Young People with Transsexualism

The Contemporary Australian Experience

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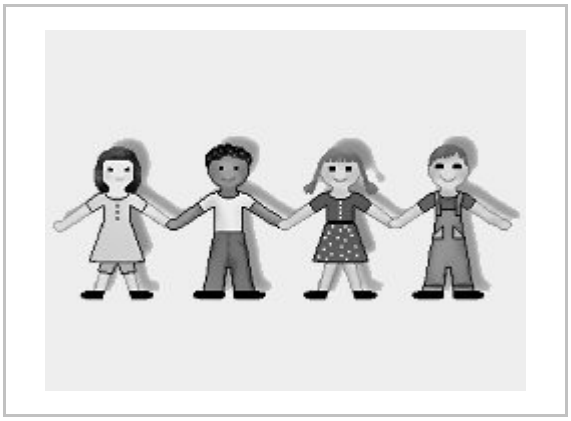

Introduction and a Discussion about Language

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

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

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

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

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

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

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

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

The need "trans-language" has to replace the "gender terms" - "masculine/feminine" with the sex terms "male/female" shows that in trying to stretch and distort the word "gender" to do the linguistic work of both the words "sex" and "gender", it actually robs both "sex" and "gender" of their full traditional meanings and linguistic potential to describe respectively and distinctly the phenomena biological diversity and diversity in gender expression. "M.T.F./F.T.M." terminology has nothing to do with gender or gender meaning words such as "masculine", "feminine" and "neuter". "M.T.F./ F.T.M." terminology was established in order to refer to a "change of a person's sex

through genital reassignment surgery". Way back when, when scientists and clinicians first employed the terms "male-to-female transsexual" and "female-to-male transsexual" they were making a quasi-biological statement based upon the now acknowledged fallacy that genital formation, and especially external genital formation, determines an individual's sex.

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

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

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

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

Hence I say that "M.T.F./F.T.M." is prejudiced, inaccurate and genitocentric [2], focussed on the genitals as being the only or primary indicators of a person's sex - thus ignoring or devaluing chromosomal, hormonal and neurological brain sex insignia; because this is what is meant when a medical scientist or clinician uses these terms.

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

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

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

As reported by Dr. Eric Vilain, paediatrician, Chief of Medical Genetics at the University of California U.S.A. in the A.B.C. Radio National "The Health Report" broadcast on 14th March 2005:

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

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

> **"Most commonly a person's sex is evaluated based on chromosomes, gonads, hormonal levels, internal genitalia, external genital appearance, and social lifestyle. With increasing sophistication and knowledge, however, more factors are being identified so that a final resolution on a person's "sex" can also involve different gene constellations as well as brain sex. [3]"**

The Re: Kevin cases required that I answer the challenge of trying to communicate my client husband's personal experience of being a male experiencing transsexualism and the broader experience of that phenomenon to the judges (and later the media) involved in the

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

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

This appreciation of the power of language to overcome expert and cultural prejudice led to the creation of a new language, which I called Affirmative Language [5], to describe the experience of diversity in sexual formation. My first attempt to publish a short dictionary of Affirmative Language was in my paper with the ungainly title The Legal Environment Following Re: Kevin: New Perceptions and Strategies for Effective Law Reform in Respect of the Legal Rights of People Who Experience Variation in Human Sexual Formation and Expression [6] delivered at the N.S.W. Anti-Discrimination Board's March 2003 Neglected Communities Forum event. From the start, people living with transsexualism, as well as people who experienced other forms of diversity in sexual formation, welcomed this new terminology that honoured their reality and spoke of their experience with some clarity. I am pleased to say that that the use of Affirmative Language has continued to grow exponentially since then. It was extensively used by the Australian Human Rights Commission in its recently (and regrettably titled) Sex Files [7] report as well as by the Chief Justice of the Family Court of Australia, Diana Bryant, in her 2009 Costello Lecture entitled "It's My Body Isn't It? Children, Medical Treatment and Human Rights" [8].

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

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

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

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

While it may once have been effective and even necessary for people who experience diversity in sexual formation and those who experience diversity in gender expression to express themselves culturally as one united "community" (including forming a loose form of community with the Gay, Lesbian and Bisexual community as in "L.G.B.T." and "L.G.B.T.I."), in order to get a cultural voice and be culturally heard, there was always a discomfort to these ungainly associations and a considerable price to be paid in terms of the mystification of the truth of the disparate predicaments, needs and interests of these diverse groups.

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

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

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

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

It is also much harder, for example, to convince the Commonwealth and State Governments of the critical need people who experience transsexualism, and especially those on the verge of adolescence, have to receive publicly funded Sex Affirmation Treatment when

such people are confused with those with gender expression issues. This is a critical human rights issue as, in the absence of receiving Sex Affirmation Treatment, many such young people who experience transsexualism self-harm or self-destruct.

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

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

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

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

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

Numbers/Prevalence

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

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

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

Typical cited prevalence numbers for transsexualism as published by Bakker and Others in 1993 [13] and adopted by W.P.A.T.H. are 1 in 11,900 for Affirmed Females [A.F.] [14] and 1 in 30,400 for Affirmed Males [A.M.].

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

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

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

Moreover, these authors postulate that by using

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

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

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

Thus, if one applied Conway and Olyslager's more conservative prevalence rate for transsexualism based upon past data methods applicable for affirmed females (1:1000) to the Australian population and applied it to both sexes, the result is that as at 30th June 2009 out of a population of 21,875,000 Australians of all ages there are likely to be 21,875 Australians who are currently experiencing transsexualism. I note that Conway and Olyslager postulate that about double the number of people who experience transsexualism in any population are likely to exhibit a preference for pan/trans-gender expression. If the current number of Australians eighteen years or younger is approximately 5,400,000, that is approximately 25 percent of the total population, then this rate of prevalence indicates that there are likely to be approximately 5,469 Australians eighteen years and younger who are experiencing transsexualism at this time.

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

Adolescent Sex Affirmation Treatment

So what is Sex Affirmation Treatment in adolescence?

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

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

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

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

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

- The adolescent diagnosis of G.I.D. indicates the condition of transsexualism in adolescence and adulthood;
- The differential diagnosis of adolescent transsexualism is reliably made; with other phenomena such as mental illness, confusion and/or discomfort as to gender or sexual identity (called "gender dysphoria" to distinguish it from G.I.D./transsexualism), homosexuality and gender non-conformity easily diagnostically distinguished applying the D.S.M. criteria for G.I.D. and the W.P.A.T.H. Standards of Care.
- The reliable differential diagnosis of adolescent transsexualism is not primarily dependent upon the individual circumstances, maturity or decision-making capacity of the individual adolescent, but rather the clarity, consistency and longevity of an adolescent's affirmation of a sex opposite to the adolescent's first assigned sex;
- The experts agree with the findings of Chisholm J. in Re: Kevin concerning the aetiology or causation of transsexualism; with the most likely explanation for the phenomenon of transsexualism being that it is a biological or physiological phenomenon whereby a human being experiences an intersexual brain/body sexual differentiation resulting in the experience of discontinuity of sexual identity between an individual's

mind and body;

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

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

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

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

Until it is formally recognised as error and set aside by government legislative action or court decision, it seems to me the direct and natural continuing consequence of the Re: Alex decision is that young Australians who experience the life-threatening and disabling condition of transsexualism and who, as they enter adolescence, should be receiving the clearly safe, successful and therapeutic medical treatment that is Sex Affirmation Treatment, will not, and they will suffer needlessly as a result.

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

system of court authorisation similar to that now existing in Australia after Re: Alex.

The Contemporary Australian Scene

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

Those who are blessed with a secure enough environment and supportive parents, simply announce to the world their innate sex beginning as soon as they are cognitively able to grasp and express the difference between the sexes; usually between four and ten years of age. And as reported by Dr. William Reiner, child psychiatrist, University of Oklahoma Health Sciences Centre in the A.B.C. Radio National "The Health Report" broadcast on 14th March 2005:

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

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

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

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

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

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

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

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

References:

[1] Full case references and a detailed discussion for this case can be found in the author's paper "Re Kevin in Perspective" published by Deakin University and accessible at True Colours

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

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

[4] Ibid.

[5] An up-to-date version of Affirmative Language with a critique of "trans-language" can be accessed at True Colours

[6] At Wallbanks Legal

[7] At Australian Human Rights Commission

[8] Both the text and audio version of this lecture can be accessed at True Colours

[9] "affirmed sex" where "sex" indicates a person's" innate sexual identity" (also sometimes called gender identity) and not a person's

sexuality or object of sexual attraction.

[10] "Gender Identity Disorder" (G.I.D.) in the Diagnostic and Statistical Manual of Mental Disorders 4th edition (D.S.M.- IV) published by the American Psychiatric Association.

[11] vigorous representation are being made through the World Professional Association for Transgender Health (W.P.A.T.H.) and directly to the American Psychiatric Association to have G.I.D. removed from the D.S.M. V or at least, transsexualism and pan/transgender expression removed from the D.S.M. V The more support the better - so make your contribution to the debate.

[12] Re: Alex - Hormonal Treatment Fam L.R. Gender Identity Dysphoria 200431 Fam L.R. 503.

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

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

[15] Presented at the W.P.A.T.H. 20th International Symposium, Chicago, Illinois, 5th-8th September 2007.

[16] World Professional Association for Transgender Health (W.P.A.T.H.)

[17] S.M.B. and J.W.B.; Secretary, Department of Health and Community Services (sic) (Re Marion) (1992) 175. C.L.R. 218/

[18] Op cit; footnote 8

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