Polare

Edition 86
January-March 2011

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-IN

Wenesday 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 image: Gina Wilson, Chairperson of OII Australia (Organisation Intersexe Internationale) is an activist, an aeronautical engineer and an energetic and dedicated advocate for the rights of the intersexed. Her article appears on p.21.

January - March 2011

No. 86

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REGULAR

FEATURES

SERVICES & NOTICES

Editor: Katherine Cummings
THE FINE PRINT

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DEADLINE

for submissions to the next edition of *Polare* is the eighth of March 2011

The Manager's Report

WOULD YOU LIKE TO HEAR BY EMAIL?

The Gender Centre is compiling a list of email addresses of those clients and friends who would like to be notified of social, support, educational and other functions and events of interest.

Just email us

reception@gendercentre.org.au

Put "Email list" in the subject line and give us your first name and Email address.

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 and dvds are not for loan but can be viewed, by appointment, in the Gender Centre.
The Library is now housed in the Office of the Information and Resources Worker.

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!

PLEASE NOTE!

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

Well, Christmas and New Year have come and gone and it is time to start thinking about the year ahead, after a very full year in 2010. Planning has already begun for 2011 in the areas of activities groups and workshops.

2010 saw an increase in organisations asking for training regarding people on their staff transitioning, we participated in a number of health conferences, in Sydney and Canberra, spoke at a number of TAFE colleges, submitted a number of submissions to the Human Rights Commission and the United Nations, provided feedback on the Police strategic plan (search and custody procedures) and so on. We farewelled our Counsellor, Gaye Stubbs, and welcomed the new Counsellor, Anthony Carlino. We also lost Jo Ball, our Residential Case Worker. We are searching for a replacement for Jo and by the time you read this we may have found one.

Outreach in 2010 increased with the introduction of services out of the Kirketon Road Centre, as well as outreach to the outer western suburbs and Canterbury Road. In 2011 we will provide an extra outreach serice per month in partnership with SWOP (Sex Workers' Outreach Project) to deliver more outreach services to clients in need.

Our Fact and Information sheets are in the process of being updated as well as our website. We are developing new resource booklets for Sistagirls and Brother Boys and these booklets will soon be sent out to stakeholders for feedback. There are also new booklets for Youth and for Parents.

In 2011 the Gender Centre will staff a booth at Fair Day, along with our partners in crime at the Inner City Legal Centre, and if anyone wants to volunteer an hour or two to help, we would appreciate it. Contact the Centre (9569 2366) with your details and we'll get back to you.

To all of you out there, the team and I hope you had a happy and safe festive season and that 2011 will be even better than 2010.

Phinn Borg

Editorial - Katherine Cummings

The time has come - again - to talk about terminology, which seems to have a life of its own, not least because there are large, assertive groups here and overseas who want to follow-the-leader rather than thinking about the way in which languages work. Rather than adopting logical forms they prefer to say "But it's always been done this way."

The biggy, of course, is the ongoing furore caused by those who want to make distinctions between various sub-classes of our transgendered community. This is partly, I fear, because they see a pecking order in the range which includes cross-dressers, pre-ops, post-ops and drag adopted for various reasons, some commercial, and some for personal amusement without any ongoing commitment to gender change, temporary or permanent.

The pecking order phenomenon is well known in almost every animal society, and humans have refined it to a complex art which attempts to define superiority in terms of race, politics, ethnic origins, nationalism, skin colour, religion ... you name it, humans have asserted that x is better than y and y should therefore be oppressed, discriminated against and learn their place. And y, in turn, will try and identify z to take an even lower place in the pecking order so that they, too, have someone to look down on.

Because, however, humans are almost infinitely complex there will always be changes in status and changes in the laws which administer status, so that one group will gain ascendency over a formerly dominant group, or, at the very least, will achieve a legal, if not actual parity. And because of human complexity there will often be movement from one group to another.

Although people seldom change their skin colour (exceptions like Michael Jackson test the rule) they can and do change their politics, their religions and their allegiance to various gender or sexual groupings. For many years I was prepared to think myself a transvestite and act accordingly but the time came when I admitted to myself, and the world, that I was transgendered. And yes, for years I imagined the correct term was transsexual, because I accepted the term in general use, rather than thinking through the assumptions and the inevitable parallel with the words homosexual, heterosexual, bisexual and asexual. In other words, the assumption that "transsexual" had something to do with sexuality and the selection of sexual partners.

But, hey, sexuality, like politics and religion, is a movable feast, and there are many who change their sexuality, with or without also changing their gender role.

And changes are not always final. People go back and forth across these so-called borders, sometimes more than once. If there is something a human being can do, some human being will do it.

So for a start, let's abandon the "holier than thou" attitude some people adopt, and recognise the fact that people change their views and even their innermost feelings mutate. The NSW Gender Centre takes the view that it exists to help **anyone** with gender issues, and the sooner that sinks in with some of the clients of the Gender Centre, the better. There is no pecking order recognised by the administration of the Gender Centre and anyone who accepts the services of the Centre is expected to treat everyone else with respect and civility.

I have said in other places that the English language, vast and powerful and beautiful in its flexibility and subtlety of nuance though it is, is also a behemoth when it comes to taming it, and an ocean liner when it comes to altering its direction. People strive to change its forms to suit their own needs and occasionally they succeed, but not often. A case in point is the personal pronoun (he, she, it), which some people see as perpetuating undesirable superiority/inferiority relationships. Those who find the feminine form demeaning or degrading for some reason, want to create mosaic monsters like "shim" (which means something else, compounding the confusion) or "zhe", "yt",

"thon", "ve", "xe", "zher", "zhim", "phe" and so on. (Google "alternative pronouns" if you wish to be driven mad by lexicographical stupidity.) This has been going on since 1850 without noticeable change in written English other than a tendency to alternate between "he" and "she" and the deplorable modern use of "their" as a singular possessive ("each student is to pick up their essay by Tuesday.")

Language doesn't work like that and the few neologisms which creep in usually do so for good reason (the use of Gloria Steinem's "Ms" through a feminist belief that a woman's marital status was nobody's business but her own) or from popular repetition and/or whimsy (Spike Milligan's invention of "the dreaded lurgy").

There have been recent attempts to use portmanteau phrases which virtually delineate an individual's medical history ("woman of transsexual background","post-op man of transsexual experience", "man with a transsexual history") but I see no reason not to adopt the terms "man" and "woman" for those who have completed their journey from one gender role to the other, and if more detail is requested, a clear description of the process of, and reasons for, transition can be supplied to the enquirer, if one feels like it.

Sometimes, when I am being whimsical, I will tell an audience I used to be transgender until my surgeon cured me, but I always hasten to add that this is not literally true. I was a woman before my transition, and hormones and surgery merely made it easier and more comfortable for me to live in my innate gender role.

As far as terminology goes, the most strident conflict revolves around the usage of "transsexual" as opposed to "transgender". The term "transsexual" is the older term and harks back to Harry Benjamin's book, *The Transsexual Phenomenon,* published in 1966, although he had published a number of scientific papers before the book came out. "Transsexual" became the accepted term for those who wished to revise their gender identities and live in an affirmed gender role.

Virginia Prince, who was born Arnold Lowman and later called herself Charles Prince when in male mode and Virginia Prince when female, apparently coined the term "transgenderist" or "transgenderal" because she wished to make a clear distinction between sex and gender and claimed in her own case to have changed one but not the other. The term "transgender", which derives from Prince's coinages has also passed through some redefinitions, with some people seeing it as a simple expression for those who change from one gender role to the other (I do not intend to enter the murky waters of multiple genders, about which I am sceptical) while others see it as an umbrella term covering every possible gender variation, however temporary or commercially inspired it may be.

I cleave to the belief that "transsexual" is misleading, partly because of the false parallel with other "-sexual" words, all of which refer to sexuality or the lack of it, and also because I do not believe that medical science has the ability at this point to change a human's sex, except in terms of cosmetic and plastic surgery and in terms of altered appearance through the influence of hormones. These verge occasionally on a true conversion (the ability through hormones to create feminine breasts and to induce lactation in formerly male breasts, for instance, and the creation of a functioning clitoris from a section of the glans or 'head' of the penis). These examples, however, merely demonstrate the overlapping similarity of the sexes in some areas [for more information, Google "male lactation"]. Surgical intervention, of course, is mostly cosmetic in changing the body's appearance.

Beyond these limited changes, the sex one is born with is, currently, the sex one will die with. I leave aside the variations involved in the phenomenon of Intersex. We have material on Intersex from the OII (Organisation Iternational Intersex) to inform this issue of *Polare* and I will be writing an overview article on Kleinfelter's Syndrome as soon as I stop writing this editorial.

The differences between sex and gender should be too well known to be laboured here. Suffice it to say that sex is physical and physiological and gender is social (and/or grammatical, in English at least, although other languages seem to divorce sex and gender more readily). A person who is sexually male and who is transgendered is mentally and socially female

(and *vice versa* for the transman). Usually the inner conviction of transgender status occurs very early in life. Treatment received by the transgendered person may make it simpler for him or her to live in her or his affirmed gender role, but it is not medical intervention that makes a person transgendered. As the name implies, "transgender" is a process, a journey, a transition, but it is all these things only in the sense that a known goal is attained and a foregone concusion is realised. By contrast the term "transsexual" is something of a con, since, however much a transgendered person desires full conversion to the other sex, there are currently no ways in which this conversion can be achieved. In fact, by virtue of some misguided and muddle-headed thinking on the part of legislators, the major medical procedures specified for "recognised" transgenders are procedures intended to remove the ability to have any kind of sex other than recreational, and the issuance of documentation appropriate to the newly attained gender role is usually predicated on the completion of "sex reassignment surgery", which, as described above, is designed to remove functioning sex organs and replace them with cosmetic approximations of the organs visually appropriate to the affirmed gender.

Conversely it is significant that those who draft legislation for our community, in NSW at least, have preferred the term "transgender" to "transsexual" for our laws, thereby displaying uncharacteristic understanding of the truth.

It would be good if we could establish some kind of consensus on terminology.

What this would require in the way of a conference, seminar, working party or standing committee is uncertain. Some terms, like "recognised" transgender are overdue for consideration. Others will never be standardised. But we should at least recognise the problem and work on it.

Katherine

A blog to the editor from SuzyQ

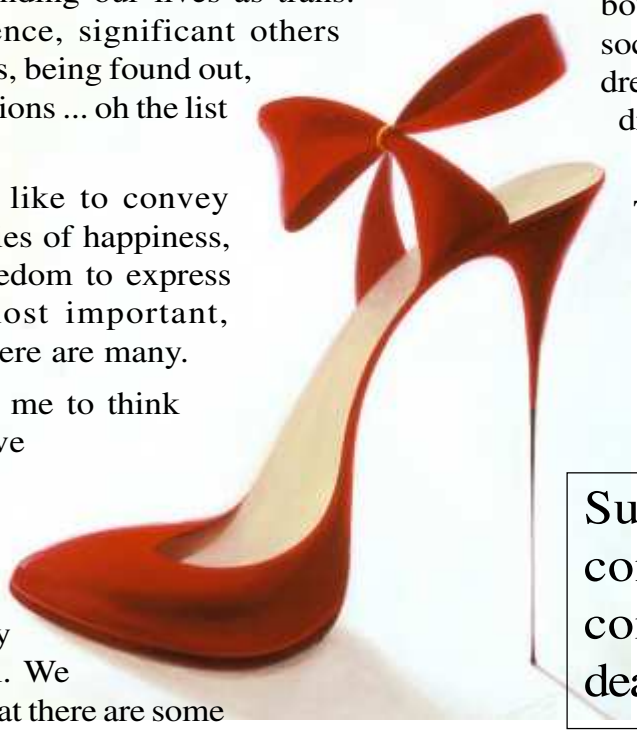
Shoes!

Okay now that I have your attention ... (I don't know of any of us who can resist shoes).

Welcome to my first post! I can tell you it's a bit scary. Who knows who might read this. As with many of you I am not completely out of the closet, so to speak. That's an interesting term, "closet". I'm not sure it really applies to us girls since we usually love to be in the closet picking out what to wear and trying on clothes.

This blog hopes to deal with some of the more serious issues surrounding our lives as trans. Issues such as violence, significant others reactions, fear, careers, being found out, sex, hormones, operations ... oh the list can go on ...

I would also would like to convey success stories. Stories of happiness, love, acceptance, freedom to express who we are and most important, laughter. Of which there are many.



It would be naive of me to think that I will not receive some email from those who would find this post sick and revolting. Periodically I may publish those as well. We all need to be aware that there are some people who will hate us without knowing us. However it has been my experience personally and from talking with my friends that most people are encouraging at best and oblivious at worst.

I'll tell you a little story. My biggest fear when I first started going out in public dressed wasn't someone attacking me. I was most afraid of the seven-year-old boy, yelling out to his mom. "Mom, look at that man in a dress! Of course in my imagination everyone would turn and stare at me.

Well it happened, sort of.

I was staying in a nice hotel on the sixth floor. The only way in and out of the hotel was by elevator. I'm sorry, honey, I am not going to walk down six flights of stairs in heels. I get to the elevator and press the down button.

The elevator stops on the fifth floor. There he is ... the dreaded seven-year-old. My heart actually stopped. Then it raced! The boy and his father entered the elevator, and nothing happened. The boy didn't even notice me. Damn, after spending two hours getting ready the father didn't notice me either.

We are a diverse group, we are heterosexual, gay, bi- and almost every shade in between. We are tranny, we are cross dressers, we are transgendered, we are transvestites, we are on hormones, we have real boobs, we have store bought boobs. Some still stuff socks. Some are 24/7, some only dress at home while alone. We all dress and when we do we are all free.

Thanks for your time.

Hugs,

Suzy

Suzy welcomes contact and comment at:
dearsuzyq@gmail.com

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

An Introduction to Rusty

Hello to all members of the trans community, and especially those who visit the Gender Centre.

My name is Rusty Nannup and I am aWatjarri-Nyungar woman. My tribal lands are in Western Australia and sometimes I return to see my friends and relatives. But more important is that I am transgendered and I have worked at the Gender Centre as Receptionist since 2007.

During this time I have met many wonderful members of the trans- community and their friends and families.

We are all different and we are all the same. We come from many diverse backgrounds but we have one special thing in common ... how we feel about ourselves, who we are and how we identify.

Rusty Nannup

My job at the Centre is as Receptionist and usually I will be your first port of call, the first voice you hear if you telephone the Centre and the first face you see as you come through the door.

I will always do my best to help you, to see that you meet the right staff member to talk to, and that you receive the right resources to read, to use or to consult, the services and resources *you* need for your particular problem.

Feel free to give the Centre a call if you want to discuss something about your gender issues, or your rights, or if you need a referral to a professional. We may not be able to solve all your problems on the first call, but you will have made a contact and can make appointments to call back or come in for a face-toface.

My thanks to you all for being who you are, and being brave enough to stand up and be counted.

Rusty

Gay, lesbian, bisexual or transgender or queer?

Aged 18 or over?

The University of Sydney is conducting a study looking at barriers to accessing primary healthcare. If you would like to find out more about our project, click here

http://glbt.med.usyd.edu.au

THE UNIVERSITY OF SYDNEY

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

FREE!
HOME TUTORING IN READING AND WRITING FOR ADULTS
(nights preferred)
Call Margot 9335 2536
or Mim 9335 2350
@ Petersham TAFE

The Counsellor's Column by Anthony Carlino

The gift of transition to your child.

Like all people, children need love and acceptance. A parent or guardian who supports a child to grow into their own person, allowing them to explore the world with a child's endearing sense of wonder provides an important element of this growth. Kindness and compassion that recognises a moment warranting intervention or perhaps the wisdom of inaction (the latter often being particularly difficult for a parent) also plays an important role.

These are universal needs which are important to a child's healthy development. They present challenges to a parent which can manifest in many ways. The parent who is transgendered has the same responsibilities as any other parent. At the same time, being a transgender parent presents its own unique challenges and attempting to discuss all of them in this column is not practicable. I would like to focus on transphobia and the impact it can have for a transgender parent.

An engaged parent who is an active part of his or her child's life will almost invariably come into contact with their child's friends and other parents. It is unfortunate that in some circumstances, when those friends and families are aware of your gender-identity, a child may encounter transphobia because of the fixed gender ideals others hold (it is equally true that they might not). This transphobia can extend to the employees of your child's school, the management of your child's sports team or number of other domains.

While the experience of bullying and transphobia can be painful for both an adult and child alike, there are steps one can take to get support if it is being experienced. As a starting point, schools are required to take action when any sort of bullying is taking place. In circumstances where someone feels that a school is not taking your concern of transphobia seriously, the Gender Centre can provide education and training to school staff. It needs to be reinforced that it is never okay for anyone to experience bullying or transphobic violence.

One of the most saddening and heart-wrenching beliefs I have heard transgendered parents communicate is the idea that it may be in their children's best interests to withdraw, as a parent, to protect the child from the experience of trans-phobia. It is important to acknowledge that this belief is coming from a yearning to protect one's child. Often that same parent has experienced trans-phobic violence themselves and, well aware of the pain and hurt it can cause, seeks to shield her or his child from this by any means. It is a genuine attempt to support a child which can have long-term ramifications for that relationship.

Anthony Carlino

Children can sometimes develop faulty beliefs about themselves. It is possible that in circumstances where a parent withdraws from a child, the child might mistakenly take on the message, "I am not worthy of love."

It goes without saying that this will have an unwanted impact on a child's development and their attachment style in both childhood and adulthood.

Children who take on this message can grow up with a sense of being "less than" others which can result in all types of creative adaptations that do not serve them in adulthood. It is important to acknowledge (for those who are scientifically minded of course!) that available research does not support concerns that a parent's being transgendered impacts adversely on a child (Green, 1998),

In contrast, remaining an engaged and active participant in your child's life, seeking to support them through challenging times offers a transgender parent a wonderful opportunity.

This opportunity is to impart what I call a "higher order" message, an unspoken gift I pick up on so often in counselling sessions and have the privilege of noticing. What message is this?

It is the message to live one's truth and move towards being the person we really are.

In a world where there is sometimes a lot of pressure to conform to ideals held by others (including gender ideals) the decision to transition has in it much wisdom that deserves acknowledgement.

What a wonderful gift transgender parents give their children as both a role model and an example of being true to themselves. To withdraw from their children's lives potentially denies them this message and in attempting to protect they may end up doing the oppposite.

Never forget that your being transgendered is potentially a great gift to your child.

To arrange for counselling at the Gender Centre please contact us on 9569 2366. Counselling is available from Monday to Thursday.

No money to study?

We can help!

The Pinnacle Foundation was established to provide scholarships and mentoring for disadvantaged gay, lesbian, bisexual, tramsgemder and intersex youth (16 to 24 years old).

No matter what your interest or what you aspire to be, we may be able to offer the financial support and resources to help you get there!

We know potential when we see it.

Applications closing soon!

Call (02) 9990 4708 or visit

www.thepinnaclefoundation.org

Gay and Lesbian Counselling

Telephone Counselling:

q General line daily 5.30pm to 10.30pm
Sydney Metro 8594 9596
Other areas of NSW 1800 184 527

q Lesbian line
Monday 6.30pm to10.30pm
Sydney Metro 8594 9595
Other areas of NSW 1800 144 527

q Face to Face Counselling:
In partnership with Jansen Newman Institute (JNI)

q Counselling session times by arrangement

q Call JNI (02) 9436 3055 or GLCS (02) 8594 9500

Smart Recovery Program - group support

q In partnership with the SMART Recovery program and Alcohol and Drug Information Service(ADIS)

q Every Monday at 6.00pm

q Call ADIS on 9361 8000 or GLCS 8594 9500

For further information please contact Chris Wilson, Training and Volunteer Co-ordinator,
(02) 8594 9500
Website: *www.glcsnsw.org.au*

The Gender Centre will be hosting an information and support group for parents who have children (any age) who are transgender or gender diverse.

The first meeting will be on Friday, 25 February from 6.00pm to 9.00pm.

A light supper will be available.

Contact Liz or Anthony on 9569 2366

Barbecues and other events

Easter Barbecue Saturday16 April (Noon to 4.00pm)

Christmas Barbecue Saturday 17 December (Noon to 4.00pm)

Locations to be advised

Watch the Gender Centre Website, Twitter and Facebook

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** _____

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 Liz or Anthony on 9569 2366.

"But is it something you can pick and choose? You wouldn't say, I'm thinking of becoming black."

"It's not the same, Dad. The point would be that I'd always been black. What I'm saying is that I've always been a boy - only now I've decided to do something about it."

"Who are you going to be then?"

"Paul. A. Patterson."

Logical - "What's the 'A' stand for?"

"Who I might have been."

"But you were Paula. I was there when you were born. To be blunt - I've seen your bits."

"That ... isn't me."

We're sailing close to the wind here. I resort to lame humour. "Paula Patterson, your gender assignment, should you choose to accept it ...".

"But that's it, isn't it? I don't choose to accept it. I can't."

"You're keeping the 'Patterson' though?"

"Yes. That's you and me: it's who we are. Paula or Paul, it makes no difference. I'll be the same person."

I want to hug her - keep her close - and safe - always. She know that. But if we get to hugging, the discussion will evaporate. We're so alike - rational, reserved, under control, wary of intimacy but needing it nonetheless.

"We, me, you," I say. "It's he/she that's the problem. It seems we're in want of a personal pronoun."

"Yeth, I are." She sniggers at her old baby-talk joke but, immediately, she's back on topic. I can see there's no avoiding it.

"Anyway," she says, "you know I've always worn boy-clothes and I've never worn make-up. So now I'm going to get my hair cut short and ..."

Last chance - "Ah-ha! So what you're telling me is that you're changing your hairstyle."

"Very funny, Dad. If I said you were a wit, I'd be half right."

"Sorry."

Avery Mathers

"So, yes, I will have short hair and ... I'll be using a chest binder. I need people to acknowledge me as he not she, Paul, not Paula - especially you. Eventually there'll be hornone therapy and surgery but that could be a while off. Like somebody told me - the being is already there but the becoming is a process."

Her hair's always been long and blonde; although it's darkened now she's in her twenties, and she keeps it tied back. For a moment, I wonder what Nel would have made of this. But she went away when Paula was hardly a year old. Paula only knew her mother at second-hand, through what I'd told her. Would it have made a difference if Paula hadn't been brought up by a single father? Would Nel have felt betrayed by her daughter switching sides? Do I?

"Dad?"

"When does it start - the becoming?"

"It started long ago. That's what you haven't been noticing."

Odd how something like this lets you - no, makes you - look again. Paula playing in the mud - filthy but delighted. Paula playing 'house' - but building them, not living in them. Lego and Meccano - never dolls. Running with the boys. Bikes and football. Skinned knees and bloody noses. The fuss she made that time when she was adamant she had to pee standing up. Has my daughter been in orbit round the ticking time bomb since before she went to school? Who should have seen it, if not me?

"So ... you're not disowning me and chucking me out of the house?"

"No - of course not."

"Just checking. Apparently it happens."

"That's what the LGB support-group people told you?"

"Yes. Lesbians, gays and bisexuals have less

problem that they used to but now its transgender that's the unacceptable face of deviation."

"They're sympathetic then?"

"Yes. Although I don't think they understand why I'm not 'proud to be trans' in the same way that they're 'proud to be gay'."

"And that would be because all you want is for people to accept you for who you are. And that doesn't involve getting in their faces and saying, Look at me, look at me, I'm different."

I study the earnest face looking across at me. Paul looks at me with those same clear grey eyes - puzzled, now that I suddenly seem to have grasped the point. "Em, ... yes ... exactly."

Yes, Paul, I see you.

I take the old black and white photograph out of my pocket. It's a little girl of three or four, playing naked on the beach. In the background you can just make out people sitting in deck-chairs.

He studies it for a few long moments.

"Who is it, Dad?"

"It's me - when I was Nel."

Are You Young and Transgendered ?
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 have encountered many disadvantages of early transition. They may lack financial security, established reputation and social acceptance. We would like to hear your suggested strategies to help in such situations.

You are encouraged to contribute material for the April-June issue of *Polare*. Please send your contribution to: The Editor, *Polare*, PO Box 266, Petersham, NSW, 2049 by 8 March 2011

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!**

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SAGE - campaigning for your rights!

Genderism in Sports Under Attack Again

Lana Lawless, a former police officer who had affirmation surgery in 2005, has successfully challenged the [US] Ladies Professional Golf Associations ban on transgendered players. LPGA had a policy that its players be "female at birth", but legal challenges have led to a revised policy to allow transgender membership. This required a two-thirds majority vote.

Lawless became known when she won the women's world championship in long-drive golf in 2008. The event was not held in 2009 and in 2010 Lawless was deemed ineligible because of her transgender status.

Transgendered tennis player, Renee Richards, who successfully sued in the 1970s for the right to compete in women's competition, feels that there are still a number of complex issues to be reconciled.

Sport is based on the principle that players should compete within groups of approximately equal skill and strength, so that competitions are divided into classes by age, weight, skill and gender. These boundaries are never totally inflexible. Boxers compete in classes above their weight division, track and field athletes compete outside their age groups. If this sort of flexibility is permissible, why should not the gender line be blurred and the reality of gender change be recognised?

Although there is no widespread consistency in the rules and policies of sporting bodies regarding transgender athletes, a number of notable advances have been made.

In 2004 the International Olympic Games Committee ruled that transgender athletes were acceptable if they had been through affirmation surgery and two years of post-operative hormone therapy. This policy has also been adopted by the United States Golf Association and the Women's Tennis Association. Caster Semenya's win after the International Association of Athletics Federations backed her right to compete, and the successes of Mianne Bagger in women's golf, Renee Richards in tennis and Kristen Worley in cycling demonstrate the slow turning of the tide. Although the Ladies Professional Golf Association established a policy of "female at birth" neither the United States Golf Association, the Ladies European Tour nor the Ladies Golf Union in Britain have similar rules.

The lawsuit by Lawless, which also named the LDA and two of its corporate sponsors, sought an injunction stopping the tour from holding events in California as well as an unspecified amount in damages.

California is one of 13 states and the District of Columbia with laws barring discrimination on the basis of gender identity.

"It looks like the LDA changed its rules to target and exclude her," said Waukeen McCoy, a civil rights attorney in San Francisco who has handled many types of discrimination cases.

Thomas Kemp, a lawyer representing the LDA, declined to comment. Ryan Rodenberg, an assistant professor of sports law at Florida State's Department of Sports Management, said Lawless' suit "could be a precedent-setting case" for athletes in the future.

Away from the courtroom, organizations are just starting to grapple with the complicated issue of gender identity.

Even before the lawsuit, the NCAA had planned to review its policies toward transgender athletes — policies that could affect everything from individual scholarships to a team's eligibility to compete in the men's or women's competitions. For now, the NCAA recommends that gender classification adhere to documentation such as voter registration or driver's licence gender statement.

With greater awareness of gender identity issues and the increasing number of transgender people competing and coming out at younger ages, more collegiate athletes will be likely to come forward, says Helen Carroll, co-author of a report released last month aimed at providing guidance to schools and universities for better practices toward transgender athletes.

When it comes to policy decisions, the debate almost always revolves around fairness. Men, it is believed, have a natural physical superiority.

[Based on an article in *USA Today]*

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Parenting Sideways by Jayke Burgess.

It is 2005; I am twenty-six years old, we are announcing to our close friends that we are pregnant with our daughter. I feel a sense of excitement and a new found lack of freedom.

Our friends are excited for us, and ask lots of questions. At this point, my partner and I appear as a lesbian couple, the friends we are sharing this with are also a self-identified lesbian couple. One of the questions they ask is,

"So, what do you want to be called as a parent?"

My partner responds quickly with "mum", and I naturally respond, without thinking, "dad".

This should have been an eye opener for me. But, it wasn't. It just felt right to me to be called dad. It felt natural; like it was the name my children would call me. Yet, here I was, a self identified bisexual in a seeming lesbian relationship, wanting to be called "dad".

Was I bowing to peer pressure, to conform to hetero-normative roles and becoming the "masculine mother" or was I just trying to make my choice of family acceptable to my Pentecostal family?

The answer is, I just could not see me. I was flying in the face of rejection of my sexuality, to add to the ever increasing basket of shame, being me, no I could not do it. It was not an option, I couldn't manage any further heartache, any further pain.

My children don't call me dad. I became paranoid about people misunderstanding this in 2005 and instead chose "mamou", the Greek name for mother.

Fast forward five years, I am beginning my process of coming out to my family, my home, as me. Will they accept me? No. Will they hate me? No. I am transgender, female to male, genderqueer and bisexual.

I didn't come out as transgender till 2009. I didn't act on this by transitioning till 2010. I have two children, a thirteen year old son and a four year old daughter. They are amazing creatures, and I love them passionately. I have never biologically parented a child; my ex-partner gifted me with two wonderful children.

My son

My son is a quiet, strong, funny, compassionate, gifted, intelligent child who watches people but doesn't give his opinion and is not prone to passionate conversation. He seamlessly disappears in to the background when he chooses to, excelling in the forefront at whatever he puts his mind too.

I decide to out myself to my son, a 13 year old brilliant sunshine of a boy. We are rumbling, and having a laugh, when I turn and say "My boy, I need to tell you something. I need to share my heart. I am transgender and will begin transition". My son is quiet for a moment, looks at me through innocent, accepting eyes and says

"So, we will be going through puberty together. That means I get to tease you about your voice breaking too!"

My heart had prepared for anger, fears, rejection, confusion, sadness, and all I received, was love and a swift tackle as I fall backwards in the next stage of our rumble.

My daughter

My daughter is loud, passionate, a person in her own right, knows her own mind and will not be swayed, only allows you in as much as she chooses, is creative, gifted, intelligent, funny and a little bit of a fantastic nut bag. She demands to be heard and will not sway her opinion without time and a good argument. I am envious of her courage.

From the age of one to one-and-a-half my daughter has continually questioned my gender. She is extremely intelligent and is able to pick up nuances in people and situations. She has wondered about my gender without

me having a clear answer for myself. She has picked up my inability to feel comfortable in the role of female, and put question to my doubts about my gender.

When I spoke with my daughter and told her I was a boy in a girls' body, she responded with silence and then a question. "So, you ARE my dad". She has some confusion around the concept that we taught her that she has two mums. So she has dubbed me "Mamou, my dad".

Translation

My daughter, who is now four years old calls to me over the wall from another cubicle in the women's toilets at the cinema, people are milling around waiting in line, all the cubicles are filled.

"MAMOU, MY DAD, WHY ARE YOU IN THE GIRL'S TOILET. YOU ARE A BOY!"

I laugh, at the imperfect timing of my four year old wonder. How do I express this to an innocent four year old mind? I ask her "Do I look like a boy". She laughs and says "Mamou, my dad, you look kinda like a boy, but a girl." I explained that when I look like a boy I will use the boys' toilets. She laughs and tells me I am crazy, I should just use the boys' toilets now, because I am a boy. She makes my heart smile.

Parenting

As a parent, I have always taken on the strong parent, who has a rumble, but will protect you when life gets tough, kind of role. Being transgender has been a blessing because I have been socialised female, and so understand my daughter. But, I am a man, so understand my son. I am able to offer my children an environment that teaches tolerance, acceptance and love of all people. I can teach them that there is no such thing as different, because what is "the same" or "normal"?

My son is thirteen, so he has spent twelve years understanding me as a female. Yet he accepts me without reservation. I feel that now that he understands me better, he actually knows how to communicate with me. I have seen positive change in our relationship. I've noticed this in quite a few relationships; people can communicate with me better now.

My daughter asks lots of questions. "Are you going to grow a beard"? "Why are you a boy with a girl's body" "Are you going to get your boobs cut off?"

My daughter asks a lot of questions. "Are you going to grow a beard?" "Why are you a boy with a girl's body?" "Are you going to get your boobs cut off?"

Some of these questions I can answer, some I find difficult to explain to a four year old mind, in a way that won't distress or harm her. When she asked if I will get my "boobs cut off", I said yes and explained that the doctor would do it.

She asked if she could have them when she grows up, will it hurt, and then that night had a dream about it that distressed her. The mother of my children and I are not together and some questions they want to ask are fielded through her and sometimes she answers them. Sometimes, she comforts their sadness at change. But, on the most part, my children have responded well.

My children will and are mourning the loss of their understanding of me as a female and a mother, but they are able to see the joy, confidence and contentedness I have found in being truly my whole self.

I have been lucky, my children have accepted me for who I am, and are allowing my journey to unfold without reservation. My children have accepted this journey better than anyone else who has chosen to be a part my journey. My children understand that I am still me.

Me

2010 is a good year to come out. It is my year. I now have a home for the person inside and it is called me. I no longer need to pass as a female, I can relax and just be...

Jayke Burgess

The Terminology of Intersex [from the OII Home Page]

THERE are two fundamental issues that must be considered when considering terminology around intersex.

Scientific nomenclature:

INTERSEX is a scientific term that describes all differences of sex biology within the animal kingdom that are not hermaphroditic. Terminology such as "hermaphrodite", "pseudo-hermaphrodite", "disorders" and "conditions" have been used in some medical literature to describe intersex differences in humans. None of this terminology is reflective of science and nor are they accurate.

In 1901 the scientific community approached a German entomologist, Goldschmidt, to suggest a term that described differences in sex biology for all animals that were not strictly hermaphroditic.

Not "hermaphrodites"

"Hermaphrodite" properly refers to animals that have a functioning set of both male and female organs so that they may reproduce with or without a mate. "Pseudo-hermaphrodite" refers to animals that have the capacity to function as both males and female at various times in their lives depending on circumstance.

Snails and worms are examples of hermaphrodites and some fish such as groupers are examples of pseudo-hermaphrodites. There are no human hermaphrodites or pseudo-hermaphrodites known to science. Natural variation and scientific discoveries may change this and our consideration of human rights might need to be revised in that event.

Goldschmidt's objective was to find a word to describe differences in sex biology where both male and female features seemed to be present at the same time but not in an hermaphroditic way. His terminology also includes features that might be described as not quite male and not quite female and others that seem to be neither male nor female. Under this nomenclature an animal that has no sex characteristics at all would be intersex.

Not a "third sex"

So far as science is concerned all human sex differences are encompassed by the terms "male", "female" and "intersex". Intersex is, however, not a third sex – it is simple a way of describing the continuum of differences from wholly male to wholly female. Humans tend to be clustered towards either end of this continuum of male and female, never reaching absolutes of either and with many having features in between.

Social nomenclature:

THERE have been many attempts at finding adequate terminology for intersex humans in social settings. It is significant none has involved a discourse with those the terminology seeks to name.

Early attempts using "true hermaphrodite" and "pseudo-hermaphrodite" were not only scientifically inaccurate, they also fed into voyeuristic ideation of an individual human being having penetrator and penetratee intercourse with themselves. Despite these shortcomings some intersex activists claim "hermaphrodite" for themselves, legitimizing it in the same way that "gay" and "dyke" have been claimed and reconfigured as badges of pride.

Although intersex has been the correct scientific nomenclature since 1901, medicine and especially those involved in psychiatry and psychology have found it difficult to adopt the term and in some instances still adhere to hermaphroditic terminology today. It is thought this is because of the theorizing of Freud, Jung and their immediate predecessors.

The term that intersex themselves discovered and adopted was the one science gave us – intersex. It is critical to an understanding of intersex as to why the use of that term is so important to us.

For intersex, more than any other way of having differences of sex characteristics – such as gender, sexual orientation or sex play – the enforcement of sex and gendering terminology and characteristics without our consent and against our will is a constant feature of how our differences are reacted to by society.

Forced into gender roles

We are assigned male or female despite our sex being unknown. We are encouraged and oftentimes forced into gender roles of man and woman. We are surgically altered so that as a man we have as few female features as possible and as a woman we have as few male features as possible. We are thought to be mentally ill if we reject our gender role and sex assignment. We are offered no respite from the sex or gender binary expectations of society. There are no provisions for behaviors other than man or woman and no sexs other than male or female for us to live out. There is a constant social pressure for

us to see ourselves as having a stake in the binary despite undeniable biological evidence to the contrary.

In short, our differences are the subject of constant erasure by a society that harbors a deep homophobic fear, even hatred, of our biology. We are the subject of constant medical experimentation that has the primary aim of eliminating our differences from the ways it is possible to be human.

Forcing yet another term upon us

Having terminology forced on us by those who have not lived intersex lives is especially objectionable.

In 2006 a group of fifty or so "specialists" in intersex differences met in Chicago to discuss what would be the appropriate terminology for intersex. They decided that in all medical literature from then on we should be referred to as having Disorders of Sex Development (DSD). This was done with the involvement of only two intersex individuals, neither of whom contributed to the debate, and without any widespread consultation with intersex.

There are no intersex people, to our certain knowledge, who use or approve of this terminology. Indeed OII considers it to be repugnant. Redefining our differences as "disordered" indicates we are not only somehow variant from the natural order of things, and it provides license to affect a "cure."

Intersex inclusion revealed as intersex exclusion

When I was first made aware of the then HREOC's decision to look into the "sex and or gender diverse community" I was impressed by the Commissioner's care to be fully inclusive.

The resultant *Sex Files* however had little to do with intersex concerns save for addressing some issues in respect of documentation. The subsequent decision of the Commissioner to prepare a white paper on non-consensual intersex surgery without intersex involvement was a considerable disappointment. The *Sex Files* in the end focused on identity, something that being intersex rarely is. Much discussion was had within OII about the terms "sex and/or gender diverse" and several things were very clear to us.

Saying everything while saying nothing

"Sex and/or gender diverse" says everything without saying anything. It was not clear from the terminology if it meant intersex any more than it means cissexual or cisgendered men and woman or males and females. It is new terminology that has little currency in mainstream perceptions. It has taken intersex activists thirty years to achieve the little penetration into the global psyche that it has so far achieved.

The new terminology once again invisibilizes intersex. We are once again subsumed by terminology that we had no part in devising, where our agreement was not sought and that is imposed on us against our will. To us this is little different to the surgery and sexing of us as infants, the subsequent denial and invisibilizing of our differences as adults and a way of once again leaving legislation open to interpretation as intersex-exclusive.

"Intersex" for 109 years

The scientific terminology for all biological differences that fall outside of expectations for maleness and femaleness has been intersex for one hundred and nine years. It is adequate and comprehensive. It is terminology that has been adopted by intersex themselves around the world. There is no need for any new terminology and any attempt at devising it without the full involvement of intersex will be rejected. Arguments that "not all intersex like being called intersex" are no more relevant or convincing than arguments that not all Australians like being called Australians and not all LGBT individuals consider themselves LGBT. Indeed there are many LGBT who are hostile to the acronym LGBT.

"DSD" = homophobia

The original argument for the adoption of DSD was because parents had a homophobic reaction to the word intersex – see Karkazis' *Fixing Sex*. Rather than address common phobias and parental fears the medical profession took it upon themselves to once again reassign us.

OII Australia agrees that the use of terms such as "sex characteristics" and "indeterminate sex" may be useful in framing laws to be intersex-inclusive, however we insist such terms cannot guarantee our rights unless those words are linked to definitions that unambiguously specify intersex by using the word intersex.

Not an identity, not an orientation

Intersex is not necessarily an identity although for some it is. Intersex is not a sexual orientation though for some it may be, and intersex is not a kind of sex play though for some it seems so. Intersex differences, like male or female differences, cannot be separated from our sense of gender, our sexual orientation or the way we go about sexual intercourse.

Intersex are complete human beings where each element of our human experience of sex is interdependent and inter-informative of each other.

We cover the full gamut of genders and sexual orientations and, I suspect, sex plays. We speak infrequently of such things in our forums so I have little by way of evidence for this. Our common feature is physical differences of sex biology.

Somewhat confusingly OII Australia does not hold that all people who have intersex differences are necessarily intersex. We refrain from assigning individuals in this way and we wish others would refrain from assigning us.

Klinefelter Syndrome: a simplified guide by Katherine Cummings

Klinefelter (or Klinefelter's) Syndrome is the most common chromosomal variation found in men. Named for Harry Klinefelter who published the first reports on the condition in 1942, it was not until the late 1950s that it was established that an extra X chromosome (XXY rather than XY) was involved. The condition occurs as often as 1 in 500 to 1 in 1,000 births. Many men live out their lives without realising they possess the extra chromosome. Because of the negative connotations of the term "Syndrome", many medical researchers now prefer the term "XXY males".

XXY males may have breast enlargement, may lack facial and body hair and have a more feminine body shape (more rounded, less angular) than other males. They are often taller than their fathers and brothers.

These physical characteristics are sometimes less important in the long run than a degree of language impairment. This is not to suggest mental deficiency but XXY males may learn to talk later than other children and language impairment can affect their success in school.

There is no certainty as to the causes, or causes, of XXY conception. There is an increase in likelihood of XXY in women of advanced maternal age but this is slight. Although, as stated above, a male may never be diagnosed as XXY, the chances are greater for this to happen before or shortly after birth, during early childhood, during adolescence or in adulthood following an infertility test.

Some parents are concerned about an appropriate age to inform a child of the XXY condition and when to inform relatives (grandparents for instance). The consensus seems to be that by the time a child is ten or eleven he may be told there are differences in his anatomy. By the time he is twelve he can be filled in on details, depending, of course, on the individual's maturity. He should be prepared for the likelihood of infertility despite the fact that he will almost certainly be able to enjoy sexual activity.

There are variations on the XXY format (also referred to as the 47,XXY karyotype). The 48, XXYY syndrome is sometimes considered to be a variation of Klinefelter's although there is some conflict over this classification.

In some cases the XXY subjects may be raised as females, or may prefer to be reassigned as females when they are informed of their condition. Because they are often tall and delicately built they can sometimes make successful careers in modelling or acting. Caroline Cossey (author of *Tula, I Am A Woman)*, who claims to have XXXY chromosomes, is a case in point, and one of the episodes of "House" skirted the issue with one of its cases concerning a female model whose mood swings and aggression were attributed to internal testes supplying a masculine level of testosterone.

According to Andrology Australia, men with Klinefelter's Syndrome will benefit from lifelong testosterone treatment.

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http://www.andrologyaustralia.org

http://www,nichd.nih.gov/health/topics/klinefelter_syndrome.cfm

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.

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*

CAH: Anre's Story by Gina Wilson

There are many ways to be Intersex; one of the most common is to have Congenital Adrenal Hyperplasia (CAH). There are two main types of CAH, 21 Hydroxylase and 11 Beta Hydroxylase, the first accounting for about 90% of all CAH. 11 Beta accounts for five to six per cent. There are several other kinds of CAH but they are rare.

Both 21 Hydro and 11 Beta can cause higher than normal production of androgens in the adrenal gland and consequent virilisation (masculinisation). CAH is generally caused by a failure to produce one or more of the hormones usually produced in the adrenal gland. When those hormones are not produced their precursors form testosterone.

Only 21 Hydro CAH is associated with life threatening illness. In 21 Hydro, two critical-to-life hormones are, to a greater or lesser extent, absent, so that the body does not process salt ("salt wasting"). The inability to retain salt leads to "adrenal crisis" that if left untreated can be fatal. Prior to the discovery of mineral corticol replacement therapy, children born with severe "salt wasting" usually died within weeks of birth. With other forms of CAH the most significant feature is ambiguous genitalia or other forms of virilisation such as hair distribution, skeletal structure and muscle mass.

Anre was born in the early nineteen fifties in a small rural town several hours drive from the nearest capital city's specialist children's hospital. Anre was born with 11 Beta CAH and was so significantly virilised that doctors attending the birth were unsure of Anre's sex.

Apart from ambiguous genitals there was no other apparent difference or illness at the time of Anre's birth. For reasons that are now impossible to determine, even through legal process, Anre was assigned female even though neither genetic testing nor internal inspection were possible at the small rural hospital in which Anre was born.

Despite the lack of illness doctors were so concerned at Anre's appearance they advised Anre's mother to attend the distant children's hospital as soon as possible. Medical experts there were unsure of the cause of Anre's differences so they contacted the then world-leading specialist hospital on Intersex differences - Johns Hopkins. The advice from Johns Hopkins was extra-ordinary.

Johns Hopkins was at that time in the process of first describing 11 Beta CAH. They knew that left alone Anre's adrenal gland would continue to produce testosterone at male levels and Anre would continue to virilise. They also knew that Anre would experience precocious puberty, short stature and skin pigmentation. Johns Hopkins advised Anre's specialists to remove one adrenal gland, take a part of that gland and retransplant it in Anre's upper thigh. If the transplanted section was able to produce sufficient mineral corticols then the remaining adrenal gland should also be removed.

Anre was three by the time the surgery was performed. While the adrenal surgery was being performed doctors decided that it was an appropriate time to conduct genital reconstructive surgery. The reasons for the decision to assign female and to confirm that with surgery cannot be determined.

Anre in later life commenced legal proceedings to recover as many of the pertinent medical documents as possible. Although the nature of the surgery and the specialists' advice s were discoverable, there is no evidence of genetic testing or internal examination prior to assignment. Anre supposes that sufficient evidence of a vagina, the position of the urethra and the relative ease of surgical assignment as female were the reasons.

At the time medical assignments of Intersex were more often male than female. There were two fundamental reasons for this: The first was the relative infancy of plastic surgery and uncertainty about outcomes. As surgical technique improved through the fifties and sixties practitioners were more and more likely to recommend definite assignments that could be assured with surgery. At the same time

theories about the plasticity of gender in infants were being proposed so that, it was thought, irrespective of innate anatomy, a child could be raised to believe they were boy or girl by social conditioning. The second was the then prevailing Victorian-era notion of male privilege. It was thought that any child would be best advantaged by a male assignment so that wherever possible children whose sex seemed ambiguous should be treated and raised as male. This notion of male privilege is still prevalent in most countries. Complexities around surgical assignments, where fully functioning genitals are the goal, makes female assignments technically easier so that, these days the desire to bestow male privilege takes second place to ease of surgical assignment.

For Anre the surgery performed was not a success. The genital reconstruction surgery was little more than a pen/clitorectomy. Surgical technique did not then extend to vaginal reconstruction. Anre's adrenal transplant failed so only one functional gland remained. This was sufficient to provide mineral corticols and continue Anre's virilisation unabated.

By age nine Anre was entering puberty, as predicted by Johns Hopkins. Anre was also exhibiting physical attributes inconsistent with the assignment of female. Further consultations with Anre's Australian specialists and those who were closely following the case from Johns Hopkins resulted in a recommendation for further adrenal gland reduction. This time it was thought prudent to leave the gland where it was and to surgically reduce its size (resection). No further attempts were made at genital reconstruction although painful dilation was recommended as a way of increasing the size of Anre's tiny vagina.

The need to be close to the children's hospital for Anre's many medical checkups caused Anre's mother to decide to move into town. This move, coupled with news that Anre's differences were most likely passed down from one of the parents, caused an irreparable rift between Anre's mother and father who then separated.

Both parents need to be recessive carriers for the child to be affected by this form of CAH. This was unknown to Arne's specialist. Although the so-called sex chromosomes X and Y were discovered by Stevens and Wilson in 1903, testing was difficult and seldom conducted. DNA itself was not described until 1953 by Crick and Watson so that a precise understanding of genetic causes for human differences was many years into the future. So far as Anre's father was concerned the mother was the problem and Anre reports "the doctors didn't disagree".

Anre recovered from the adrenal section surgery but the resection was so extensive that satisfactory production of mineral corticoids (a class of steroid hormones characterised by their influence on salt and water balances) could not be achieved. Anre was discharged with monthly then annual follow ups. Doctors became concerned at low levels of mineral corticoids and prescribed a regime of replacement therapy, then only just coming into use. The long term consequence of this medication was unknown so Anre was part of a study group measuring the side effects of the new drugs.

By the age of fifteen Anre was being prescribed dexamethazone. The side effects of this drug are quite profound. Weight gain and mood swings made Anre a reluctant user and every opportunity to avoid the drug was taken. Anre retained sufficient adrenal function to, for the most part, get by without chemical assistance. Anre's inconsistent use of the drugs prescribed caused considerable angst amongst medical specialists both at Johns Hopkins and in Australia. Anre could not be convinced to consistently take drugs and so was dropped from the study group. What followed was a lifetime of struggle with increasing suspicion and hostility between Anre and the specialists. Over time endocrinologists retired or left the hospitals Anre attended so that the whole process began anew with each replacement.

Anre attended school, achieving normal education levels and enjoyed a happy childhood with mother and siblings.

At about the age of 23 Anre decided to forgo dexamethazone permanently and lived drug free for twenty years. In that time Anre lived a normal life working in chemical engineering for a major Australian company.

I met Anre as an adult of roughly my own age and wondered how Anre had managed adolescence and the twenties, years when most people find a partner and settle down to family life. Anre told me ,with much regret and blame to those who had attempted to normalise, that a sex life was impossible. The surgery performed essentially removed Anre's penis/ clitoris and left non functioning genitals. Anre retold conversations had with mother about the kind of life that lay ahead. That life would not include a partner. Both Anre and Anre's mother remained single and lived together until Anre's mother died recently.

From time to time Anre became ill, often for reasons unconnected with CAH. Doctors nonetheless took every opportunity to convince Anre to return to dexamethasone treatment even when it was obvious that there were no symptoms of mineral corticoid deficiency. On more than one occasion Anre was threatened with psychiatric sectioning because of this refusal. Anre's mother was a vigorous and strong supporter of Anre's stand and opposed any attempts to characterise Anre as "mad".

To this day Anre has a strong and reasonable fear that doctors may force medication irrespective of consent or need.

By the age of forty five Anre's adrenal gland could no longer produce adequate hormones. Two factors were the cause: the original reduction surgery especially the scarring that resulted and the side effects of dexamethasone which, over time, suppresses adrenal function. Long term continuous use of dexamethasone then commenced which resulted in complete failure of Anre's adrenal gland and medically induced Addison's disease. (See iatrogenic illness)

The side effects Anre can now look forward to is increased bone fragility, Diabetes mellitus, psychological lability, glaucoma, muscular atrophy, skin disease and hypertension. Interestingly hypertension is the single most dangerous consequence of 11 Beta CAH. All of the other consequences: genital differences, short stature, skin pigmentation and infertility cause no illness. The medication that Anre was prescribed recreated the very thing any intervention should have prevented.

The sole purpose of all of Anre's surgery and medical interventions was to prevent virilisation and reverse what virilisation had taken place in what was thought to be a girl and later a woman. The interventions were not for the good of the client. They were designed to erase differences of sex within a society that found those differences repulsive. That they were not concerned with Anre is demonstrated by the specialists' absolute refusal to engage in a dialogue to determine how Anre felt about sex, gender or the surgeries and their deafness to Anre, then and now, when concerns were voiced.

Anre is now in the late fifties of life. Just what awaits so far as aged care and the consequences of the many years of dexamethasone replacement therapy is a cause of great anxiety. Anre's mother, the great defender of Anre's rights, is no longer there to argue and protect. Anre's extended family is now distant, old and has little understanding of Anre's special situation. The fear of medical practitioners is high with several in recent times hinting at mental instability because Anre insists on seeing and interpreting test results and on having copies for private records. On occasions Anre has insisted doctors' notes be destroyed when they have made personal, insulting observations and once has had the Australian Medical Association intervene on matters of privacy and consent.

Anre now lives quietly with two dogs and an amazingly encyclopaedic understanding of endocrinology. Anre's life shows what can happen when medical practitioners intervene not only without consent but against every ethical precaution one would imagine being exercised when the whole of an individual's life could be ruined by experiments gone wrong.

It is easy to think that the kinds of things that happened to Anre are now in the past and were a consequence of an imprecise medicine and the budding understanding of genetics and endocrinological differences such as CAH. Sadly this is not the case.

Medical practitioners have now abandoned Intersex as a term that describes physical differences of sex anatomy. In its stead they use

a new term Disorders of Sex Development (DSD). This terminology applies to people with different sex anatomies even when there is no illness associated with that difference. Differences such as Anre's where one might live a full and contented life without any medical intervention whatsoever, as happened until plastic surgery was raised to its current levels of proficiency, are now routinely subjected to genetic scrutiny and surgical intervention so that the individual is placed unquestioningly on one side or the other of the sex binary divide. Unquestioningly, that is, until the child becomes an adult and rejects the decisions that have been made without their consent.

The current protocols for the management of CAH recommend early surgical intervention for children like Anre. Experts claim the surgery is much improved. They are reluctant to admit all surgeries leave scar tissue and scar tissue is insensate.

They are reluctant to ask their patients what kind of sex life they enjoy and ignore studies that say adults that had surgeries as children do not enjoy sex. They are reluctant to admit that no single surgery will resolve Intersex differences and many surgeries will be necessary.

They are embarrassed to admit that vaginal reconstruction requires constant dilation to prevent scar tissue closing up the wound, dilation of three- and four-year-old children on a daily basis.

They are reluctant to admit they have done no long term follow-ups on their clients, indeed they make no attempt to keep track of them and have no idea what kind of life they have left for their patients to sort out.

They still conduct unethical experiments on Intersex children and proceed with surgeries without full and informed consent primarily from the child , but even the parents are not put in touch with other Intersex so they can know what lies ahead for their child if they should proceed with surgery.

Doctors test children as young as five with vibrators to see if their surgeries are successful and advise pregnant women who may be carrying a CAH child to take dexamethasone to prevent ambiguous genitalia and same sex attraction. They give this advice despite the potentially horrific side effects to both mother and child and before it is known for certain the foetus is CAH.

Medicine still performs these outrages on Intersex without reference to courts of law or ethical committees. Compare this with the experience of a transchild who is in need of hormone blockers. It is routine for that child to be required to make application to the Family Court for permission to undertake such a drastic and life altering decision. Adrenal resections for CAH children are still common and some parents go so far as allowing full adrenaletomies. Such surgeries do nothing to alleviate the symptoms of CAH indeed adrenaletomies also remove adrenalin production. The target of such surgeries is testosterone and the prevention of virilised children, especially those supposed to be girls.

CAH specialists and parents constantly refer to their XX children as CAH girls, they refuse to acknowledge Intersex, they exclude CAH adults who are Intersex and they moderate their Internet notice boards to prevent talk about Intersex. In recent discussions about dexamethasone in the *Hastings Journal* and mainstream media no mention is made of Intersex differences despite the intention of the medication being the prevention of just that.

The main CAH support group in America, run by parents and doctors, supports the administration of dexamethasone to pregnant women and recommends their members to her clinics. They have helped distribute research questionnaires on behalf of Dr Sheri Berenbaum on tomboy and lesbian behaviour in CAH children and offered spirited defences of Dr Dix Poppa's procedures that include the sexual stimulation of five year olds.

Clearly Intersex CAH children cannot depend on medicine or even their parents to guarantee their rights to genital autonomy. Clearly only full human rights protection in legislation and law for those of us born with anatomical differences of sex will bring an end to these disgraceful practices. ■■■

Graduate Diploma in Sexual Health

The University of Sydney

Faculty of Health Sciences

Do you or have you ever considered yourself transgender?
Are you a parent of a transgender child or adult?
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 gender variant children and their parents?
Elizabeth Anne Riley, in conjunction with the **University of Sydney**, is doing her PhD and conducting research entitled:
Gender Variant Children: Views of Professionals, Parents and Transgender Adults [Ref. no. 11203]
If you would like to 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.

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.

PLEASE NOTE:

The email address for Resources and Polare is:

resources@gendercentre.org.au

NB Please put the word 'Polare' somewhere in the subject line

Community Contacts Cancelled

The Gender Centre regrets that following misuse of the service Community Contacts will no longer be provided. Unfortunately growing reports of predatory actions by some 'contacts' forced us to take this action.

Advertisements of a service nature (e.g. "For Sale", "Accommodation Wanted" or "Accommodation Available") will continue to be published.

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

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Proudly broadcasting to the gay, lesbian, bisexual and transgender communities in Sydney's West and all those friendly to the issues

THE GOAL OF "Queer Out West" is to provide a forum for groups and individuals to let the community know about social events, fund-raisers and other community activities in the western suburbs, as well as playing some great music and having a bit of fun along the way!!

So join Joe, Paul, Beverly, Suze, Matt and Kathy every Monday night from 10.00pm until midnight.
Do you want to contact us? There are a number of ways...

For social events, fund-raiser and out n' about contact
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Fax: (02) 9605.3252
or write to:
PO Box 3357 Liverpool, NSW 2170
For general enquiries, community news, contact Joe or Paul via:
email: queeroutwest@hotmail.com
phone: (02) 9822 8893 (10pm-midnight only)

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. Contact details on the Directory pages.

PLEASE READ THIS!

If you are moving, or changing your email address, please tell us. Undeliverable copies 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. To make an appointment please contact a Gender Centre Staff member on 9569 2366 or email *reception@gendercentre.org.au*. Bookings are essential

The Proposed Revision to the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association DSM 5 by Jessica Williams

Jessica Williams

I hope this will be the first of a short series of articles that will explore certain interrelated themes of contemporary interest for transsexuals and for transgendered people generally. It begins with an outline of the changes proposed by the American Psychiatric Association (APA), a leading professional association of psychiatrists in the US, to its diagnostic manual. Some of these changes are relevant for transsexuals. They include changes to the language used to refer to gender variance, the concepts which professionals use when referring to gender variant clients or clients experiencing "gender incongruence", and the diagnostic criteria themselves. There appears to be a quiet revolution underway in professional circles, by which *they* refer to *us,* which is important, for example, if you flinch when being referred to as a person suffering from a mental disorder or possessing a *disordered identity* (Gender Identity Disorder), simply because you may be gender variant.

[Note: The APA uses Roman numerals to refer to the successive editions of the DSM so that Roman numeral "IV" means 4, and "V" means 5.]

At irregular intervals, the APA reviews its Diagnostic and Statistical Manual of Mental Disorders, which is usually abbreviated simply as "DSM". It is a significant document and represents an attempt by the APA to provide a common language and standard criteria for the classification of mental disorders. It is used in the United States and to varying degrees around the world by psychiatrists, psychologists, insurance companies, drug regulation agencies and pharmaceutical companies. The current version DSM IV-TR, which was published in 2000 is being revised and the revision is referred to as DSM V and is the fifth since the first edition in 1952.

I suppose that at first glance, if you are not a professional working in the area of mental health this news is hardly breathtaking. After all, the DSM is not binding on Australian psychiatrists or psychologists. For transsexuals and certain transgendered people however, the DSM is an important document indeed. Ever since the second version in 1968, the DSM has been the only manual produced by a professional body anywhere which recognised "Gender Identity Disorders" (GID) and provided criteria by which clinicians could diagnose patients who may be suffering distress as a result of being "gender variant". I am putting these phrases in quote marks because for many people who regard themselves variously as being in some way gender variant or transgendered, the labels themselves can be contentious terms. Nevertheless, because the DSM reflected the Standards of Care (SOC) first developed by Harry Benjamin in 1966 in his book "The Transsexual Phenomenon", it developed considerable status among mental health professionals working with transgendered clients. The Standards of Care subsequently became the ongoing focus of the work of the former Harry Benjamin International Gender Dysphoria Association, now known as the World Professional Association for Transgender Health (WPATH).

Before getting into the proposed changes themselves, it should be recognised that there is a lively debate in the various gender communities about the very role and necessity for medical gatekeepers. Beyond that, there is also a questioning of the much wider issue of the necessity for legal regulation of any person's gender. Indeed, the very medicalisation of gender variance has been vigorously contested in some circles. Leaving Harry Benjamin's contribution to one side for a moment, these ideas often surface in debates within the communities regarding, for example, the necessity to sacrifice one's fertility in order to achieve internal and external

gender congruence. More and more transgendered people are questioning the necessity for married couples to divorce, where one spouse is undertaking medically assisted gender reassignment and seeking to obtain legal recognition of their preferred gender status. These debates often stray into politically contentious areas within contemporary Australia, such as the current movement in support for same-sex marriage.

At this point I believe some personal disclosure is appropriate. I am a woman who has managed to achieve that status after a long and, at times, painful struggle. I am by no means alone in this. I am a woman who comes from a transsexual background, viz., my birth-assigned gender was male, and that was changed in 2008. I am a woman who has fathered two children and who has four grandchildren. I am fortunate in that I enjoy good relations with my children and grandchildren. Most of my family and siblings and most of my friends accept me as a woman called Jessica. Outside of my family, I find my acceptance by many old friends who knew me before I transitioned, and new friends who have only known me as Jessica, to be wonderfully affirming. Despite this, I am also aware that I am visibly transgendered. I see no point in deluding myself about this. Even if I could afford additional surgical procedures (apart from my GRS), my skeletal frame still transmits its own gender signals. Not for nothing did I enjoy the physicality of country living! I mention this not to complain about my "lot in life", rather to introduce the concept of a specifically *transgender* identity to which I will return later in this paper.

Harry Benjamin's great contribution in 1966 was to develop the original standards of care which could be used by medical professionals in caring for clients seeking relief from an inability to live successfully in their birth-assigned gender and to deal with the high levels of stress generated by conflict between their innate and assigned genders. Indeed it can be argued that the only framework in which transsexual clients could seek relief in the second half of the 20th century, was the medical model. Further, this model provided the framework through which sympathetic governments around the world eventually introduced procedures by which transsexuals could obtain legal recognition of their innate gender.

From a clinical perspective, the medical and surgical treatment parameters and standards of care have improved significantly over the years and a high degree of functional and cosmetic success is often now achieved. However, this earlier, *medically pathologising* model from 1968 reflected in earlier versions of DSM has outlived its "use-by date" and this is now reflected in the changes that the American Psychiatric Association is proposing to introduce in DSM V.

Dr Harry Benjamin

This is not to deny that there remain many other issues to be addressed, even from a clinical perspective. For example, transsexualism is conceived by many in the medical profession as a self-diagnosed condition and viewed with scepticism: there is as yet no medical test which can definitively provide an objective clinical identifier for the way we feel. As a result, governments in Australia regard gender-affirming surgical interventions as elective, and place the procedures in a group that includes cosmetic

procedures, ineligible for government financial support through Medibank.

So what exactly is proposed by the APA? The new diagnostic criteria are shown below:

DSM IV 302.85
GENDER IDENTITY DISORDER IN ADOLESCENTS OR ADULTS

PROPOSED REVISION (DSM V)

Gender Incongruence (in Adolescents or Adults)

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months duration, as manifested by two or more of the following criteria [2,3,4]:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated sex characteristics)

2. A strong desire to be rid of one's primary and.or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, the desire to prevent the development of the anticipated secondary sex characteristics)

3. A strong desire for the primary and/or secondary sex characteristics of the other gender

4. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)

5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)

6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)

Subtypes

With a disorder of sex development (i.e. intersex)
Without a disorder of sex development (i.e. intersex)

(Source: *http://www.dsm5.org/Proposed Revisions/Pages/proposed revision.aspx?rid=482)*

What are the significant differences between this and the earlier version (DSM IV-TR) which at first glance looks very bland?

First, there is now a separate set of criteria for children (302.6) where previously the criteria were included with those of adults. These will be discussed below.

There is now provision for a diagnosis to be made in a client who also presents with a Disorder of Sex Development. This is often referred to as *"intersex"* and previously there was no such provision. In fact in DSM IV-TR, individuals with intersex conditions were specifically excluded. See the heading "Subtypes" in the box above for the proposed version, and below *diagnostic criterion C* in DSM IV.

DSM IV - TR

302.85 GENDER IDENTITY DISORDER IN ADOLESCENTS OR ADULTS

Gender Identity Disorder

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In children, the disturbance is manifested by four (or more) of the following:

1. Repeatedly stated desire to be, or insistence that he or she is, the other sex
2. In boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
3. Strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex
4. Intense desire to participate in the stereotypical games and pastimes of the other sex
5. Strong preference for playmates of the other sex

In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or to be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. In children, the disturbance is manifested by any of the following:

In boys, assertion that his penis or testes are disgusting or will disappear or assertion it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games and activities.

In girls, rejection of urinating in a sitting position, assertion that she has, or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion to normative feminine clothing.

In adolescents or adults, the disturbance is manifested by symptoms such as pre-occupation with getting rid of primary and secondary sex characteristics (e.g. request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

C. The disturbance is not concurrent with a physical intersex condition.

D. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

Specify if (for sexually mature individuals):
Sexually attracted to Males
Sexually attracted to Females

Two other important changes are: First DSM V replaces the word "sex" (e.g., "insistence that he or she is of the other sex") found frequently in DSM IV with the word "gender" (e.g., "marked gender incongruence"). The exception is where references are made in DSM V to "primary or secondary sex characteristics". This has been done to make the criteria applicable to individuals with a Developmental Sex Disorder (DSD-i.e., Intersex).

DSM V removes the requirement to specify the sexual orientation of clients seeking a diagnosis. (See the specifier at the foot of the table above setting out the DSM IV criteria.) This appears to be consistent with the general thrust of the proposals which have emerged from the APA Working Group, to move awareness from diagnostic criteria which require the clinician to identify the existence of a *gender identity disorder*, and the client to demonstrate ability to conform to a gender binary model (e.g.female versus male). Although not explicitly stated, hetero-normative gender conformity in sex roles is implied by the earlier criteria: viz., MtF would be expected to be sexually attracted to men, and FtM to be sexually attracted to women. None of this applies with the proposals for DSM V.

Transgendered Children

Since the publication of DSM IV the clinical management of very young transgendered clients has become a professionally and politically contentious issue. In North America, clinicians were reporting increasing numbers of very young children, typically from age three to five, presented by distraught parents because of their child's adamant refusal to accept their birth-assigned gender role. Clinicians increasingly found that the diagnostic criteria (DSM IV) were of little use in dealing with these clients. Over time, longitudinal data emerged from these clinics indicating that many of these children did not go on to present in adolescence with symptoms of gender incongruence but typically began to indicate same-sex sexual preferences and in other cases heterosexual social and sexual development.

Clinicians began to have concerns that a premature diagnosis of gender incongruence could well have a "lock-in" effect, when in fact the behaviour patterns exhibited by these children which may have been distressing to parents, formed a part of normal psychological growth and development.

In response to professional concerns and to meet the needs of transgendered children a separate set of diagnostic criteria has been developed. In contrast to the criteria for adolescents and adults where the number of diagnostic indicators has been reduced typically to three, there are six criteria proposed for children. The language has been strengthened typically with phrases such as "a strong desire to be of the other gender" or "a strong dislike of one's sexual anatomy".

Critique of the Proposed Revision

The responses from professionals have been positive. The WPATH, in its response applauds many of the diagnostic changes put forward by the working group, adding that "it is clear that the workgroup has made a serious effort to respond to the criticisms over the years by both consumers and professionals in the area of transgender care". (WPATH: *Response of the World Professional Association for Transgender Health to Proposed DSM 5 Criteria for Gender Incongruence.* 25 May 2010)

Thus the changes are reflected in both the language and the criteria used. The proposed change in name from Gender Identity Disorder to Gender Incongruence is less pathologising and no longer suggests that one's *identity* is disordered. This is not a trivial matter. This

pathologising is regarded by many in transgender communities as one major cause for the very high levels of stigma associated with being transgendered. Further, the very high levels of social stigma are the major cause of the high levels of psychological distress and morbidity experienced within transgendered communities.

The changes with regard to Intersex clients, the new separate criteria for transgendered children and the removal of the requirement to specify sexual orientation have all been well received by professionals.

The WPATH does have criticisms which focus on several issues: Continued inclusion of the diagnosis or its removal; the very broad reach of the diagnostic criteria; the desirability of separate or combined diagnoses for adolescents and adults; the name of the diagnosis; and the location of the diagnoses within the DSM. Two of these are interesting.

The very broad reach of the diagnostic criteria indicates a marked divergence of views within the WPATH focus group. WPATH prefers the term "gender dysphoria" rather than "gender incongruence", because they argue that this better reflects that a diagnosis is only necessary (WPATH's view) when clinically significant levels of distress are associated with gender variance in a client.

They argue, moreover, that the term "gender incongruence" implies that congruence is the norm and that incongruence is by definition problematic, which is not necessarily the case. WPATH believes that in removing "distress" and "impairment" from the diagnostic criteria undercuts the necessity for having a diagnosis. It is distress and impairment which lead transgendered clients to seek treatment.

"If there is no distress or suffering and no treatment is desired, why is a diagnosis needed?

(WPATH: *Response of the World Professional Association for Transgender Health to the Proposed DSM 5 Criteria for Gender Incongruence. 25 May 2010)*

The answer appears to be found in the debate about where to place the diagnoses in the new DSM. This has not yet been decided by the APA, but WPATH responded that any location which depathologises gender variance is seen as acceptable, as long as it does not endanger health insurance coverage for transgender-specific health care.

Towards a Transgender Identity – Dichotomy or Diversity

From a historical perspective, there has been a marked evolution during the 20th Century in the diagnostic concepts and possible treatments available to people who sought help for feelings of distress experienced because of a conflict between their perceived and birth-assigned genders.

Although transgendered people have existed throughout recorded time and across many cultures, the development of medical technology, especially since 1945, has steadily transformed the options available to gender-variant people. This is no accident. Although surgical procedures existed before then, it was only in 1931 that the male sex-hormone testosterone was first synthesised, it was 1934 when progesterone was first isolated and 1938 when the British chemist Charles Dodd synthesised the first synthetic oestrogen which later gave rise to the first contraceptive pill.

In 1966, the work of Harry Benjamin enabled sex-reassignment to become the treatment of choice, replacing earlier attempts at behaviour modification through psychotherapy.

The task of the medical professionals was to determine whether the client was a "true transsexual", that is a woman trapped in a man's body or a man trapped in a women's body, or a transvestite whose primary motivation for cross-dressing and spending time in the cross-gender role was regarded as sexual and/or compulsive.

Before the 1990s, the treatment for both transsexualism and cross-dressing followed a binary conceptualisation of gender. Transsexuals were candidates for a change of sex. Cross-sexed hormone therapy and sex-reassignment surgeries were recommended. The emphasis in the "real life test" was on "passing" in the "opposite" gender role.

Increasingly, however, transgender people describe their gender identities in ways that transcend a dichotomous view of gender. The following tables list responses received when transgender individuals were asked to respond to the following query: "Please describe how you identify in terms of your transgender identity". Responses were categorised as reflecting dichotomy or diversity (Bockting 2008). The conclusion is that there is no one way of being transgender.

DICHOTOMY
Female (MtF/Male (FtM)
Female with the genitalia of a male (MtF)
Woman with a correctable birth defect
Woman with a transsexual history
Displaced male (FtM)
Boy whose syringe gives him the testosterone his balls cannot
Man to male (FtM)
Formerly transsexual
Survivor of transsexuality
Closet transsexual
God just made a slight error

(From Bockting, W. *2008 Self-identification of gender identity among a national sample of the US transgender population* (N=1,229)

DIVERSITY
Transgender
Post-op man of transsexual experience
75% female, no plans on surgery or hormones
Shemale
Bigender/two spirit
Gender neutral/genderless/neither male nor female
Androgyne
3rd gender
Pan/poly/omni-gendered
MtF dyke/tomboy/butch queen/FtM Fag
(Non-biological) intersexed female to none of the above
Gender queer: female codied but neither female nor male in gender

(From Bockting, W. *2008 Self-identification of gender identity among a national sample of the US transgender population* (N=1,229)

Given this diversity, treatment protocols are changing. Clinical management now focuses on a more individualised approach rather than following a standardised protocol of sex-reassignment. HRT and genital reconstruction surgery (GRS) are no longer part of linear progress to "sex-reassignment", but are treatment options which may be used in conjunction or standing alone. "The motivation for GRS today is not so much to 'change sex' or confirm gender identity, but more to improve body image and improve sexual functioning". (Bockting 2008)

Given this increasing flexibility in treatment parameters however, the "gender diverse" universe still needs to intersect with a largely gender-binary world of the wider community in which we live. A binary world in which our non-transgendered fellow-citizens often cannot make the distinction between gender identity and sexual orientation and do not understand that "who we are" is separate from "whom we prefer to relate to".

Even within the "gender-dichotomous" world, however, there exists a debate in the wider community about what it means to be a "woman" or a "man". There are plenty of examples of families where the husband is a "stay-at-home" husband and carer of the children and the wife is the bread-winner. Later the roles within the family may revert to a more "traditional" pattern. There are women who play rugby and cricket and men who are ballet dancers as well as husbands and fathers (in either hetero or same-sex families).

There are examples of same-sex couples who are parents and decide how the child-rearing burden will be shared and who will be the primary breadwinner. Women increasingly comprise more than 50% of the graduation lists in professions such as law, and engineering as well as dominating the lists in traditionally feminised occupations such as nursing and teaching.

All these decisions of daily life are also made within families in which one parent may be transgendered. The only distinction between "women" and "men" in these two circumstances is that transgendered men and women usually reach that status some time after receiving a birth-assigned gender. That means that the experiences of transgendered men and women will inevitably be different from those of their natal brothers and sisters. That difference has positive as well as negative dimensions: If we only focus on the negative aspects of this exclusionary process, we will neglect the positive contribution that transgendered men and women can make to debates about gender relations and the unique perspectives we can offer.

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American Psychiatric Association Proposed Revisions to DSM5302.85 Gender Identity Disorder in Adolescents or Adults
http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=482

News Items of Interest

TRANSGENDER GRANTED ASYLUM IN AUSTRALIA

A Malaysian transgender who had gender affirmation in Thailand has been granted refugee status in Australia as she claims forced return to Malaysia would result in imprisonment, whipping and a life of prostitution. The Refugee Review Tribunal has affirmed that she qualifies as a member of a persecuted social group.

FAMILY COURT GRANTS GENDER AFFIRMATION TO 16-YEAR-OLD

Justice Linda Dessau of the Family Court has granted permission to a 16-year-old schoolboy to proceed with hormone therapy preparatory to gender affirmation as a female. The decision was backed by the child's parents, six specialists and the child's lawyer. Justice Dessau has specified that the child's sperm is to be obtained and frozen in case he wishes at some future date to have children.

OPENLY TRANSGENDER MODEL HAS BIG YEAR

Lea T., who is Givenchy's openly trans-sexual super-model, has appeared not only for Givenchy's May campaign but has also appeared in Italian *Vanity Fair* and in French *Vogue* (naked). Lea said, "Maybe a transsexual will open this magazine and think: That's cool. We can be whatever we want. That's why I did the Givenchy campaign."

Lea T

BRANSON TO BE "AIR STEWARDESS"

Having lost a bet to rival car-racing team owner Tony Fernandes, Richard Branson will be required to serve as a female flight attendant on AirAsia X flight in February 2011. Branson will wear makeup and high heels to fulfil the terms of the bet. He will, of course, hate every minute of his cross-dressing ordeal...

Or not.

[I hope he shaves his beard. Ed.]

National Women's Health Policy Fails Intersex Women

by Zoe Brain

The needs of some groups of women were particularly highlighted and these included young, perinatal, lesbian, bisexual, transgender, intersex and older women.

There's no actual mention of Intersexed women in the Mental Health section below. Nor in Reproductive health, nor anywhere else. In fact, that's a the only mention of the word "Intersex" in the entire document. As a mental health issue. Intersex is not a mental health issue, to state the obvious. It's a biological one, requiring expert, well informed whole-of-life medical care. The reason why it's mentioned under "mental health" is the frustration Intersexed people have because of medics who know nothing about the situation, the problems Intersex women have in the area of reproduction, access to even basic health care, the legal problems (such as having to be put on a list containing sex offenders volunteering for chemical castration to reduce their sentences in order to obtain necessary medication at a reasonable cost) and a whole lot more.

Zoe Brain

I would have expected something on "sexual and reproductive health" rather than "mental health" when it came to Intersex. Something on "accessing health care services" too. You know, the idea that we might not want our genitalia mutilated, that we may need a lot of assistance in order to have children. That we face enormous barriers of ignorance in the medical profession, forcing us to become our own endocrinologists and experts on hormones...

Maybe it is a mental health issue, for this is enough to drive anyone crazy.

Putting them in the header - then completely omitting them from the body of the document - is typical of the lip-service paid to Intersex people. The document addresses none of the very real health concerns of Intersex people. Zero, nada, zip.

As for transwomen - they're classified as "women who identify themselves as lesbian". Really?

"Women who identify themselves as lesbian are more likely to experience violence. A recent Victorian study found that 85 per cent of lesbian, gay, bisexual and transgender Victorians had been subject to heterosexist harassment and violence in their lifetimes, and 70 per cent of the respondents in the past two years. Nearly half the people in the survey reported hiding their fear of violence and harassment".

Needless to say, many trans women don't in fact identify as lesbian. Or bi- for that matter. There's an abyss of misunderstanding here.

The Queensland figures are as follows:

Received verbal abuse:
* 69 per cent of females
* 92 per cent transgender male to female

Physical assault without a weapon:
* 15 per cent of females
* 46 per cent transgender male to female

Physical attack with a weapon, knife, bottle or stone:
* 6 per cent of females
* 38 per cent transgender male to female

Any bets that the figures for the rest of Australia aren't similar? That while the majority of lesbians are put in genuine fear by homophobic unprintables who threaten them with "corrective rape" or worse, it's mostly trans women who actually end up in the ER? For them, "facing significant health issues" all too often means learning how to walk again because of brain injury, or having to wear a colostomy bag. Not so much in Australia, thank goodness, but it happens here too.

There's a complete lack of mention when it comes down to accessing health care services. There are very few doctors who won't see female

patients, but many who won't see trans women - or will but are totally clueless. In Canberra, it is impossible to complete transition without travelling interstate. There are only two GPs who regularly treat transpeople, one of whom treats Intersexed people too. One endocrinologist, part time. None advertises what they do, they keep it quiet to avoid problems. No psych support from anyone qualified to give it.

The majority of trans women in Australia now travel overseas to complete treatment, the few surgeons here do very few procedures, and while sometimes good, often with less than stellar results by any standards.

There are no drugs listed under the PBS (Pharmaceutical Benefits Scheme) for treating transsexuality. Other diagnoses have to be used, and in the case of some Intersexed and all pre-op trans women, that means being put on a register along with sex offenders who volunteer for chemical castration. Once on, never off.

All of these are health issues. Health issues that Intersex and trans people have been complaining about not just for years, but decades, with no result.

A report like this doesn't help.

Reference: *Australia. Department of Health and Ageing. National Women's Health Policy 2010. Summary - Mental Health*

http://www.health.gov.au/internet/main/publishing.nsf/Content/A3D713CE1DCD64E5CA257457001D4ED0/$File/Womens_Health_Policy.pdf

And An Editorial Comment

I came across Zoe Brain's blog this morning, (6 Jan.) as I was finishing off *Polare*. I thought it was an important issue to raise because our community so often falls between the cracks in the edifice erected by heteronormative, binary-sex builders and because it is often so difficult to obtain information in clear, unambiguous terms on topics which are vital to our health and social wellbeing.

The fact that an official policy document can be issued, presumably without consultation with the whole community it serves, and can be so flawed on factual matters, is dismaying to say the least. To suggest that transwomen universally identify as lesbian suggests that there was no real attempt made to survey the community. Of course we are only a tiny part of the population of Australian women, but we are a discrete part (or two discrete parts if you wish to preserve the distinctions between transgender and Intersex) and we have special health and medication needs not shared by most women, but which are vital to our wellbeing and sometimes to our survival. There should be a more careful and informed study of our community and an Addendum should be added to the Policy by the Department of Health and Ageing.

Zoe mentions that because there are no drugs listed under the PBS for treating transgender and Intersex other [false] diagnoses must be adopted to obtain necessary medication. In order to obtain Androcur (for instance) it is necessary for a transgender or Intersex to state that she is a deviant male who needs to have her sex drive suppressed, with the corollary that she will be placed on a register of sex offenders. If this is true, it is appalling, but I have not been able to verify it. The situation arises if one is trying to obtain Androcur as an Authority Drug, i.e. through the PBS at a lower cost than standard. Since it is an expensive drug this would, however, apply to many, probably the majority, of transgenders. But my attempts to discover whether in fact use of the "deviant male" diagnosis would automatically place one on a sex offenders register was avoided by the woman I contacted for information. I was rather curtly informed that any attempt to use the "deviant male" diagnosis would render one subject to immediate prosecution for fraud. In a telephone interview I conducted with Professor Steinbeck he said it was at one time definitely an approved anti-androgen for use with transgenders, but transgender was later removed from the list of acceptable diagnoses. Why? Androcur is important in suppressing androgens in the transitioning transgender. My attempts to find out why transgender was removed from the accepted diagnoses for Androcur usage were ignored. And is the threat of automatic inclusion in the sex offenders registry accurate or is it an urban myth?

Can anyone provide facts? Katherine

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**
5.30pm-10.30pm seven days on
(02) 8594 9596
1800 105 527
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

Shop 3, 146 Gordon St
Port Macquarie NSW 2444
Tel: (02) 6584 1163
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

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

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

HIV AWARENESS AND 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

Directory Assistance

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

GAY AND LESBIAN COUNSELLINGSERVICE OF NSW (GLCS)
A volunteer-based community service providing anonymous and confidential telephone counselling, support, information and referral services for lesbians, gay men, bisexual and transgender persons (LGBT) and people in related communities.
Counselling line open daily from 5.30pm - 10.30pm
(02) 8594 9596 (Sydney Metro Area - cost of local call, highe for mobiles)
1800 184 527 (free call for regional NSW caler only)
Admin enquiries: (02) 8594 9500 or admin@glcsnsw.org.au
website: www.glcsnsw.org.au

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)Sundays

PO Box 22, Kings Cross, NSW, 2011
Tel: (02) 9360.2766
Fax: (02) 9360.5154

LES GIRLS CROSS-DRESSERS 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
MCC Sydney is linked with MCC churches in Australia as part of an international fellowship of Christian churches with a secial concern for any who feel excluded by established religious groups. MCC deplores all forms of discrimination and oppression and seeks to share God' unconditional love and acceptance of all people, regardless of sexual orientation, race or gender.
96 Crystal St, Petersham, 2049
Phone (02) 9569 5122
Fax: (02) 9569 5144
Worship times:
10.00 am and 6.30 pm
office@mccsydney.org
http://www.mccsydney.org.au/

MOUNT DRUITT SEXUAL HEALTH CLINIC
Provides free, confidential and respectful sexual health information, assessment, treatment and counselling.
Ph: (02) 9881 1206
Mon 9.00am-4.00pm
Wed 9.00am-1.00pm
Fri 9.00am-1.00pm

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 USERSAIDS 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 1, 162 Marsden (cnr. George St)
Parramatta 2150
Ph: (02) 9843 3124
Mon, Wed, Fri 9.00am-4.00pm
Tue 9.00am-1.00pm
Fri 9.00pm-1.00pm

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
103/5 Redfern Street, Redfern, NSW, 2016
(Redfern Community Health Centre, enter via Turner Street)
Tel: (02) 9395 0400
Fax: (02) 9393 0411

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

Directory Assistance

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

SYDNEY WEST HIV/HEP C PREVENTION SERVICE

Needle and syringe program
162 Marsden St, Parramatta, NSW 2150
Ph: (02) 9843 3229
Fax: (02) 9893 7103

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 bisexual, 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

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 - 4.30pm177 Albion Street, Surry Hills, NSW 2010
Tel: (02) 9360.5388

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.
Westlund House,
16 Gordon Street, Acton,,
ACT, 2601
GPO Box 229, Canberra, ACT, 2601
Tel: (02) 6247 3443
Fax: (02) 6257 2855
E-mail:
aacswop@aidsaction.org.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

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

Directory Assistance

PYCIS
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, medica-tion 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

CHANGELING ASPECTS
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 transsexualism and a network of their parents, families 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.trucolours.org.au
Email: Mail@truecolours.org.au

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 trans-gendered. 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) 4382-8791
Fax: (64) 4801-5690

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

Classifieds

FLATMATE wanted to share three bedroom house in Blackheath, Blue Mountains with one other, a forty-year-old M2F, Near Katoomba, fifteen minute walk to train and shops, off-street parking available. Own room, furnished or unfurnished in furnished house. Large yards in quiet area. Veranda and enclosed courtyard/ barbecue area. Laundry with washer and dryer. Large lounge room and shared bathroom with combine shower/bath. Phone and Broadband Internet services available plus use of computer. Slow combustion fireplace in lounge room.
Rent $135 pw and bond (neg.). Share electricity and water expenses. Share phone and Internet if required. Happy to share food/cooking or separate if preferred.
Suit M2F/F2M single person. Jobseeker/ Unemployed/ Pensioner welcome. Looking for long-term flatmate to share and make a home. Sorry, no short-term.
Email: jessicats@y7mail.com
or phone:
0457 003 062 (ask for Mark)

Males Become Females

Scientists have shown that male frogs exposed to a frequently used weedkiller are feminised by the chemical. Ten per cent of the frogs affected mated with males and produced offspring. All the offspring were male.

Umm. Does anybody know what flavours it comes in? And who do we have to kiss to become a frog?

Dressmaker and Tailor

Specialising in Transgender
Contact: Adele N. Dunne,
0404 215 519
Adele.N.Dunne@gmail.com

STOP PRESS! ***lAST MINUTE Q&A with KC***
Q. Where can I buy vaginal dilators? What do they cost?
A. The Amielle Dilator Kit (four dilators in different sizes, KY jelly, cleaners and instruction book) is sold by D&M Diabetes and Medical Supplies P/L., PO Box 271, Flemington, VIC, 3031, at a cost of $161.00. Payment is required in advance by bank cheque, money order or direct deposit.
[Ed. Note. Consider cruising the sex shops and looking at vibrators as an alternative.]

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:
www.seahorsesoc.org
Email: *crossdress@seahorsesoc.org*
Membership enquiries, change of details etc. contact Membership Secretary,
PO Box 6179, West Gosford, NSW, 2250

"crossdress with dignity"

Are You Embarrassed by Ugly and Unwanted Facial or Body Hair?

You are not alone, and there is a permanent solution. Everywhere people are raving about the results of this amazing method!

It is medically and scientifically proven safe to permanently remove your unwanted hair so that it NEVER grows back. This process (called Multi Probe Electrolysis) has 130 years of tried, tested and proven safe and effective guaranteed permanent hair loss results.

Multi Probe Electrolysis is suitable for:

All areas of the body
All skin types and skin colours
All hair types and hair colours

Comments from satisfied clients

My skin feels so soft now; I am not embarrassed to be kissed anynore; I just feel so free; I thought I would have to live with this hair, now I know I don't - thank you; I can talk to people and look at them again; 12 years and nothing has grown back - you changed my life; I have so much more confidence; I wish I knew about Permanence a long time ago

Our Guarantee

Our treatment has transformed the appearance of thousands of people. We are so confident in our results we put our 100% money back Guarantee behind our work! If in the unlikely event you are not truly satisfied with your treatment, then we insist on givimg you back your money - NO QUESTIONS ASKED!

So phone Sydney's most sought after Hair Removal Specialists for Results **NOW**. Say goodbye to your ugly unwanted hair forever and let us focus on achieving what you want, and this we do every day. The first 27 people to call and mention this ad will receive our special introductory offer - ***you pay only $99*** *for $165 of Value* ***- a saving of $66.***

Consultation	**Valued at $60**
30 Minute Treatment	**Valued at $75**
Melfol Aftercare cream	**Valued at $30**

City
Dymocks Building,
Level 3
428 George St, Sydney
9221 8595

Drummoyne
170 Victoria Road,
Drummoyne
9719 1391

www.permanence.com.au

PERMANENCE

The permanent hair removal specialists

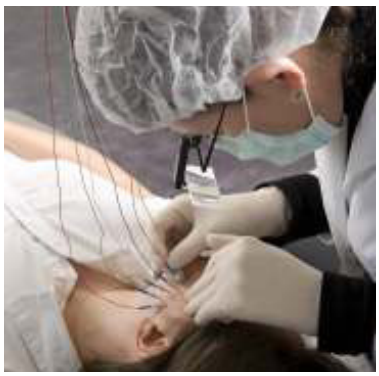
The Permanent Solution...

in Permanent Hair Removal

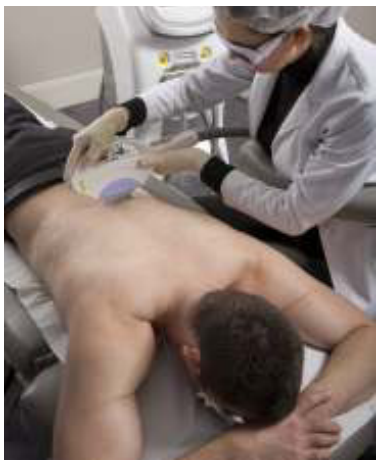
For those who are embarking on the transition from male to female, the permanent removal of hair is vital. However, with so many clinics and procedures to choose from, it's crucial that your chosen solution is reliable, safe and permanent.

At Advanced Electrolysis Centre, we have been specialising in permanent hair removal since 1996, continually improving the methods and the technologies that deliver the best results. You'll be in the hands of our experienced and qualified specialists, where you'll receive the ultimate level of personal care and attention.We also offer on-site parking for our 3hr clients subject to availability.

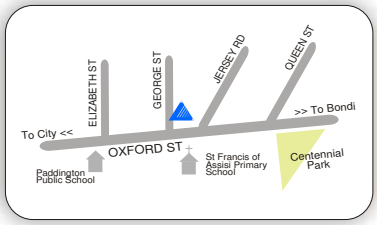
Galvanic electrolysis is a scientifically proven technique that is effective no matter what type of hair you have, and no matter what colour skin. It works perfectly, even if you have blonde or grey hair. However if you have dark hair this can be treated by laser or IPL, or in many cases a combination to achieve a true permanent result.



So, whether you are in need of some general information, or you have already decided on a method that best suits your needs, come in for a chat and get expert advice on how to effectively be free of your unwanted hair FOREVER!



- Multi probe galvanic 16, 32 and 64 (Dual operator) follicle treatment
- Guaranteed Permanent Results
- Skin Rejuvenation
- Pigmentation Reduction
- Red Veins & Rosacea



advanced
ELECTROLYSIS CENTRE

Phone: (02) **9362 1992**
9 George Street (just off Oxford St),
Paddington
aecsydney.com.au