wrote her mother a letter saying that she should have been born a girl, they sought medical advice and were told that it could just be puberty, the feelings deepened but she had to wait until she was sixteen before receiving hormone treatment - she transitioned on her sixteenth birthday.

Hormones and Puberty

Body shape is controlled by *oestrogen* and *testosterone*. During puberty, while boys are amassing bone and muscle thanks to their developed testes pumping out androgens (particularly testosterone), a high concentration of oestrogen in the female body results in the typical girl gaining nearly thirty-five pounds (15kg) of so called reproductive fat deposited on the hips and thighs rather than on the waist. Another female hormone, *progesterone*, also plays a significant and complementary role, most particularly in the development of breast tissue.

Professor Cohen's policy is that if it appears that the gender dysphoria feelings are becoming stronger then puberty blockers should be prescribed to temporarily halt puberty until they are sixteen. When they are sixteen, and quite certain that they have the wrong body, they can be prescribed hormones as well as to begin to change their outward appearance to more closely match their chosen sex. "After that comes the actual sex-change operation".

Hormone Treatment for Young Transsexual Girls

Ideally, in order to maximise the physical benefits, low level oestrogen treatment of the young transsexual boy-to-girl should begin at age eight to nine years. Before the onset of male puberty (at about age eleven, but can vary ±two years) a bilateral orchidectomy (castration) should be performed to remove both testes and hormonal treatment then increased (additional oestrogen, later supplemented with progesterone) to initiate a female type puberty.

When an orchidectomy is done before puberty, the results in terms of increased physical feminisation and decreased masculinisation are much more dramatic than when it is done after puberty.

Even if this pre-puberty ideal is not possible, the female hormonal treatment of the transsexual boy-to-girl can still have remarkable results if begun while the body is still at its most receptive age - the critical puberty years between about eleven and seventeen(depending on the individual), but the earlier the better.

It is no coincidence that so many transsexual women who famed for their looks had begun taking hormones by seventeen - Jenny Hiloudaki, Tula, Hari-su, Roberta Close, Dana International, etc.

Doctors certainly seem to agree that giving - for example - a thirteen-year-old transsexual boy-to-girl doses of oestrogen will make her physically far more attractive as an adult women. However they also agonise about the possible negative consequences - and perhaps their potential legal liabilities from prescribing female hormones to "boys".

As a poor alternative to beginning full female hormone treatment in a young transsexual boy-to-girl, many medical specialists (who are often reluctant to start irreversibly feminising hormonal treatment until the girl is at least age sixteen) instead prescribe a GnRH analogue such as *Zoladex* (Goserelin Acetate) or *Lupron* (Leuprolide Acetate) which prevents or dramatically reduces gonadal hormone production, including testosterone, thus preventing the onset of the masculinising changes of adolescence.

The drugs are normally administered with a nasal spray, or via a weekly or monthly subcutaneous injection into the abdomen. While this treatment does nothing to promote female physical characteristics in the girl, it does at least prevent or greatly slow a male type puberty with its physical effects, and Dutch studies have recently confirmed the effectiveness of such treatment.

Unfortunately GnRH analogues are expensive drugs, but they are preferable for adolescents over the cheaper anti-

androgens such as *Aldactone* (Spironolactone) and *Androcur* (Cyproterone Acetate) which are commonly prescribed to post-puberty transsexual women.

Young transsexuals often struggle to understand the medical "best practice" guidelines that affect their life. When Riley was twelve she was to start taking both oestrogen and testosterone blockers. It had been explained to her that this would make her body more feminine, her voice would not deepen and she would develop breasts - but that she would be infertile. Her reaction was "But I can adopt babies ... why can't the doctors take my testicles off now?"

A rare example of the medical community responding to the needs of young transsexual was achieved in Germany when it was revealed in 2007 that doctors had prescribed puberty blocking and later female hormones to a twelve year old 'Kim', formerly Tim.

At age two, Tim was trying on his older sister's clothes, playing with Barbie dolls and saying "I'm a girl." By age four Tim was refusing to get to his hair cut and wanted to cut off his "thing". For the sake of a normal life his parents increasingly accepted their son Tim as being their daughter Kim.

The situation reached a crisis when Kim grew increasingly distressed at becoming like other adult transsexuals with big hands and deep voices, whom she thought looked ridiculous when they dressed like women.

Kim Petras [on the cover of this issue] knew she was female from the age of two. Transitioned at thirteen. Had affirmation surgery at sixteen.

Her father said "We saw Kim as a girl ... not as a problem. ... [she] reacted badly to the first signs of puberty... At that stage we realised that she was terrified of growing facial hair and her voice breaking".

Kim's parents decided to help her get a sex change and consulted psychiatrists across Germany. Some condemned their support of their child's desire to undergo a sex change, or suggested that she be kept under observation in a closed psychiatric ward. But Dr Bern Meyenburg, the head of a clinic for children and adolescents with identity disturbances at Frankfurt University, concluded that the child was serious. He wrote in his diagnosis: "Kim is a mentally well-developed child who appears happy and balanced. 'There is no doubt of the determined wish, which was already detectable since early childhood. It would have been very wrong to let Kim grow up to be a man."

Dr Meyenburg had once strongly opposed hormone treatment for children but changed his mind when one of his patients refused to listen and ordered hormones over the Internet, then went abroad at seventeen and had a sex change operation for a few thousand euros. Dr Meyenburg admits that he was angry at the time, but said that today the woman is a law student and one of his happiest patients. He now allows young patients to enter hormone treatment early, before puberty complicates a sex change. "They simply suffer less," he said, "it would have been a crime to let Kim grow up as a man".

Dr Achim Wuesthof, who is now treating Kim at a clinic in Hamburg, said: "Imagine a man who suddenly starts growing breasts or a woman who starts growing a beard against their will – that is how Kim and people like her experience puberty."

Kim was thus prescribed female hormone therapy when just twelve, and by age fourteen was fully transitioned and living as a girl - with her identity and medical insurance cards changed to her new name and female sex. By special dispensation she was allowed to have sex-assignment surgery at the age of sixteen although German law will normally only allow this at the age of eighteen.

Effects of Early Hormonal Treatment

Early hormone use (i.e. during puberty) in a trans-girl allows a typically normal female body shape to develop, with significantly more fat and less muscle than otherwise, the girls post-puberty body shape and "figure" will become far closer to female than male norms in its proportions. In general, increased levels in the blood plasma of oestrogen and progesterone will stimulate and promote the growth of female secondary sexual characteristics (breasts, fat distribution, pubic hair pattern, ...) while the reduction in the levels of androgens such as testosterone will, if early enough, completely prevent the development of male ones (deepening of voice, facial hair, muscular development ...).

Female hormonal treatment has a dramatically greater effect if begun before a male puberty has started (on average age twelve, but plus or minus two years) than after after a male puberty has completed (on average seventeen, plus or minus). This is a severe problem given the great reluctance to doctors to assist transsexual patients under age eighteen. Incidentally, the anticipated and achievable benefits from starting female hormones decline rapidly in the decade after puberty ends.

Maximum possible feminsation occurs if hormonal treatment begins just before a male puberty would have start started. Very conveniently, girls tend to start puberty two years earlier then their male peers, so high dose hormone therapy intended to initiate a full female type can be safely started by age eleven, although in practice it is often deferred to twelve or even later, particularly if the individuals physical development allows that. If her testes were removed in

infancy or childhood, then for health reasons low level hormone therapy should be begun by age nine - an age at which many girls begin to notice some initial puberty changes, in particular the development of breast buds.

As indicated already, surgeons have become very reluctant in recent years to perform a bilateral orchidectomy (castration) on even young intersexed patients, let alone gender dysphoric boys. Failure to do so, however, does accept the slight risk that even suppressed testes might produce enough androgens for a very sensitive body to react to them. The nightmare scenario is a confused body going through a double male *and* female puberty - the girls hips broaden and her breasts swell under the influence of oestrogen therapy, but simultaneously her voice deepens and facial hair appears due to the testosterone being produced by her testes.

There seems to be no consensus amongst clinicians as to whether pubertal development is more 'natural' in XY girls with oestrogen producing ovaries, than in XY girls (more commonly intersexed rather than transsexual) taking hormone replacement therapy (HRT) following early orchidectomy. This lack of consensus can actually be considered a good indication of the great effectiveness of early hormone therapy.

The reduction in levels of "male" androgen hormones caused by oestrogen treatment will also have some slight affect on the skeleton - reducing male type 'ruggedisation' and enhancing female type features, for example slightly broadening the pelvis and helping reduce the girl's adult height (by perhaps an inch or two) compared with her height if she had experienced a male puberty. While hormones play an important role in post-pubertal body shape, however, it's thought that the male "Y" chromosome is mainly responsible for skeletal growth. As a trans-girl is genetically "XY" she will thus still experience some degree of skeletal masculinisation, even if she commences female hormone treatment at eleven or twelve. In general, her physical characteristics as determined by her skeleton (height, skull, hand and foot size) will lie between the male and female norms post-puberty - although more towards the former than the later. This not necessarily bad as the western idea of feminine beauty is for tall and leggy women. As an adult, the woman will typically be both tall compared to the average woman (67½" vs. 64¼") and have long legs - both absolutely (32½" vs. 30") and relative for her height, ideal for those girls with ambitions as a model!

In a genetic girl, her increasing production of oestrogen during puberty causes her skeleton to mature so that growth eventually stops. Oestrogen treatment can speed up this bone maturation by accelerating the completion of growth in the growth plates (the zones of growing cartilage near the ends of children's bones) and thus suppresses growth somewhat, by up to two inches. Pediatric endocrinologist sometimes prescribe large doses of oestrogen (usually Ethinyl Estradiol) for a period of several years to deliberately restrict growth in excessively tall girls, and the same technique can be used to help induce in young transsexuals a final height in the typical female range of 61 - 67". However, obtaining supervised treatment for a transsexual boy-to-girl is difficult, arguing that height is not a disease, endocrinologists are becoming increasingly reluctant to treat even a genetically female "XX" adolescent unless bone growth X-rays show that excessive adult height for a female (over 71") appears likely.

Commencing treatment during puberty will produce mixed results - e.g. the voice may have already deepened irreversibly but facial hair growth is prevented or greatly reduced.

Roberta Close, started hormones at age sixteen.

Overall, the physical results of early hormonal treatment should be extremely successful, the girl developing a well feminised physique with full breasts (although rarely as large as the girl would like), no beard, plentiful scalp hair, and an unbroken female type voice. It's difficult to over-exaggerate just how great these advantages are, and how much of a disaster each year of delay is for the transsexual girl whose skeleton and body is rapidly turning in to that of a man. The end of puberty is a fundamental and irreversible physical marker, from which the plausible effects of feminising hormonal treatments on the body of a transgirl/woman decline with depressingly rapid speed. For any transsexual woman starting treatment when already physically mature (and this merely means age twenty onwards), a muscular and robust stature; a deep and masculine sounding voice; obvious facial beard growth; and a receding hairline, are just four of the immediate challenges that may seriously threaten her ability to pass convincingly as a woman. She also faces the high cost of electrolysis, breast augmentation, facial feminisation, etc.

Hormone Regimens in Transsexual Girls

There seems to have been little published research with regard to the dosage of hormones in young transsexual patients, however research which relates primarily to Androgen Insensitivity Syndrome (AIS) patients may be applicable to transsexual girls. *Zachmann et al* cite one AIS patient who had undergone orchidectomy in whom oestrogen administration was started at the earliest estimated pubertal age of 10.3 years in the form of Premarin 0.625 mg three times weekly. It was found, however, that this stopped growth of the girl prematurely and the authors felt that it would have been better to have given the patient

0.005-0.01 mg ethinyloestradiol daily, instead. From studies of patients with Turner syndrome it has been suggested that to ensure normal pubertal growth, physiologic oestrogen replacement should be started at the appropriate bone age of about eleven years and should not be delayed in the hope of achieving a greater mature height. *Batch et al* suggest a regime of five micrograms of ethinyloestradiol daily for the first six months, increasing to twenty micrograms daily by the end of puberty.

Soule et al. suggest that the best course of action may be to perform an orchidectomy just before puberty (at eleven years in a case quoted) followed by oestrogen therapy with regular bone density measurements. This policy, it is suggested, reduces any slight risk of malignant transformation of the gonads and ensures adequate oestrogen activity throughout the critical years of bone accretion.

Oestrogen levels are, however, higher in XX girls than in XY boys, even in childhood. XX girls start producing oestrogen at eight or nine (i.e. a year or two before breast development) so several clinicians therefore recommend early oestrogen supplements in XY girls, irrespective of whether or not the gonads are in place.

Early hormone treatment is not a miracle, but the benefits such as female hair pattern, breast development no beard growth, no Adams apple, no broken (deep) voice, are immense.

Females Hormones and Attractiveness

A very awkward problem for psychologists advocating delayed hormonal treatment for young transgirls is that as result they will be physically less attractive as a woman to men.

There is a strong and direct correlation between the level of a girls oestrogen levels during puberty and how attractive and feminine she is perceived as a woman. For example the hormone has lasting effects on bone growth and tissue formation as well as the appearance of the skin during the average seven-year-long puberty. Miriam Law Smith of the University of St Andrews states the hormone has a crucial role in determining facial appearance, giving thirteen-year-old's doses of oestrogen will "certainly make them more attractive [to men]" although she adds "who knows what other effects the hormone may have?" As regards the last comment, pubertal girls who have been prescribed oestrogen to prevent excessive height (over six feet) may, according to one study, subsequently suffer from lower fertility.

Passing and Sexual Orientation

There seem to have been no formal clinical studies, but it seems certain that young male-to-female women are far more likely to complete their transition and settle well into their new lives than those who transition at a later age. It is also very likely that a far higher percentage of young transsexual women identify themselves as heterosexually attracted to men than when compared to older transwomen.

About 95% of natal "XX" women consider themselves as being heterosexual. By comparison, studies of the sexual orientation of post-SRS transsexual women indicate that only half are heterosexual and exclusively select males as sexual partners; nearly one-fifth are lesbian and sexually attracted only to females; and about one-third are bisexual. However these studies cover all age groups (with an average age in the thirties or even forties), and are almost certainly not representative of the relatively few young transsexuals who transition before the completion their male puberty. For under twenty-ones, I would suggest that there are very few girls who do not consider themselves to be heterosexual, and have or would like to have, a boyfriend.

Unlike older transsexual women, young transsexual girls rarely have had any sexual activity before they transition, and if they do it's likely to be of a homosexual nature, generally playing a female role during intercourse. Mentally they are often only erotically stimulated by men, although overall their sexual urges may be very low because of puberty suppressants. When released from such drugs and placed on hormone therapy, they become just as interested in boys and men and sex as other girls of their age - if not more so. "G", a nearly sixteen-year old transgirl undergoing an intense female puberty thanks to being on hormones illicitly obtained by her parents, may be quite typical when she writes: "I can't stop thinking about my [neo-vagina] ... I want to be ['screwed'] by any guy in sight. I was even thinking about my teachers and my best friend's dad." But this girl does not expect to undergo SRS for years yet.

Kelly van de Veer had her affirmation surgery at nineteen.

Unlike older transsexual women, young transsexual girls rarely have any problems passing easily and naturally, and assimilating themselves as women. For example, in one survey (*Sex Reassignment of Adolescent Transsexuals: A Follow-up Study*, Cohen, 1997) of young transsexuals, all the male-to-females were satisfied with their appearance after hormone therapy, and it was the interviewer's observation that it was difficult to discern any signs of their [genetic] sex. Most of the girls had been approached in a flirtatious manner, and not one had been approached by strangers as if they were still of the male sex, 60% expressed satisfaction with their vaginoplasty, and had experienced sexual intercourse without problems. The author of the study suggested that part of the adolescents' success was due to the fact that

they more easily pass in the desired gender role because of their convincing appearance. With one exception the voices of the girls were not male sounding, and early anti-androgen treatment apparently had acted in a timely way to block facial hair growth and the lowering of the voice.

Somewhat disputably, the study also stated: "Another aspect of this relatively positive outcome may be attributable to the criteria for treatment eligibility. ... [The] patients selected for early treatment not only are among the best-functioning applicants, but probably they also belong to the subtype of so-called "homosexual transsexuals" (that is, individuals who are, before SRS, sexually attracted to same-sex partners) .... They are also referred to as "primary" or "early-onset" transsexuals."

An early transition seems to make passing and relationships with men much easier.

Nevertheless, success in passing may well be an important factor in young trans-girls being far more likely to have a heterosexual sexual orientation than transsexuals who transition as adults. It's clear that trans-women who transition at a young age are almost always physically able to go stealth, they typically do as soon as possible, and often quickly begin to have boyfriends and eventually a husband. The desire for a normal relationship with a man tends to pull the transwoman away from any open acknowledgement of her transsexuality and male past, as she feels (unfortunately often correctly) that the relationship may not survive the revelation. In the balance between personal happiness and revealing "the whole truth and nothing but the truth", most people choose happiness. The experience of this site is that when a young transsexual outs herself, she often soon regrets it - and for good reasons.

Deborah Davis, is believed to be Australia's youngest affirmation surgery at the age of seventeen.

Sex Re-assignment Surgery

After hormones and transition, the next and final step is sex-reassignment surgery. Extraordinarily, only about 1% of SRS operations performed by western surgeons are on girls under age twenty (and almost all of these are eighteen or nineteen). The reasons seem to be a combination of the *Standards of Care* guidelines, the need for a two year real life test when a hormone supported transition can only begin no earlier than age sixteen, money, the requirement for parental permissions in some countries, the reluctance of surgeons to operate on very young transsexuals, and the extreme rarity of under-twenty (or indeed under twenty-five) surgery candidates compared with older candidates - the median average age of European transwomen at the time of their SRS is mid-to-late thirties, with a mean average age of around forty.

By interesting contrast, one study of 195 Thai male-to-female transsexuals found that "many participants had transitioned very early in life, beginning to feel different from other males, and identifying as non-male by middle childhood. By adolescence many were living a transgendered life. Many took hormones, beginning to do so by a mean age of 16.3 years, and several from as early as ten years. Many underwent surgeries of various kinds, on average in the twenties, with one undergoing SRS as early as fifteen years".

Clair (formerly Alex) Farley told her parents that she was gay when she was thirteen. After a suicide attempt at age fifteen she told a counsellor "I feel that I should be a girl". She finally transitioned at age eighteen and began hormones. "My hips widened, my thighs thickened and tiny breasts started to appear". She finally had her SRS at age twenty-three, "a few days later I pulled out a hand mirror and got a first glimpse of my new vagina ... it was badly bruised but I couldn't have been more excited, I was all woman".

Parental Support - Changing the Rules

Considering all the advantages of early treatment of the young transsexual, it's unsurprising that it is now increasingly demanded (and obtained) by increasingly knowledgeable transsexual children and their parents. Sources such as the Internet and TV documentaries mean that children and parents are often no longer accepting as gospel the advice of an experienced and over-loaded doctor or psychiatrist. For example in 1997 there were an estimated 600 transitioned transsexual children (usually defined as under eighteen) in the UK. A few years earlier the acknowledged figure would have been a handful. Another study published in November 2005 suggested that there were 2000 young transsexuals in the UK age fifteen-nineteen - although with no further definition of their status. [*Note:* The figure of 600 excludes the very small proportion of "XY" intersex children born in the UK with ambiguous genitals who are assigned to the female gender by doctors while still babies, perhaps twenty-forty each year deriving from USA figures. There are also many children with "male" genes who were identified at birth as female and then brought up as girls, for example there are perhaps 3000 "XY" women in the UK who were born with Androgen Insensitivity Syndrome.]

Supportive parents are undoubtedly influencing a 'system' and a medical profession that was in the 1990's retreating rapidly from early treatment and accommodation of young transsexuals. After a decade-long reaction to the tragic David Reimer affair, it has become recognised that it is necessary to separate and differentiate between the

Vanessa Lopez started puberty blockers at seventeen. Female hormones from age eighteen. Surgery at twenty.

voluntary and non-voluntary gender reassignment of children. While numbers are still small, there is nevertheless an increasingly willingness by doctors and the "system" to support and aid the early reassignment of children. The revised guidelines in the current version 6 of the "*Standards of Care*" issued in 2001 makes it slightly easier for young transsexuals to officially obtain treatment , including puberty-delaying drugs.

But doctors still face circumstances where a failure to support young transsexuals in order to comply with guidelines can seem at best totally unreasonable. For example, in 2006 a five-year boy was allowed to enrol in kindergarten as a girl with a "gender-neutral name" in Florida, USA, having been diagnosed with gender identity dysphoria (GID) two years ago earlier. The parents said the child refused to wear boy's clothing and repeatedly said she hated having a penis - often trying to hide it between her legs. Officials said that were already a number of trans-students in the school system but none as young as kindergarten age, they expected that the youngster would go unnoticed as a girl. Can she be denied female hormones at age eleven-twelve?

Meanwhile, in Japan a seven year old boy with GID, Ryoko Kanda, was allowed to enrol as a girl at a school in the prefecture of Hyogo, about 270 miles west of Tokyo after being diagnosed with gender identity disorder at age six. The school has not told other parents about the switch, and a spokesman for the local school board said there had not been any complaints from other students or from the boy's parents since his enrolment. He stated that the boy's name is listed with girl students, she uses the girls' bathroom, attends a girls' gym class and wears a girl's swimsuit at the school pool.

The official also said "At this point, we are relieved that the child was accepted into [second] grade and is being raised in a healthy manner", he added that the school district would watch his case closely and reassess the decision as the boy reaches puberty. Katsuki Harima, a psychiatrist specializing in gender identity disorder, said the decision to allow the boy to enrol as a girl seemed appropriate, but would get complicated as he grew older. Harima said the boy is not old enough to determine whether he really has the disorder. A boy who behaves like a girl does not necessarily have gender identity disorder and he could discover as he grows older that he wants to be male.

Conclusion

There is no doubt that for the best possible final outcome, the sex-reassignment treatment of a gender dysphoric (i.e. transsexual) male-to-female boy/girl should be started as early as possible - ideally before puberty. Compared with the experiences of older transsexuals, the results are often almost magical. All the current evidence indicates that the under-eighteen transgirl will identify totally with her new female gender and appearance, passing well both psychologically, socially and physically; and be far more happy as a female and have no regrets. She will still face problems of course, such as hiding her lack of periods and admitting her inability to bear children to a potential husband, but these are a totally different set of problems from what a decade's delay would have imposed upon her - such as an inability to pass due to her beard, deep voice, a bald patch, in addition to having a wife and children.

The Cohen study mentioned above concluded: "Even adolescent applicants who are functioning well will need a lot of guidance through the process of sex reassignment. However, provided they manage to pass SRS without problems, they have a lot to gain. They can catch up with their peers and devote their attention to friendships, partnership, and career."

Nicole Roukema knew she was a girl at three, and transitioned at thirteen. She plans to have SRS.

It is unfortunate that the medical profession, while also advancing, is doing so very slowly, partially due to a lack of facilities and specialists.

In the UK only one National Health Service Gender Identity Clinic, the *Portman and Tavistock Clinic* in London, is able to offer specialist psychiatric and endocrinology services for transsexual children - and this for a population of fifty-eight million people!

Despite the improving situation - the transsexual who transitions while still under the age of eighteen rather than older remains very much the exception rather than the rule.

Final Note:

I would like to give a huge thanks to all the girls who have contributed to this page in some way.

Please send any comments, feedback or additions to theWebmaster.Copyright (c) 2008, Annie Richards. Last updated: 23 November, 2008

The Lesbian and Gay Anti-Violence Project can be contacted on (02) 9206 2116 or 1800 063 060

PLEASE NOTE!

Apart from the Wednesday night drop-ins, you should make an appointment before coming to the Gender Centre. This helps us to plan and saves you disappointment.

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 2193 BORONIA PARK, NSW 2111

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

"crossdress with dignity"

Two Films from the Gender Centre/ICLC February Trans Film Festival Reviewed in Brief

Screaming Queens

Susan Stryker, former executive director of the GLBT Historical Society of Northern California, is one of the people responsible for the award winning film "Screaming Queens", which records the Compton's Cafeteria riot which preceded New York City's Stonewall by some three years.

The documentary has been brilliantly edited, bringing a real feeling of immediacy to the events which led up to the 1966 riot, using archival footage of the area, interviews with some of those who were there and participated in the protest against heavy-handed policing, and a minimum of reenactment footage dramatising key moments which sparked off the popular protest.

The situation was quite similar to that at Stonewall, with police harassment of gay and transgendered patrons of Compton's, a twenty-four hour cafeteria in the Tenderloin district of San Francisco. I am told some of the footage comes from later protests, but this merely emphasises the point that the struggle was widespread and ongoing.

Stryker and her colleagues are to be congratulated on the clarity with which they tell the story, including interviews with police who were the villains early on but later appeared to reform and take a more balanced and reasonable view of the situation.

KC

She's A Boy I Knew

This documentary, which tells the transition story of Canadian transgender woman, Gwen Haworth, is one of the most skilfully made and moving documentaries I have ever watched. Gwen is a talented film-maker and her story is also the story of her family (parents and siblings). her best friend and her wife, Malgosia, who continued to love Gwen after she transitioned from Steve and still does, although they have now broken the marital tie and .Malgosia has remarried.

Haworth adopts a point-of-view approach which is particularly forceful as her near and dear ones talk frankly, and sometimes tearfully, to the camera.

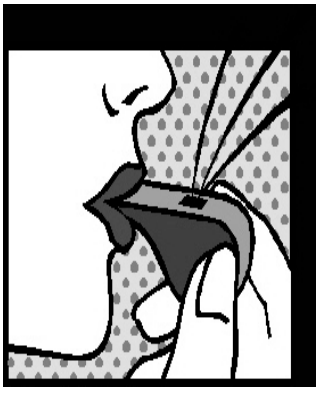
At least Gwen's family have reached a point where they can talk about their own experiences. Too often stories of transgender are focussed too demandingly on the feelings of the transgender. Here we see the full gamut of effects on the family, ranging from deep sense of loss to an underlying belief that the change was inevitable and that peace has come to Gwen after her ordeal.

Gwen holds nothing back and does not spare herself in telling of the ordeal of winning and losing that is transition.

Many strong chords will resound in those of us who have walked the same difficult path. I cried more than once asI watched.

KC

Goods and Services:



May I Have Your Attention Please!

An ad. this size costs $11 an issue, including GST.

To Place an Advertisement for Goods and Services in *Polare*: Please contact the Editor of *Polare:* resources@gendercentre.org.au or by faxing details to 9569.1176 attention to *Polare* Editor. Advertisements are included in *Polare* based on the space available in the magazine. Advertisements in this section should not contain images or logos and should bear some specific relation to the transgender community. Services and goods provided by and for transgender people are preferred.

Goods and services advertisements are the responsibility of the Advertiser under the Trade Practices Act. The Gender Centre does not imply an endorsement of the goods, services or advertiser. The Gender Centre recommends that consumers exercise common sense and draw their own conclusions on the goods and services advertised in *Polare*. The Gender Centre will not be held responsible for any misfortune nor will it indemnify readers against any harm incurred. The distribution of *Polare* is targeted and is not intended for general distribution.

Directory Assistance

New South Wales

THE GENDER CENTRE

Counselling
Provides counselling to residents and clients living in the community. For more information or an appointment contact the Counsellor on Monday, Tuesday, Wednesday or Thursday 10am - 5.00pm.

Outreach service
Available to clients in the inner city area on Tuesday nights from 6.00pm to 2.00 a.m. and on Thursdays from 10am - 5.30pm by appointment only. Monday and Wednesday afternoons and Friday 10am - 5.30pm. Also available to clients confined at home, in hospital or gaol - by appointment only. For an appointment contact Outreach Worker - 9569 2366.

Social and support service
Provides social and support groups and outings, workshops, forums and drop-ins. For more information contact the Social and Support worker. 9569 2366

Resource development service
Produces a range of print resources on HIV/AIDS, medical and other information relevant to people with gender issues and their service providers. We provide printed information including a quarterly magazine *Polare* and a regularly updated website at: www.gendercentre.org.au .
For more information contact the Resource Development worker on Monday or Wednesday 9569 2366

Drug and alcohol service
Provides education, support and referral to a broad range of services - By appointment only. For an appointment contact the Outreach or Social and Support worker 95692366

Residential service
Provides semi-supported share accommodation for up to eleven residents who are sixteen or over. Residents can stay for up to twelve months and are supported as they move towards independent living. They are also encouraged to consider a range of options available to meet their needs. A weekly fee is charged to cover household expenses.
Assessments for residency are by appointment only and can be arranged by contacting the Counsellor, Outreach worker or Social and Support worker 9569 2366.

For partners, families and friends
Support, education and referral to a wide range of specialist counselling, health, legal, welfare and other community services are available for partners, families and friends of people with gender issues. For more information contact the Social and Support worker 9569 2366.

For service providers, employers and others
Advice, support and workshops are also available to employers, service providers, students and other people interested in gender issues. For more information contact the
Gender Centre Co-ordinator,
7 Bent Street
or PO Box 266
Petersham NSW 2049
Tel: (02) 9569.2366
Fax: (02) 9569.1176
coordinator@gendercentre.org.au
http://www.gendercentre.org.au
For after hours counselling contact **Lifeline** on 131 114 or the **Gay and Lesbian Counselling Service**
4pm-midnight seven days on
(02) 9207.2800
1800 805 379
http://www.glcsnsw.org.au/

2010 - TWENTY10/GLBT YOUTH SUPPORT

Twenty10 is a NSW-wide organisation that provides support to young transgender, lesbian, gay and bisexual people who are having trouble at home or are homeless. We provide accommodation support, counselling, case management and social support. We also provide information and referrals for young GLBT people and their families and do community education programs throughout NSW.
PO Box 553, Newtown, NSW, 2042
Youth callers needing help:
Sydney local: (02) 8594 9555
Rural NSW : 1800.65.2010
All other callers:
(02) 8594 9550
Fax: (02) 8594 9559
Email: info@2010.org.au
Web page: www.twenty10.org.au

ACON - AIDS COUNCIL OF NSW

Information and education about HIV/AIDS, caring, support for people living with HIV/AIDS.
9 Commonwealth St,Surry Hills, NSW 2010
PO Box 350 Darlinghurst NSW 1300
Tel: (02) 9206.2000
Fax: (02) 9206.2069
tty: (02) 9283 2088

ACON - HUNTER

129 Maitland Road
PO Box 220
Islington 2296
Tel: (02) 4927 6808
Fax: (02) 4927 6485
hunter@acon.org.au
http://www.acon.org.au

ACON - ILLAWARRA

47 Kenny Street,Wollongong
PO Box 1073,Wollongong,NSW, 2500
Tel: (02) 4226.1163
Fax: (02) 4226.9838
www.acon.org.au

ACON - MID-NORTH COAST

4 Hayward Street
Port Macquarie NSW 2444
Tel: (02) 6584 0943
Fax: (02) 6583 3810
mnc@acon.org.au
POB 1329, Port Macquarie, 2444

ACON - NORTHERN RIVERS

27 Uralba Street
Lismore NSW 2480
PO Box 6063
South Lismore NSW 2480
Tel: (02) 6622.1555
or 1 800 633 637
Fax: (02) 6622 1520
northernrivers@acon.org.au

ACON - WESTERN SYDNEY

6 Darcy Road,
Wentworthville, 2145
Tel: (02) 9204 2400
Fax: (02) 9891 2088
aconwest@acon.org.au

AFAO (AUSTRALIAN FEDERATION OF AIDS ORGANISATIONS)

National AIDS lobby and safe sex promotion organisation.
PO Box 51
Newtown 2042
Tel: (02) 9557 9399
Fax: (02) 9557 9867

ALBION STREET CENTRE

HIV testing, clinical management, counselling and support, treatment and trials for HIV/AIDS.
Tel: (02) 9332.1090
Fax: (02) 9332.4219

ANKALI

Volunteer project offering emotional support for People Living with HIV/AIDS, their partners, friends and carers. One on one grief and bereavement service.
Tel: (02) 9332.1090
Fax: (02) 9332.4219

ASTRA (ASSOCIATION OF SEXY TRANSVESTITES)

An erotic social club for the bold and the beautiful! All ages, shapes and sizes. Discreet meetings, weekly parties.
PO Box 502, Glebe NSW 2037

BOBBY GOLDSMITH FOUNDATION (BGF)

Provides direct financial assistance, financial counselling, employment support and supported housing to people in NSW disadvantaged as a result of HIV/AIDS.
Tel: (02) 9283 8666
free call 1800 651 011web
www.bgf.org.au; email
bgf@bgf.org.au

BREASTSCREEN

Phone 132050

CATHOLIC CARE

PO Box 3127, Bankstown
Square, Bankstown, NSW, 2200

CENTRAL TABLELANDS TRANSGENDER INFORMATION SERVICE

Provides information and directions for anyone seeking medical or psychological assistance in changing gender. Provides information on gender friendly services available in the Bathurst, NSW Area. Brings together transgenders, their families and friends and provides support and understanding in a non-counselling atmosphere.
Operates 9 am - 8pm Mon - Fri
Tel: 0412 700 924

(CSN) COMMUNITY SUPPORT NETWORK

Transport and practical home based care for PLWHA. Volunteers welcome. Training provided.
Sydney Mon-Fri 8.00am-6.00pm
9 Commonwealth St, Surry Hills
Tel: (02) 9206.2031
Fax: (02) 9206.2092
csn@acon.org.au
PO Box 350 Darlinghurst NSW 1300

Western Sydney and Blue Mountains
Mon-Fri 9.00am-5.00pm
Tel: 9204 2400
Fax: 9891 2088
csn-westsyd@acon.org.au
6 Darcy Rd, Wentworthville, 2145
PO Box 284, Westmead, 2145

Hunter
Mon-Fri 9.00am-5.00pm
Tel: 4927 6808\Fax 4927 6485
hunter@acon.org.au
129 Maitland Road, Islington, 2296
PO Box 220, Islington, 2296

MacKillop Centre - Hunter
Training and development opportunities for PLWHA
Tel: 4968 8788

Illawarra
Mon-Fri 9.00am-5.00pm
Tel: 4226 1163:Fax: 4226 9838
illawarra@acon.org.au
47 Kenny St, Wollongong, 2500
POB 1073, Wollongong, 2500

Mid North Coast
Outreach project: by appointment
Tel: 6584.0943
Fax: 6583.3810
4 Hayward Street, Port Macquarie, 2444
POB 1329, Port Macquarie, 2444

FTMAustralia

Resources and health information for all men (identified *female* at birth), their partners, family and service providers. For information contact FTMAustralia .PO Box 488, Glebe, NSW, 2037
www.ftmaustralia.org
mail@ftmaustralia.org

HIV AWARENESS AND SUPPORT

For HIV positive IDUs and their friends. Meets on Wednesdays. Contact Sandra or Tony at NUAA.
Tel: (02) 9369.3455
Toll Free: 1800.644.413

INNER CITY LEGAL CENTRE

Available to discuss any legal matter that concerns you.
Tel: (02) 9332.1966

INTERSECTION

Coalition group of lesbian, gay, transgender and other sexual minority groups and individuals working for access and equity within local community services and their agencies.
Christine Bird (02) 9525.3790

KIRKETON ROAD CENTRE

Needle exchange and other services
Clinic Hours:
Monday to Friday, 10am - 6pm
Saturday to Sunday, 2pm - 6pm
Outreach Bus - Every Night
100 Darlinghurst Road
(Entrance above the Kings Cross Fire Station - on Victoria Street)
PO Box 22, Kings Cross, NSW, 2011
Tel: (02) 9360.2766
Fax: (02) 9360.5154

LES GIRLS CROSSDRESSERS GROUP

An independent peer support group for transgender people. Free tuition, job assistance, friendship and socials, general information. Bi-monthly meetings.
Coordinator,
PO Box 504 Burwood NSW 2134

(MCC) METROPOLITAN COMMUNITY CHURCH

MCC Sydney is linked with other MCC churches in Australia as part of an international fellowship of Christian churches, with a special concern for any who feel excluded by established religious groups. MCC deplores all forms of prejudice, discrimination and oppression - and seeks to share God's uncomditional love and acceptance of all people, regardless of sexual orientation, race or gender.

96 Crystal Street, Petersham 2049
Phone: (02) 9569.5122
Fax: (02) 9569.5144
Worship Times:
Sundays 10.00 am and 6.30 pm
office@mccsydney.org
http://www.mccsydney.org.au/

MOUNT DRUITT LUXFORD ROAD CLINIC

Provides free, confidential and respectful sexual health information, assessment, treatment and counselling.
Ph: (02) 9881 1733
Mon 1.00pm-4.00pm
Wed 9.00am-12.30pm
Fri 9.00am-12.30pm
Every second Thursday 9.00am-12.30pm

NEON

is a support and social group for transgender people of all ages. It's a chance to get together and discuss experiences, gain support and make friends. We meet at the ACON Hunter office on the lastWednesday of every month from 7pm-9pm and on the second Wednesday from 7pm-8pm
Tel: (02) 4927 6808 (ask for Cath)

NEWCASTLE SWOP

SWOP at Newcastle has a Mobile Sexual Health Team
0249 276 808

NORTHAIDS

A community based organisation providing step down and respite care for PLWHA on the Northern Beaches.
Tel: (02) 9982 2310

NUAA - NSW USERS AND AIDS ASSOCIATION

A peer-based community organisation providing education on safe injecting, safe using and safe sex. Information on services for injecting drug users. Free needles, swabs, water, spoons, condoms, dams, gloves and lube. Free newsletter and material on HIV and AIDS and other topics of interest or concern to people using drugs illicitly.
345 Crown St., Surry hills, 2010
PO Box 278, Darlinghurst, NSW, 1300
Tel: (02) 8354 7300
Tollfree: 1800 644 413
Fax: (02) 8354 7350
admin@nuaa.org.au

PARRAMATTA SEXUAL HEALTH CLINIC

provides free, confidential and respectful sexual health information, assessment, treatment and counselling.
Level 2, Parramatta Health Service,
158 Marsden (cnr. George St)
Parramatta 2150
Ph: (02) 9843 3124
Mon, Wed, Fri 9.00am-4.00pm
Tue 10.00am-4.00pm
Thu 4.00pm-7.30pm

PLWHA (PEOPLE LIVING WITH HIV/AIDS)

PO Box 831, Darlinghurst NSW 2010
Tel: (02) 9361.6011
Fax: (02) 9360.3504
http://www.plwha.org.au/
Katoomba:
P.O. Box 187
Katoomba NSW 2780
Tel: (02) 4782.2119
http://www.hermes.net.au/plwha/
plwha@hermes.net.au

POSITIVE WOMEN

Can offer one-on-one support for HIV positive transgender women. Contact Women and AIDS Project Officer or Women's HIV Support Officer at ACON.
Tel: (02) 9206.2000
http://www.acon.org.au/education/womens/campaigns.htm

REPIDU

Resource and Education Program for Injecting Drug Users
Mon - Fri, 9am - 5pm Sat & Sun, 1 - 5 Deliveries Tue, Fri 6 - 9
151 Pitt St, Redfern, NSW, 2016
Tel: (02) 9699.6188

RPASEXUALHEALTHCLINIC

provides a free and confidential range of health, counselling and support services

SAGE FOUNDATION (Sex and Gender Education Foundation)

A voluntary lobbying organisation made up of gender variant people to lobby the government to ensure equal treatment in all respects of life. Sage is non-profit. All welcome.
Ph: 0421 479 285
Email:
SAGE_Foundation@yahoogroups.com

SEAHORSE SOCIETY OF NSW

The Seahorse Society is a non-profit self-help group funded by members' contributions. Open to all crossdressers, their relatives and friends. We offer discretion, private monthly social meetings, outings, contact with other crossdressers, a telephone information service, postal library service and a newsletter.
PO Box 168,Westgate,NSW 2048
or Tel: 0423125 860
www.seahorsesoc.org
crossdress@seahorsesoc.org

SOUTH COAST of NSW from

Ulladulla to the VIC Border. We are a group of like-minded people trying to establish a social and support group. Jen Somers, Sexual Health Counsellor, Narooma Community Health Centre, Marine Drive
Narooma, NSW 2546
Tel: (02) 4476.1372
Mob: 0407 214.526
Fax: (02) 4476 1731

jenni.somers@sahs.nsw.gov.au

(SWOP) SEX WORKERS OUTREACH TRANSGENDER SUPPORT PROJECT

Provides confidential services for people working in the NSW sex industry.
69 Abercrombie Street
Chippendale NSW
PO Box 1354
Strawberry Hills NSW 2012
Tel: (02) 9319.4866
Fax: (02) 9310.4262
infoswop@acon.org.au
www.swop.org.au/

SYDNEY BISEXUAL NETWORK

Provides an opportunity for bisexual and bisexual-friendly people to get together in comfortable, safe and friendly spaces. Pub social in Newtown on 3rd Sunday of every month followed by a meal. All welcome.
PO Box 281 Broadway NSW 2007
Tel: (02) 9565.4281 (info line)
sbn-admin@yahoogroups.com
http://sbn.bi.org

SYDNEY BISEXUAL PAGANS

Supporting, socialising and liberating bisexual pagans living in the Sydney region.
PO Box 121, Strawberry Hills NSW 2012

SYDNEY MEN'S NETWORK

Welcomes FTM Men.
PO Box 2064, Boronia Park, 2111
Tel: 9879.4979 (Paul Whyte)
paulwhyte@gelworks.com.au

SYDNEY SEXUAL HEALTH CENTRE

Provides free, confidential health services, including sexuality, sexual function, counselling and testing and treatment of STDs including HIV..
Level 3, Nightingale Wing,
Sydney Hospital, Macquarie St, Sydney, NSW, 2000.
Tel: (02) 9382 7440 or freecall from outside Sydney 1800 451 624

Directory Assistance

(8.30am-5.00pm) Fax:(02) 9832 7475
sshc@sesahs.nsw.gov.au

TOWN & COUNTRY CENTRE

Drop In Centre - Weekly Coffee Nights - 24 hour ph line - regular social activities - youth services - information, advice and referral - safer sex packs and more! - for bi-sexual, transgender folks and men who have sex with men
80 Benerembah Street, Griffith
PO Box 2485, Griffith, NSW 2680
Tel: (02) 6964.5524
Fax: (02) 6964.6052
glsg@stealth.com.au

TRANS MASH

For younger Trans people (25 and under). Newcastle area.
Contact Judi Butler
j.butler@acon.org.au

WESTERN SYDNEY HIV/ HEP C PREVENTION SERVICE

Needle and syringe program
158 Marsden St, Parramatta
NSW 2150
Ph: (02) 9843 3124
Fax: (02) 9893 7103

WOLLONGONG - TRAN

Transgender Resource and Advocacy Network.
A service for people who identify as a gender other than their birth gender. Providing a safe and confidential place to visit, phone or talk about gender issues.
Thursday AND Friday 9am - 5pm
Tel: (02) 4226.1163

WOMENS & GIRLS DROP IN CENTRE

is a safe, friendly drop-in Centre in inner Sydney for women with or without children. Shower, relax, read the paper, get information, referral and advice.
Monday to Friday - 9.30 - 4.30pm
177 Albion Street, Surry Hills
NSW 2010
Tel: (02) 9360.5388

YOUTHBLOCK HEALTH & RESOURCE SERVICE

Free, safe and holistic health service for young people aged between 12-24 years in the inner-West and Canterbury areas of Sydney. Medical, dental and counselling services and music, visual arts, Aboriginal cultural and health promotion programs available. SPACE program for young people questioning their gender or sexuality.
142 Carrilon Ave, Camperdown
Ph: 9516 2233

A.C.T.

AGENDER AGENDA is a non-profit group committed to providing support, education, information and relief to people living with any tupe of sex or gender related condition (whether symptoms are physical or mental and are attributable to genetic or other origin).
PO Box 4010, Ainslie, ACT, 2602 Ph: 0412 882 855
Fax: (02) 6247 0597
Email: polar@homemail.com.au

AIDS ACTION COUNCIL OF ACT

The AIDS Action Council of the ACT provides information and education about HIV/AIDS, caring, support services for people living with HIV/AIDS
Westlund House, Acton, ACT 2601
GPO Box 229, Canberra, ACT 2601
Tel: (02) 6257.2855
Fax: (02) 6257.4838
info@aidsaction.org.au

PLWHA (PEOPLE LIVING WITH HIV/AIDS)

People living with HIV/AIDS ACT provides peer based support, advice and advocacy for people with HIV/AIDS in a relaxed friendly environment.
Westlund House, Acton ACT 2601
GPO Box 229, Canberra ACT 2601
Tel: (02) 6257.4985
Fax: (02) 6257.4838
plwha.act@aidsaction.org.au

SWOP ACT (SEX WORKER OUTREACH PROJECT)

Provides services for people working in the sex industry in the ACT.
29 Lonsdale Street,
Braddon, ACT, 2601
PO Box 67, Braddon, ACT, 2601
Tel: (02) 6247 3443
Fax: (02) 6247 3446
E-mail: actswop@webone.com.au

Northern Territory

NORTHERN TERRITORY AIDS & HEPATITIS COUNCIL

Incorporating Services and Support For HIV Positive and Hepatitis Positive people.

- Needle Syringe Program
- Sex Worker Outreach Project
- Peer Project GLBTI Community Education, Social & Emotional Support
- ATSI Project - Indigenous Gay Men & Sister Girls
- Community Education

Tel: (08) 8941 1711
Freecall: 1800 880 899
www.ntahc.org.au
info@ntahc.org.au

Queensland

(ATSAQ) AUSTRALIAN TRANSGENDERIST SUPPORT ASSOC. OF QLD.

A non-profit organisation providing counselling, support, referral and information, crisis counselling, drug and alcohol for transgender people, their families and friends.
Ph: (07) 3843 5024 8am-6pm
Email: trans.atsa@bigpond.com
www.atsaq.com
PO Box 212, New Farm, Qld, 4005

BRISBANE GENDER CLINIC

Doctors from private practices with an understanding of the transgender community ARE available for consultation by appointment each Wednesday afternoon from 1.30pm to 5.30pm.
Phone (07) 3837 5645
Fax: (07) 3837 5640
Level 1, 270 Roma Street,
Brisbane 4000

CAIRNS SEXUAL HEALTH SERVICE

A public health clinic with an interest in and experiece of transgender medicine. Doctors, nurses and psychologist with referral to other services as required.
The Dolls House, Cairns Base Hospital, The Esplanade, Cairns
Ph: (07) 4050 6205

GOLD COAST SEXUAL HEALTH CLINIC

A public sexual health clinic with an interest in and experience of transgender medicine. Medical staff, nursing staff, dietician, psychologist. Referral to speech pathology, endocrinologists, psychiatrists, surgeons available. Consultations free, by appointment.
2019 Gold Coast Highway
PO Bopx 44, Miami, Qld, 4220
Ph: (07) 5576 9033
fax(07) 5576 9030

QUEENSLAND GENDER CENTRE

Transsexual semi-supported accommodation available to those who identify as Transgender and who are drug and alcohol free. Accommodation available for six or twelve months.
PO Box 386, Chermside South, QLD 4032 Ph: (07) 3357 6361
www.queenslandgendercentre.org

SEAHORSE SOCIETY OF QLD

We provide a safe environment for members and other persons in their lives to meet and socialise and offer counselling where possible. We are wholly self-funded And open to both sexes no matter what their sexuality
PO Box 574 Annerley QLD 4102
www. geocities. com/ WestHollywood/8009/
seahorse@powerup.com.au

(SQWISI) SELF HEALTH FOR QUEENSLAND WORKERS IN THE SEX INDUSTRY

Provides a confidential service for trannies working in the sex industry in Queensland. Offices in Brisbane, Gold Coast and Cairns. Also has an exit and retraining house for sex workers wanting to leave the sex industry.
PO Box 5649, West End Qld 4101
Tel: 1800 118 021
Fax: (07) 3846 4629
Email: sqwisib@sqwisi.org.au

Andrejic Arcade, Suite 32,
55 Lake Street,
PO Box 6041, Cairns, Qld, 4870
Tel: (07) 4031 3522
Fax: (07) 4031 0996
Email: sqwisic@sqwisi.org.au

Level 1 Trust House
3070 Gold Coast Highway,
Surfers Paradise, Qld, 4217
PO Box 578, Surfers Paradise, Qld 4217
Tel: 1800 118 021
Fax: (07) 5531 6671
Email: sqwisigc@sqwisi.org.au

Level 3 Post Office Arcade
Flinders Street, Townsville, Qld, 4871
PO Box 2410, Townsville, Qld, 4810
Ph: 1800 118 021
Fax: (07) 4721 5188
Email: sqwisit@sqwisi.org.au

Directory Assistance

TRANSBRIDGE
A support group for transgenders in the Townsville area. We have connections with sexual health, mental health, AIDS counselling and others by association.
Transbridge Support, PO Box 3572, Hermit Park, QLD 4812
If we can help you at any time we have a mobile phone for twenty-four hour support at:
0406 916 788
email: transbridge@mail.com

South Australia

CARROUSEL CLUB
A non-profit, social group that operates as a support group for persons with gender issues, and provides social outlets. Produces a Club Newsletter every two months.
PO Box 721, Marleston SA 5033
Tel: (08) 8411.0874
ccsai@hotmail.com
www.geocities.com/carrousel_2000

CHAMELEONS
Counselling, information and support aimed at minimising the isolation of transgender people in South Australia.

PO Box 2603
Kent Town SA 5071
Tel: (08) 8293 3700
Fax: (08) 8293 3900
AH: (08) 8346 2516

DARLING HOUSE COMMUNITY LIBRARY
A non-profit, community based resource that operates as a joint project of the AIDS Council of SA and the Gay and Lesbian Counselling Service of SA Inc.
64 Fullarton Rd Norwood
PO Box 907 Kent Town
South Australia 5071
Tel: (08) 8334 1606
Fax: (08) 363.1046
Freecall: 1800 888 559

SHINE - SEXUAL HEALTH
Networking and Education South Australia Inc. (formerly Family Planning South Australia) provides sexual and reproductive health services for the South Australian community.
17 Phillips Street, Kensington, SA. 5068 Tel: (08) 8431 5177
Fax: (08) 8364 2389

(SATS) SOUTH AUSTRALIAN TRANSSEXUAL SUPPORT GROUP
A support group for transsexuals who have changed or are about to change their gender role and for their partners.Also provides information on transsexualism for the community and people with gender identity difficulties.
SATS C/o PO Box 907
Kent Town SA 5071
or the Gay and Lesbian Counselling Service (Gayline) on: (08) 8422 8400 or country on 1800 182 223 or Sarah on 0409 091 663 or www.tgfolk.net/sites/satsg/hrt.html
email: satsgroup@yahoo.com.au

Tasmania

WORKING IT OUT
Tasmania's sexuality and gender support and education service providing counelling and support, mentoring for lesbian, transgender and intersex (LGBTI) Tasmanians and education and training programmes to schools, workplaces, government and non-government organisations Office hours vary from office to office.
Hobart, 39 Burnett St, North Hobart (03) 6231 1200 or 0429 346 122
Launceston, 45 Canning St, Launceston
Burnie, 11 Jones St, Burnie (03) 6432 3643
www.workingitout.org.au
Email: coord@workingitout.org.au

Victoria

CHAMELEON SOCIETY OF VICTORIA Inc.
While the group does not meet on a regular basis it is there to provide support and information to those requiring assistance with all matters.
PO Box 79
Altona, VIC.3018
Telephone message bank service (03) 9517 9416
email:
chameleonvicgirls@hotmail.com
robr@vicnet.net.au

FTM PHALLOPLASTY CONTACT
Michael is F2M who has had GRS and is willing to be contacted for information and support around Gender Reassignment Surgery for F2Ms in particular phalloplasty as performed by the Monash Medical Centre Gender Team.
Michael Mitchell. Tel: 0405 102 142
Tel: (03) 5975 8916 messagebank
pathwaysau@yahoo.com.au

GENDER AFFIRMATION AND LIBERATION
is a caring self-help group for transexed people. It meet monthly to support people who are in the process of gender/sex affirmation (transitioning or transitioned).
PO Box 245, Preston, VIC, 3072
Tel: (03) 9517 1237
http://groups.yahoo.com/groups/gaal1

PROSTITUTES COLLECTIVE OF VICTORIA
RhED in the sex industry
Are you interested in contributing to **RED**, the magazine produced by the RhED Program? If you are, please contact RhED on (03) 9534 8166 Mon-Fri 10am to 5pm

SEAHORSE CLUB OF VICTORIA Inc.
A fully contituted self-help group financed by members subscriptions. Full or postal membership is open to transpersons who understand and respect the purpose of the club. Partners are also considered to be members. We have private monthly social meetings with speakers from relevant professions. Besides a monthly magazine and a library, we offer a contact mail service.
GPO Box 86, St Kilda, VIC, 3182
Tel: (03) 9513 8222
http://home.vicnet.net.au/~seahorse
seahorsevic@mbox.com.au

(TGV) TRANSGENDER VICTORIA
Transgender Victoria is dedicated to achieving justice and equity for people experiencing gender identity issues, their partner, families and friends. We provide support on a range of issues including education, health, accommodation and facilitating assistance with workplace issues for those identifying as transgender, transsexual or cross-dresser.
PO Box 762, South Melbourne, VIC, 3205
Tel: (03) 9517 6613 (leave a message)
transgendervictoria@yahoo.com.au
www.vicnet.net.au/~victrans

Western Australia

CHAMELEON SOCIETY
Provides support to crossdressers, their relatives and friends.
PO Box 367,
Victoria Park WA 6979
Tel: 0418 908839 (8pm-10pm)
Email: chameleonswa@email.com
www.chameleonswa.com

FREEDOM CENTRE
93 Brisbane Street, Northbridge, Perth, WA 6000
Ph: (08) 9228 0354 (opening hours
(08) 9482 0000(admin)
Fax: (08) 9482 0001
Email: info@freedom.org.au
Web: www.freedom.org.au
Provides peer support, information, referrals and a safe social space for young people (under 26) who are gay, lesbian, bisexual, transgender, transsexual, queer and questioning. We have a monthly drop-in specifically for Trans- and/or gender diverse young people called Gender Q (see below) on the first Thursday of every month from 5-8pm.

GAY AND LESBIAN COMMUNITY SERVICES
2 Delhi St, West Perth, WA, 6005
Ph: (08) 9486 9855
Counselling line (08) 9420 7201
Counselling line country areas 1800 184 527
Email: admin@glcs.org.au
Web: www.glcs.org.au
Gay and Lesbian Community Services provides telephone counselling and other support services for people with diverse sexuality and gender. They have an excellent referral list for trans* friendly doctors, psychs etc.

GENDER-Q
Meets at the Freedom Centre (93 Brisbane Street,, Northbridge Perth WA) on the first Saturday of every month from 1pm-4pm. It is a free peer-based support session for young people (aged 25 and under) with diverse gender expression. Significant others welcome.
Freedom Centre, PO Box 1510, West Perth 6872, WA
Tel: 9228 0354
www.freedom.org.au
email: info@freedom.org.au

INTERNATIONAL FOUNDATION FOR ANDROGYNOUS STUDIES (IFAS)
See International listings on p.39

MAGENTA
Magenta offers support, education and information to transgender, male and female workers in the sex industry: PO Box 8054 PBC Northbridge, WA 6849
Tel: 08. 9328 1387
Fax: 08. 9227 9606

PERTH INNER CITY YOUTH SERVICE (PICYS)
PO Box 1062, West Leederville, WA, 6901

Directory Assistance

Ph: (08) 9338 2792
Fax: (08) 9388 2793
Email: *picys@westnet.com.au*
PICYS provide medium to long-term support and accommodation for young people aged 16 to 25 who would otherwise be homeless. PICYS staff are well informed about TTI issues and are trained to provide young people with specialised support. TTI-specific resources and referrals to medical professionals.

TRANSCOMMUNITY WA

We provide peer support for, information resources about, and advocacy on behalf of, people who are transitioning, are planning to transition, or have transitioned. We also organise discreet social events at which significant others and supporters of our membership are welcome. Contact Lisa on 0427 973 496, email lisasonau@yahoo.com.au

TRANSWEST: THE TRANSGENDER ASSOCIATION OF WESTERN AUSTRALIA (INC)

Support, information, advocacy and social events for all kinds of transgender and transsexual people. Established 1997
PO Box 1944,
Subiaco, WA, 6904
Mob: 0407 194 282
hmpperth@cygnus.uwa.edu.au
www.geocities.com/transwest_wa

TRUE COLOURS PROGRAM

1st floor, Trinity Buildings,
72 St Georges Terrace. PERTH, WA, 6000
Ph: (08) 9483 1333
Fax: (08) 9322 3177
Email:
jaye.edwards@unitingcarewest.org.au
Web*:*
www.unitingcarewest.org.au
*T*he True Colours program aims to promote safe and inclusive rural and regional communities where young people with a diverse sexuality and gender, their families and friends are supported and affirmed. This program offers support to young people who are coming out as well as educating the community services sector and community members about the impact of homophobia and heterosexism on these young people, their families and friends.

WELLBEING CENTRE OF WA

Service for people with blood-borne diseases such as Hep C and HIV/AIDS. This service is for people with issues such as health problems,relationships, medication and alternative therapies.
162 Aberdeen Street,
Northbridge
Tel: (08) 9228 2605

www.free2be.org,au is a WA based website for DSG youth that has a section on gender too (www.free2be.org.au/gender.html

National

(ABN) AUSTRALIAN BISEXUAL NETWORK

ABN is the national network of bisexual women, men and partners and bi- and bi-friendly groups and services. ABN produces a national news magazine, houses a resource library and is a member of the International Lesbian and Gay Association (ILGA).
PO Box 490, Lutwyche QLD 4030
Tel: (07) 3857 2500
1800 653 223
ausbinet@rainbow.net.au
www.rainbow.net.au/~ausbinet
IRCL (oz.org network) A.B.N.

AIS SUPPORT GROUP (AUSTRALIA)

Support group for Intersex people and their families. We have representatives in all Australian States.
PO Box 1089
Altona Meadows, VIC, 3028
Tel: (03) 9315 8809
aissg@iprimus.com.au
www.vicnet.net.au/~aissg

AUSTRALIAN WOMAN NETWORK

Australian WOMAN Network is primarily a lobby and health support group for people who experience the condition of transsexualism, their families, friends and supporters. There are email discussion lists for members as well as a bulletin board providing places for both public and member-only access. There is also a large archive of related material available for education and research purposes.

www.w-o-m-a-n.net

CHANGELINGASPECTS

A caring national support organisation for Transsexual people, their partners and families. For information, please write or call.
email:knoble@iinet.net.au
www.changelingaspects.com

FTMAustralia

Resources and health information for all men (identified *female* at birth), their partners, family and service providers. Contact FTM Australia for more information.
PO Box 488, Glebe, NSW, 2037
www.ftmaustralia.org
mail@ftmaustralia.org

TRUE COLOURS DIVERSITY

True Colours represents young people who experience trans-sexualism and a network of their parents, families and supporters throughout Australia. Whether you are a parent, a family member, a carer, a friend or a young person experiencing the diversity in sexual formation called transsexualism - you have come to a friendly place. True Colours offers mutual support and advocacy for young people with transsexualism and their families. We also offer a parents/ caregivers email discussion group.

Web: www.truecolours.org.au
Email: mail@truecolours.org.au

Directory Assistance

International

AGENDER NEW ZEALAND
A caring national support organisation for Cross/ Transgender people, their partners and family. For a detailed information pack, please write or call.
PO Box 27-560
Wellington New Zealand
Tel: (64) 0800 AGENDER
president@agender.org.nz
www.agender.org.nz

BEAUMONT SOCIETY
Non-profit organisation for crossdressers throughout Great Britain. Social functions, counselling and a contact system for members. Provides a magazine - Beaumont magazine
BM Box 3084
London WCIN 3XX
England
www.beaumontsociety.org.uk/

BEAUMONT TRUST
The Trust is a registered charity, the aim of which is the support of transvestites, transsexuals, their friends and families. It fosters research into both psychological and social aspects of transvestism and transsexualism and can provide speakers to address other organisations. It produces literature and arranges workshops, develops befriending facilities and assists with conferences.
The Beaumont Trust, BM Charity, London WC1N 3XX.
http://www3.mistral.co.uk/gentrust/bt.htm

CROSS-TALK
The transgender community news & information monthly.
PO Box 944,Woodland Hills CA 91365U.S.A.

FTM INTERNATIONAL
A group for female to male transgender people. Provides a quarterly newsletter - FTM.
160 14th St
San Francisco, CA, 94103
http://www.ftmi.org/
info@ftmi.org

FTM NETWORK UK
A support group for female to male trans people. Provides a newsletter - *Boys' Own*
FTM Network, BM Network, London, WC1N 3XX, England.
www.ftm.org.uk

GENDERBRIDGE Inc.
Support and Social Society for people with gender identity issues, their families, partners and professionals involved in care, treatment and counselling.
PO Box 68236, Newton, 1145, New Zealand
Phone: (64) (09) 0800 TGHELP (0800.84.4357) (24 hrs)
www.genderbridge.org
info@genderbridge.org

GENDER TRUST (THE)
A help group for those who consider themselves transsexual, gender dysphoric or transgendered. Provides trained counsellors, psychologists and psychotherapists and a there is a referral procedure to a choice of other therapists.
The Gender Trust
PO Box 3192, Brighton
BN1 3WR, ENGLAND
http://www3.mistral.co.uk/gentrust/home.htm
gentrust@mistral.co.uk

INTERNATIONAL FOUNDATION FOR ANDROGYNOUS STUDIES (IFAS)
Support, information, advocacy and social events. An incorporated body established to advance the health, well-being, basic rights, social equality and self-determination of persons of any age or cultural background who are transgender, transsexual, transvestite or intersex, or who are otherwise physically or psychologically androgynous as well as gay, lesbian and bisexual people.
PO Box 1066
Nedlands, WA, 6909, Australia
Mobile ph: 0427 853 083
http://www.ecel.uwa.edu.au/gse/staffweb/fhaynes
IFAS_Homepage.html
www.IFAS.org.au

IFGE INTERNATIONAL FOUNDATION FOR GENDER EDUCATION
Educational and service organisation designed to serve as an effective communications medium, outreach device, and networking facility for the entire TV/TS Community and those affected by the Community. Publisher of materials relevant to the TV/TS theme. Produces TV/TS journal -*Tapestry*.
PO Box 229, Waltham, MA 02254-0229 U.S.A.
http://www.ifge.org/
info@ifge.org

IKHLAS
IKHLAS drop in centre is a community program by Pink Triangle Malaysia. Provides an outreach project, HIV/AIDS information, counselling, medication, workshop and skill building for transgender people in Kuala Lumpur Malaysia.
PO Box 11859, 50760
Kuala Lumpur Malaysia
Tel: 6.03.2425.593
Fax: 6.03.2425.59

ITANZ INTERSEX TRUST AOTEAROA OF NEW ZEALAND
Registered non-profit charitable trust to provide a number of educational, advocacy and liaison services to intersexuals, their parents, caregivers, family, friends and partners within the Community and those affected by the Community.

PO Box 9196, Marion Square
Wellington, New Zealand
Tel: (04) 4727 386 (machine only) Fax: (04) 4727 387

PROSTITUTES COLLECTIVE OF AUCKLAND - NEW ZEALAND
PO Box 68 509,
Newton, Auckland,
New Zealand

PROSTITUTES COLLECTIVE OF CHRISTCHURCH-NEW ZEALAND
Provides a confidential service for trannies working in the sex industry.
PO Box 13 561
Christchurch,
New Zealand

PROSTITUTES COLLECTIVE OF WELLINGTON - NEW ZEALAND
Provides a confidential service for trannies working in the sex industry.
PO Box 11/412, Manner St
Wellington New Zealand
Tel: (64) 482-8791
Fax: (64) 801-5690

Every effort has been made to include accurate and up-to-date information in this directory. To amend your listing fax (02) 9569 1176 or email the Editor on resources@gendercentre.org.au

The Gender Centre runs a Youth Support Group(16-25 years old)

The next group will start when we have eight people interested in participating and will run for eight weeks

Call the Gender Centre

9569 2366

All gender questioning trans and gender queer young people are welcome to participate

Are You Young andTransgendered ?
Do You Write Creatively?

Interestingly?

Do You Want To Have Your Say?

We Want You To Have Your Say!

The Gender Centre Administration would like to see more material for *Polare* coming from the under twenty-five segment of our community. We are aware that the problems and experiences of transgenders who transition early are different from those of transgenders who transition late. We would like to have these differences defined so that we can campaign to improve the legal, social and therapeutic conditions of those who transition early. Such people may not have had the advantage of making their way in the world in their assigned gender but may instead have encountered all the disadvantages of early transition. They may lack financial security, established reputation and social acceptance and we would like to hear your suggested strategies to ameliorate such situations.

You are encouraged to contribute material for the October-December 2009 issue of *Polare.* Please send your contribution to: The Editor, *Polare*, PO Box 266, Petersham, NSW, 2049 by 8 March 2010

This One's For The Boys

Once a month the Gender Centre will host a "boys only" drop-in on a FRIDAY night.

The next will be on Friday 5th Februaru 2010.

Come along, have a meal, meet new friends and listen to our guest speakers. Watch Twitter for updates.