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## MEN WHO WOULD BE WOMEN

I have been told that to become a specialist concerning Gender Identity Disorder and Transsexualism, you have to read and write papers about the subject. I not only read and write about the subject, but also research it and with some success have been able to amend laws and clarify our rights. Add to the fact that from the age of 6, I have known that I was wrong, and the fact that I am now 75 so for those intervening 69 years I have been well aware of the fact, as I live it 24/7, as do many others.

These are some of the details that the professionals we have to deal with should be considering when they assess us. They are based on my observations and experiences.

## TRANS HISTORY

So far as Trans people are concerned, I liken it to the history of this planet. We are out of the Jurassic period, although still trying to be pushed back into it by religious orders. Now we are part of the way through the dark ages, when people like us were pilloried and burnt at the stake as witches.

We are still suffering hugely from the same mindset that was prevalent then. Homophobia, transphobia, call it what you will since there is little difference between then and now. We hurt no one, but suffer hugely at the hands of those who don't or won't understand. There seems to be a continuing lack of willingness to even try to understand our plight.

Trans people are still being killed, bashed, maimed and abused both verbally and mentally, which in some instances has, it seems to me, only stopped short of being burnt at the stake. This is all because we dare to show our true selves to the world at large. It makes no difference if you are a cross-dresser, transgender or transsexual or any of the other myriad variations between male and female.

Once we were revered as shaman, who invariably was either the clan leader, religious leader or medicine person. That came to an end when the religion of the church came into being, as these people accept nothing outside of what they consider to be normal. I

would ask what in this world is normal within the confines of gender and sex. People are people, no matter what colour, race, creed or religion they belong to. Some of us suffered a quirk of nature before birth and this; to me is really an ongoing part of evolution. More to the point it is more like evolution in reverse, as we strive to obtain what we had eons ago as shaman.

We are here in every walk of life, and if allowed, we can and do make a very great contribution to society at large.

The need for informed education about the transgendered at all levels is an absolute must, as many people are unaware of our existence. Those who may be aware and have an idea of the problems we face on a day to day basis have no understanding of the difficulties transgendered face in trying to live a full life in our correct sex/gender. Often we have to contend with not just family that does not understand, but Government at all levels who make life as hard as they can, when it comes to amending documentation. This is something that only Trans people are *forced to do*. This can be a daunting task for many, as we are faced with a lack of empathy and minimal help when we try to amend documentation which can be in excess of forty items. Government does not help, due to the total lack of consistency between departments in the state and federal governments.

This of course puts us under immense pressure, that can and does lead to stress and stress related health problems. This also leads to self harm and in many cases attempted or achieved suicide. There is very little research or understanding of our problems, which also include long term use of hormones and their known side affects in regard to clots, embolisms DVT and other bad reactions.

All we are asking for is to have a friendly and consistent approach to our problems, so that we know how to go about amending documentation so that we can get on and enjoy our lives. Towards this end, we are not asking too much for some TLC and understanding from family, friends and society at large, and in so doing to be finally understood by mankind at large.

## STRESS

As you can imagine, all of the above places an inordinate amount of stress on those who are faced with the outlook of going through the minefield as laid out above. Many will not bother, as they see it as too hard, too confusing and continually outing your self.

As you can imagine, or can you really place your self in our shoes, this stress can have dire consequences in regard to health and welfare. This can lead to several types of self harm and even suicide, due to all the pressures that are placed on us, and not withstanding, having to cope with every day life.

Our Health is definitely at risk because of these factors, which are not made easier as we attempt to follow the protocol imposed on us so that we can express our true selves.

## Coming out as part of Stress

This is most probably the most difficult thing a person will ever undertake in life. It makes no difference if the person is 5 or 60 years old; the ramifications are much the same. The only good thing about coming out earlier in life is that one will not compound events by getting married and having children. This is what most of the older ones have done due to the repressive social conditions that existed in the first thirty to fifty years of their lives. These people not only have to explain to parents if still living, but to loved ones in long established families of which they may be seen as the senior male or female, so coming out is fraught with difficulty. If a person is lucky he or she will retain the love of friends and workmates. If not, then that person is alone in a hostile environment. It may turn out that the person receives no support from family, friends, and employer, and thus has seriously put at risk his or her income and home. That means the person must start from scratch—possibly all alone and that can be very disheartening, not to mention extremely hard!

Generally I have found that the use of photos of the new you, seem an acceptable way of introducing the new 'you'. This allows people to determine whether they wish to see the new 'you', as seeing the person for the first time "in the flesh" can be a daunting situation for many, as well as making some feel embarrassed and uncomfortable. If they wish to meet you 'In the flesh' they then have the opportunity to say so. I and many others have used this approach to good effect.

Coming out at school for a child is not recommended. There are too many shades of grey in the process which confront a child who only understands black and white. The outlook children have on life is mostly the result of their parent's attitudes, education, and upbringing. To expect any child to understand why a boy plays with dolls and doesn't want to climb trees is hard. For such children to accept and be accepted requires the infrastructure of a highly developed family group system, where questions may be answered by adults without the interference of underlying bigotry, bias and attitudes from previous generations. Men can often be responsible for making thugs out of their male children. Teasing, bullying and peer pressure to conform to what is seen as 'normal' are rife in any school up to the student age of about fifteen. This is what drives a society to remain static in its attitudes and mores and for populations to continue to feel 'safe and secure'. If we ever manage to control those factors of school life, society can undergo changes in every generation. Presently, any real change takes three generations.

Children are actually fairly androgynous up to the age of about ten, most of us who have transsexual tendencies do not need any medical intervention until that time. We would love to be treated as our mental gender, but we have pretty much come to terms with the wait, even if we know that sex change is possible by medical intervention later on. Doctors favour 'the wait' since there is no physical symptom that can be determined that may give them the indication of true mental gender. I would suggest that some tempering might be possible if doctors were allowed to help to balance the endocrine system of a child that feels gender alienated. At present, no doctor will put themselves out on a limb as far as that. Legally we are not allowed to alter our systems till way past the point that we have been damaged irreparably by virilisation (the masculinisation of the skeleton, face, voice and hair growth). After the case of Alex and under strict supervision, it is now possible that some chemical intervention can be prescribed to postpone the natural onset of masculinity or femininity.

## The Demons that Plague the Transsexual from a Personal Point of View

The brain has done its work. There is no longer room in your mind for denial. So, you are alone! Where do you go from here? Who will support you? Where do I find support? These are the big questions!

Internal demons are now working overtime. The peer pressure, guilt and parental forming are telling you that you are a boy, so act like one! We become more macho than most males would ever be! We go into sport, the real rough stuff, the armed services, marriage and children, mortgage and all that is expected of a male. You are now husband and father, and perhaps grandfather too. We have been forced into a cultural belief system that because we are equipped with male genitals—we are men.

Wrong. At some stage those cultural demons will drop out and your mind will force you to become the woman you are supposed to be. You tell your partner, children, family, friends and workmates and if lucky you will remain part of their lives. If you do secure that position, it now means that you are living in an entirely new relationship with your partner. Most cannot adjust to this aspect of marriage, they married a man, not another woman (this is also a cultural bind from the past since you were always supposed to marry the person that you fall in love with). This may cause the female to feel lesbian and therefore she feels that she can no longer go on in the marriage. Those partners that do accept the change or the ones that did fall for a person and not a label may last the whole distance, but many, even after supporting a transsexual partner for a while, find that it is just too much for them to fly in the face of embedded cultural and social barriers and so they may eventually go their own way.

If the marriage is to continue, do we now live as sisters, friends or lesbians? Most partners are not lesbian; they need and require the company of a male. You have now left that area, as you are becoming, or have become female. Over time many will opt for another relationship with a new male partner and who can blame them? On the other hand you may well meet a male partner. Have you thought of that?

The reality of where you fit in socially will have a lot of influence on your future since open western culture is often closed once one has gone beyond the limits of the sex, gender and sexuality divide. I would like to state that we are not gay, as so many in society seem to think we are. Our problems stem from the gender (brain) and sex (i.e. what is between the legs) which are not congruent. After SRS, mental and physical gender have been affirmed at last. The brain is satisfied. Now there are five directions that a transsexual can follow, in the same way that a post-pubescent teenager may experience either consciously or unconsciously. Those directions are, of course, gay, lesbian, bisexual, heterosexual and A-sexual, so some female to male (FtM) may well become gay, and some male to female (MtF) become lesbian. We now have these choices because at last our brain and gender are in congruency.

## Health and Assessment

Where do we start on this journey of exploration that we are about to undertake in order to arrive at our true selves? Hopefully we are able to find a GP who has some understanding of gender dysphoria/transsexualism (GID/TSism) so that we can be referred to a psychiatrist or psychologist.

We now have to expose our innermost feelings to the 'gate keepers'. This is our term for the medical fraternity that will decide if we are mad, have GID (Gender Identity Disorder), and are gender dysphoric or transsexual. Don't forget, we know within ourselves what we really are and feel abused again at having to prove this to someone who has had no formal training in the fields of gender dysphoria or transsexualism (currently there are no formal qualification in gender studies in Australia). In the main they will learn from the presenting patient (when one of us walks into their practice—yes

we are as just rare as that. But the rarity factor appears to be shrinking, dramatically. In this way the GPs can then use it as an adjunct specialty to that practice. However, many doctors, over time, do become very well informed and we seek these people out by experience and word of mouth. The down side of this is that many of those who are able to assess us are coming up to retirement and there are few if any young psychiatrists or psychologists taking up the gaps (not sufficient incentive to interest new doctors).

If we are accepted as transsexual, then after (possibly) many months of assessment, we are referred to an endocrinologist for a drug and hormone regime. Again we have to 'out' ourselves and this is only the beginning of a long journey.

We become frustrated at the lack of expertise, time taken to arrive at a decision and the ever increasing cost. Most (of us) are on a pension of some sort, perhaps the result of depression and/or unemployment caused by the pressure of society to conform to the stereotypical norm, so cannot afford these high costs.

Bearing in mind that the assessments are based (sometimes loosely) on the Harry Benjamin Standard of Care (HBSOC), now known as WPATH, which was formulated as a guide for transsexuals, it makes one wonder how we survive! The Benjamin standard of care details paths to be followed in determining what condition we suffer. It states that the GP should refer you to a psychiatrist or a psychologist who over a period of months will assess your mental state. If given the OK, then an endocrinologist will give a drug and hormones regime after five blood tests in order to ascertain what current levels are in your body and to make sure that your renal system can cope. The tests are:- liver, kidneys, testosterone levels, oestrogen and prolactin. Prolactin is checked for the first two years of hormone therapy due to the interaction between it and oestrogen. Many transsexuals do not adhere to this pathway and instead, buy drugs and hormones on the internet, this is colloquially known as 'self medding'. This can be dangerous when there is no one to monitor the affects of the drugs and hormones.

If put onto drugs and hormones, transsexuals are given a testosterone blocker, which is usually aldactone. In some cases androcur is given. This is usually only given after SRS, when it is not required, as the testes have been removed, so very little testosterone is now manufactured. If people are put onto androcur and not informed that they will be listed as sexual deviants which is what happens to their medical records this is totally wrong. We are not sexual deviants by any standard.

We are also expected to live in role full time in the lead up to surgery, so that we can be assessed as to how well we are accepted in our new role. Again, we know what we are, and have known from a very early age that we were in the wrong body (our terminology) but are still reliant on the assessments from the medical fraternity in order to be able to undergo SRS, if we choose this path. There are reasons to not do so, and they should be respected and taken into account when we wish to amend documentation. They are:

- The choice not to have surgery, but live in your preferred gender/sex.
- Lack of funds, for surgery, and many of the other costs that are incurred.
- Advice from the surgeon that surgery could be life threatening.

However, if the assessments by these people are OK, one can then move on to settling on a surgeon in order to have SRS (sex re-assignment surgery). The transsexual will need two reports from psychiatrists/psychologists and one from an endocrinologist in order to be able to undergo SRS, the operation that will make you complete; the person you should have always been.

At present there are only two places that perform this operation in Australia, one in Melbourne and one in Sydney. Other than these, people must go off-shore to somewhere like Thailand. This then raises the problems of travel in regard to passport and the terrifying thought of travelling on a male passport, but presenting as a female.

The following paragraphs have been selected from printed advice sent out by me from *Changing Aspects* at various times over the last few years.

## Cost

The cost of change is very high and therefore beyond the means of many.

This now really is 'coming out' and means that you have declared yourself to all around you. We discussed this previously and raised all the problems and pitfalls that you are likely to face, but there are more.

Now you maybe exposed to discrimination, vilification and physical violence, or just plain verbal abuse. All of it can be hurtful and soul destroying and may make you feel that you should revert to your previous status. Some do, but their demons usually have their way and they come back to their preferred (brain) gender. All of these four areas are covered by law, but it has been found to be easy to find ways around that so that they do not cross the line on the laws pertaining to discrimination, vilification, violence and abuse.

You have much more than this to contend with in order to reach your goal. If you are out of work and on a pension, then it makes it harder than ever. You need female clothes and make-up to hide that five o'clock shadow, in order to look feminine. Money for medical appointments and scripts, it is all getting out of hand. Some at this point will look to prostitution in order to make the money they need. Add to this the fact that you probably need to get rid of that facial fuzz, as the drugs and hormones will not do this. Nor will they get rid of that basso profundo voice that may require speech therapy or even an operation. More money is needed for electrolysis, laser or ELOS. Some will use tweezers on the hairs and some will even wax their face. The last two are cheap, but painful and laser and ELOS is not cheap, but something has to be done to achieve the right appearance, as continual shaving is not going to be the answer in the long term.

Electrolysis is permanent, but very costly. It may take up to 300 hours to clear the beard and at \$80.00 per hour, unless able to negotiate a better price, comes to \$24000.00 just to clear the face—and it hurts. Laser is not permanent, but will hopefully get you the desired effect a lot quicker, but it is still not cheap, and neither is ELOS. If you have white hairs, then it will take even longer. White hairs are no problem for electrolysis as it gets rid of those too, but it means hundreds of hours of needles in your face! Some transsexual girls get lucky and the hair does stop growing with HRT but don't count on it.

You have now acquired a femme name, so start to think about change of name. The bank account needs to be healthy for this...more money! You apply for and receive a document from Births, Deaths and Marriages in your state of birth, or where domiciled if born abroad, stating your change of name. As discussed earlier, now begins the rest of the people to notify about this name change (your old name is no longer legal). In Queensland you need a letter from your psychiatrist on his headed notepaper to take to the transport department in order to get your drivers licence changed to female as well as the name change. As Churchill said, 'this is not the end, nor even the beginning of the end, merely the end of the beginning'.

All of these can be changed as pre-op transsexual. Others can only be done after SRS and will be listed later. You may find that you are issued with new health cards, but these will still be registered in your previous name until after SRS. This can cause some confusion when claiming refunds, as Jane Doe comes up as John Doe. The positive in all this is that you have really started your full transition and have now established your new identity, WELCOME!

By this time you have your letters from your psychiatrists and endocrinologist and are talking to your surgeon about when you can have SRS. This is of course dependent on the money situation and we will discuss that later. At this point in time, talk to as many surgeons as you can. Keep in mind your right to choose who and where. Choice is open to all, so do not be pushed or rushed into going where you are not comfortable with! If you are not one hundred per cent happy in your mind that now is the time to go ahead with SRS, it is preferable to wait even if it is six months or six years and then be completely happy that you have made the right decision. This is a for life decision, and there is no (real or imagined) way back! If you are pushed, or rush into SRS before you are ready, or for all the wrong reasons, you could end up living a life of anguish or even go so far as to suicide. The time and even the decision are yours, and no one else's. It is your life and you are the one who will suffer the consequences good or bad.

For many, the costs of all of this, is again beyond their means. Some who are on pensions will have entry to the PBS system, but most costs are born by the Trans person.

Costs, like everything in life increase year by year, so it is best to look at the web sites concerned, in order to help make that final decision.

At present in Australia, being a member of top private medical benefits you will have an advantage, as the cost of the bed per night and the operating theatre are covered. You only have to pay the surgeon and anaesthetist. At present there are rebates for both of these via Medicare and Private health. You can negotiate for these rebates to be paid direct to the surgeon and anaesthetist. This will have the effect of lowering up front costs to be paid to them. Each part of the operation is allocated a number for the rebate. These amounts are reviewed each November.

As this is not considered to be 'plastic surgery' and we are allocated numbers in order to claim rebates, I have had confirmation from my accountant and another in Sydney that 'If working, you can claim the net fees after rebates against your tax return'. This would mean that anything over \$1500.00 can be claimed at 20 cents in the dollar. I would reiterate that any other operations other than SRS are not claimable, as they are considered to be 'Plastic Surgery'.

## Education

We are not gay as many think we are. After SRS we have five choices of sexuality. They are gay, lesbian, bi-sexual, heterosexual and a-sexual. Up until then we look at our gender (brain) and sex (between the legs) and realise they are not congruent.

As stated above, there are very few medical people qualified in the field of GID/Transsexualism. It is currently not part of their curriculum here in Australia to my knowledge, as they rely on what the Royal College of Psychiatrists (RCP) in the UK to determine if it will be added to the curriculum. However, gay, lesbian and bi-sexual are listed.

Many take up the learning curve when we present to them in need of help. Those that are good are eagerly sought out to help with our journey of self discovery. As most do not understand, they try to treat the symptoms and not the cause. This is even now happening where the youngsters are concerned and making them and their parents very confused about what is already a very serious situation. They are often told that 'it is a phase, and they will grow out of it' in some instances this will be true, but in many others it will not, as the child has GID/Transsexualism. If wrongly diagnosed, this then condemns the child and parents to extreme difficulties that they have to face with the possibility of self harm and suicide to consider as being very real.

Young boys sit to pee, young girls stand. Young boys tuck from an early age in order to look more feminine down below. I would ask whether this is innate, as it happens to us even if we are not aware of what a vagina looks like if we have no sisters. Young boys

have been known to cut off their penis and young girls try to remove their breasts which are anathema to them. As we get into puberty and the whole male/female reactions start to change our bodies, it is the worst time for us, as this is not supposed to be happening. Suddenly boys find that, that thing between their legs seems to have a mind of its own with erections and wet dreams. For girls it is the onset of their menses and breast growth that causes them great discomfort.

We are currently in the area now of puberty blockers and the debate for and against. I believe that if anything can be done to alleviate the problems that I faced in puberty it is good from the point of view that it gives time for careful consideration and also stops the wrong growth patterns emerging. If it is not that you are GID/Transsexual, then come off the blockers and go into a late puberty. I certainly would have welcomed this when I was young, but back in the 1940s and 50s and 60s this was no where in sight.

### Quotes from abroad

The Equalities and Human rights Commission recognises the right of UK citizens to be protected from unlawful discrimination on the grounds of gender identity.

Equality and Human Rights Commission (2008) Equality and Discrimination, Available on line at [www.equalityhumanrights.com](http://www.equalityhumanrights.com)

Furthermore, a recent paper prepared by GIRES and many of the UK's leading authorities on atypical gender development stated that:

It is imperative to emphasise that attention to the needs of trans people should be extended on the basis of human rights, justice and equality. Medical and scientific findings are often amended and clarified, but the right of individuals to appropriate care and respect remains.

GIRES et al. (2006) Atypical Gender Development – A review, International Journal of Transgenderism, 9(1) 29-44

From a very early age many of us express the fact that we do not feel right. We later begin to identify this as “being born in the wrong body”. Very early we learn that to express our selves as any thing other than male is asking for trouble. We are told we are male and should and must live as such. This is anathema to us, but if we don't then it is made amply clear what the consequences will be if we do not adhere to being male. This can and does lead to being beaten and suffering mental and physical abuse. Sissy boys are not acceptable, where as tomboys are, as they are given more latitude to develop over time as either a Trans person, or a straight person, as they grow out of being a tomboy. This can also happen with sissy boys, but in the mean time all of the above can happen. It is not helped one bit, when doctors tell parents ‘that it is a phase they are going through and will out grow it’. The symptoms are looked at, but never the real underlying cause, Transsexualism. This is largely due to the fact that most doctors are not aware of the condition. To have a sissy boy in the family is like having a stigma and is perceived as a sign of weakness that must be eradicated, as there are perceived powerful ramifications for family and friends of a sissy boy. For many it means that the family is more concerned about the family well being and not the unfortunate child suffering from transsexualism.

Because of this, many younger ones are forced out of home because the family will not accept this phenomenon. Those who succumb to this in later life are not only forced out of home and family, but stand to lose their job, friends and have none or very little support. Many lose heart and become frustrated and depressed at what lies ahead without support and understanding of their problems. In these cases, many attempt suicide, or achieve it, as at the time it appears far more preferable to what they are facing on a day to day basis due to the ongoing traumas they have to face.

We have to come to terms with all of the situations that will face us, as we progress from crib to grave. I have thought of 13 that we have to face in this time, and that does include the problems at law. These are the lead points from the changeling Aspects resource.

- 1 REALISATION
- 2 COMING OUT
- 3 SIGNIFICANT OTHERS
- 4 ASSESSMENT
- 5 DRUGS AND HORMONES
- 6 LIVING IN ROLE
- 7 TRANSITIONING ON THE JOB
- 8 OPERATION, SEX AFFIRMATION SURGERY
- 9 LIFE AFTER SEX AFFIRMATION SURGERY
- 10 EVERY DAY LIVING AND RELATIONSHIPS
- 11 OLD AGE
- 12 CARE FACILITIES
- 13 LAW

Viewpoints of the Council of Europe Commissioner for Human Rights.  
Thomas Hammarberg

“Discrimination against transgender persons must no longer be tolerated”

[05/01/09] During missions to member states of the Council of Europe, I have been reminded of the on-going discrimination many face on account of their gender identity<sup>1</sup>. Transgender persons encounter severe problems in their daily lives as their identity is met with insensitivity, prejudice or outright rejection.

There have been some extremely brutal hate crimes against transgender persons. One case which received media attention was the murder in Portugal of a homeless, HIV-positive, Brazilian transgender woman, called Gisberta Salce Junior. She was tortured and raped by a group of young men, thrown into a well and left to die.

My discussions with non-governmental organisations defending the rights of transgender persons indicate that a number of such hate crimes go unreported – even in serious cases. One of the reasons appears to be a lack of trust in the police.

Some people seem to have a problem with the mere existence of human beings whose outer expression of their inner gender identity is not the same as their gender determined at birth. Aggression against transgender persons cannot however be excused as resulting from ignorance or lack of education. These attitudes cause serious

harm to innocent and vulnerable people and must therefore be countered.

I have been struck by the lack of knowledge about the human rights issues at stake for transgender persons, even among political decision-makers. This is probably the reason why more has not been done to address transphobia and discrimination based on gender identity. The result is that individuals are discriminated against all over Europe, in areas such as employment, health care and housing.

In a number of countries, the problem starts at the level of official recognition. Transgender persons who no longer identify with their birth gender, seek changes to their birth certificates, passports and other documents, but often encounter difficulties. This in turn leads to a number of very concrete problems in daily life when showing one's ID papers – in the bank or the post office, when using a credit card, or crossing borders.

One well-publicised case related to Dr. Lydia Foy in Ireland who sought to have her legal gender changed from male to female on her birth certificate. After ten years of struggle, in 2007 the Irish High Court finally ruled that the State was in breach of Article 8 of the European Convention on Human Rights.

The European Court of Human Rights has ruled that States are required to recognise legally the gender change of post-operative transsexuals<sup>2</sup>. In one case, Christine Goodwin, a post-operative male to female transgender person, complained about sexual harassment in the workplace, discrimination in relation to contributions to the National Insurance system, and the fact that she was prevented from marrying a man (because she was still legally male).

The Court stated that “the very essence of the Convention was respect for human dignity and human freedom. Under Article 8 of the Convention in particular...protection was given to the personal sphere of each individual, including the right to establish details of their identity as human beings.”<sup>3</sup>

In some European countries, it has now become possible to correct official records and obtain a new first name. However, in other countries a change of birth certificate is simply not allowed. In a large number of Council of Europe Member States, such changes are permitted only upon proof that the transgender person has been sterilised or declared infertile, or has undergone other medical procedures, such as gender reassignment surgery or hormone treatment. The individual's sincere affirmation of their gender identity is not seen as sufficient, and the suitability of the medical procedures for the person in question is not considered.

Additionally, many countries require that a married person divorces before his or her new gender can be recognised, even though the couple itself does not want to divorce. This in turn may have an impact on children of the marriage. In fact, in several countries the parent who has undergone the gender change will lose custody rights. Legislation requiring divorce needs to be reformed in the spirit of the best interests of the child.

To require surgery as a prerequisite to enjoy legal recognition of one's gender identity ignores the fact that such operations are not always desired, medically possible, available, and affordable (without public or other funding). It is estimated that only

10% of transgender persons in Europe actually undergo gender reassignment surgery.

Even access to ordinary health care is a problem for transgender people. The lack of trained staff familiar with the specific health care needs of transgender persons – or simply prejudice towards transgender people - render them vulnerable to unpredictable and sometimes hostile reactions.

In the United Kingdom, male to female transgender persons have been struggling to get their gender status accepted for the purpose of pension benefits. In spite of overwhelming legal arguments they have so far been denied the pension rights that other women in the country (who were born female) enjoy without question.

There are other obstacles encountered in day-to-day life. A major problem for transgender persons is harassment and discrimination at work. Some leave their jobs to avoid it, while others avoid gender reassignment surgery for fear of stigmatisation.

Data presented by EU's Fundamental Rights Agency shows that in some countries the unemployment rate of transgender persons can reach up to 50%. Some jobless transgender persons are unable to find employment, and see no other option but to work in the sex industry. A report from Human Rights Watch on Turkey called attention to the situation of transgender sex workers in that country - victimised by violence, drug addiction, sexual abuse, lack of health insurance, homelessness, police attacks, and a high risk of HIV/AIDS.

To date, very little factual information is available on the situation of transgender people in Council of Europe Member States. This information is needed urgently to determine the extent of the problems faced.

There is no excuse for not immediately granting this community their full and unconditional human rights. Council of Europe Member States should take all necessary concrete action to ensure that transphobia is stopped and that transgender persons are no longer discriminated against in any field.

Thomas Hammarberg

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Notes:

1. Gender identity is understood to refer to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech and mannerisms. [\(back\)](#)

2. Most recently, in *L. v Lithuania*, Application 27527/03, 11 September 2007, para. 56. [\(back\)](#)

3. *Christine Goodwin v. United Kingdom*, Application 28957/95, judgment of 11 July 2002. [\(back\)](#)

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I have included the above, as it very succinctly puts our case.

### SEX AFFIRMATION SURGERY

States and Territories require you to "Alter or Remove all reproductive organs as per attached.

If we are to retain the current criteria that exists, that being the requirement of the "Alteration or removal of a person's reproductive organs" in order to qualify for a 'Recognised Details Certificate/Birth Certificate', they must have undergone sex affirmation surgery.

Reproductive organs to me mean, testes in the male and ovaries and uterus in the female. The penis and vagina are but delivery systems.

Currently a double mastectomy is considered as part of the reproductive system, but an orchidectomy is not. Surely, this is plainly wrong, as the breasts play no part in reproduction; only coming into use after the baby is born. On the other hand, the removal of the testes ceases the supply of semen, so that procreation cannot occur. This is but a very extreme form of vasectomy. An orchidectomy also stops the major source for the production of testosterone.

If we are to continue to follow these paths, then it is amply apparent that 'GenderQueer' does not fit the requirement of "Alteration or removal of the reproductive organs"

As stated at the beginning, the Australian system does not recognise "Non Surgery" as related in the requirement. Therefore a Recognised Details Certificate cannot be offered in their new gender/sex.

On the other hand, the requirement to be divorced in order to amend a birth certificate is draconian and unconstitutional, especially in light of the Federal Attorney-General's letter of the 17 March 2009, as well as the case by case basis allowed by the Passport Office. Also it flies in the face of 'Re-Kevin' which is now widely accepted as the major break through with regard to staying married after surgery.

These, plus a form of temporary legal cover for the youngsters who are going through transition using their birth certificate issued at birth have no form of legal standing in their preferred gender/sex. These are my main concerns.

This now opens up an interesting dialogue, if we are to come to terms with the law as it stands in Australia, or the law as some would want it.

Yours Sincerely, Kathy Anne Noble.  
President, Changeling Aspects  
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## EXTRACTS FROM WPATH SOC SIXTH VERSION

### III. Diagnostic Nomenclature

**The Five Elements of Clinical Work.** Professional involvement with patients with gender identity disorders involves any of the following: diagnostic assessment, psychotherapy, real-life experience, hormone therapy, and surgical therapy. This section provides a background on diagnostic assessment.

**The Development of a Nomenclature.** The term transsexual emerged into professional and public usage in the 1950s as a means of designating a person who aspired to or actually lived in the anatomically contrary gender role, whether or not hormones had been administered or surgery had been performed. During the 1960s and 1970s, clinicians used the term true transsexual. The true transsexual was thought to be a person with a characteristic path of atypical gender identity development that predicted an improved life from a treatment sequence that culminated in genital surgery. True transsexuals were thought to have: 1) cross-gender identifications that were consistently expressed behaviorally in childhood, adolescence, and adulthood; 2) minimal or no sexual arousal to cross-dressing; and 3) no heterosexual interest, relative to their anatomic sex. True transsexuals could be of either sex. True transsexual males were distinguished from males who arrived at the desire to change sex and gender via a reasonably masculine behavioral developmental pathway. Belief in the true transsexual concept for males dissipated when it was realized that such patients were rarely encountered, and that some of the original true transsexuals had falsified their histories to make their stories match the earliest theories about the disorder. The concept of true transsexual females never created diagnostic uncertainties, largely because patient histories were relatively consistent and gender variant behaviors such as female cross-dressing remained unseen by clinicians. The term "gender dysphoria syndrome" was later adopted to designate the presence of a gender problem in either sex until psychiatry developed an official nomenclature.

The diagnosis of Transsexualism was introduced in the DSM-III in 1980 for gender dysphoric individuals who demonstrated at least two years of continuous interest in transforming the sex of their bodies and their social gender status. Others with gender dysphoria could be diagnosed as Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type; or Gender Identity Disorder Not Otherwise Specified

(GIDNOS). These diagnostic terms were usually ignored by the media, which used the term transsexual for any person who wanted to change his/her sex and gender.

The DSM-IV. In 1994, the DSM-IV committee replaced the diagnosis of Transsexualism with Gender Identity Disorder. Depending on their age, those with a strong and persistent crossgender identification and a persistent discomfort with their sex or a sense of inappropriateness in the gender role of that sex were to be diagnosed as Gender Identity Disorder of Childhood (302.6), Adolescence, or Adulthood (302.85). For persons who did not meet these criteria, Gender Identity Disorder Not Otherwise Specified (GIDNOS)(302.6) was to be used. This category included a variety of individuals, including those who desired only castration or penectomy without a desire to develop breasts, those who wished hormone therapy and mastectomy without genital reconstruction, those with a congenital intersex condition, those with transient stress-related cross-dressing, and those with considerable ambivalence about giving up their gender status. Patients diagnosed with GID and GIDNOS were to be subclassified according to the sexual orientation: attracted to males; attracted to females; attracted to both; or attracted to neither. This sub-classification was intended to assist in determining, over time, whether individuals of one sexual orientation or another experienced better outcomes using particular therapeutic approaches; it was not intended to guide treatment decisions.

Between the publication of DSM-III and DSM-IV, the term "transgender" began to be used in various ways. Some employed it to refer to those with unusual gender identities in a value-free manner -- that is, without a connotation of psychopathology. Some people informally used the term to refer to any person with any type of gender identity issues. Transgender is not a formal diagnosis, but many professionals and members of the public found it easier to use informally than GIDNOS, which is a formal diagnosis.

The ICD-10. The ICD-10 now provides five diagnoses for the gender identity disorders (F64):

Transsexualism (F64.0) has three criteria:

1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment;
2. The transsexual identity has been present persistently for at least two years;
3. The disorder is not a symptom of another mental disorder or a chromosomal abnormality.

*Extract from WPATH SOC Sixth Version*

The authors regard "transgender" as something of a nonsense since the term's popular meaning varies according to usage in any particular place and it has not been properly defined by either medicine or the law. The term was originally coined by Charles (Virginia) Prince, a cross-dresser who lived as a woman but had no desire to be, or any belief he actually was, a woman. Prince was a heterosexual, married man who found the "transvestite" label pejorative. He actively excluded people with transsexualism from his cohort of cross-dressers because he understood the considerable difference they represented. See discussion in Dallas Denny, 'Virginia's Ordeal: S.P.I.C.E. Organisers should be ashamed' (2000) 89 *Transgender Tapestry*, 21.

*EXTRACT FROM VICTORIA'S JUSTICE STATEMENT: RIGHTS OR RHETORIC? BY Karen Gurney and Eithne Mills. Deakin University Law School*

If we are accepted as being in the wrong body, we are then subjected to hours of assessment and possible therapy in order to determine that we are sane and also that we are Transsexual/Gender Dysphoric or not. If we are accepted as being TS/GD, we then have to undergo blood tests to determine the levels of Testosterone and Oestrogen. In the WPATH Standard of Care, sixth version 2001 the pre health requirements of blood tests are the following "For those receiving estrogens, the minimum laboratory assessment should consist of a pre-treatment free testosterone level, fasting glucose, liver function tests, and complete blood count with reassessment at 6 and 12 months and annually thereafter. A pre-treatment prolactin level should be obtained and repeated at 1, 2, and 3 years. If hyperprolactemia does not occur during this time, no further measurements are necessary. Biologic males undergoing estrogen treatment should be monitored for breast cancer and encouraged to engage in routine self-examination. As they age, they should be monitored for prostatic cancer". *Extract from WPATH SOC Sixth Version*

Then it means that we are allowed to go onto hormones and a testosterone blocker. For us older Trans people it means that as we were not allowed to take puberty blockers we have lost the advantages they offer, in as much as we will now be subjected to puberty as a male, and all that infers. If on the blockers, we will not suffer from height, muscle bulk, facial hair, deep voice and other male features, such as erections and ejaculation in the form of wet dreams..

*"Fully Reversible Interventions.* Adolescents may be eligible for puberty-delaying hormones as soon as pubertal changes have begun. In order for the adolescent and his or her parents to make an informed decision about pubertal delay, it is recommended that the adolescent experience the onset of puberty in his or her biologic sex, at least to Tanner Stage Two. If for clinical reasons it is thought to be in the patient's interest to intervene earlier, this must be managed with paediatric endocrinological advice and more than one psychiatric opinion.

Two goals justify this intervention: a) to gain time to further explore the gender identity and other developmental issues in psychotherapy; and b) to make passing easier if the adolescent continues to pursue sex and gender change. In order to provide puberty delaying hormones to an adolescent, the following criteria must be met:

1. throughout childhood the adolescent has demonstrated an intense pattern of cross-sex and cross-gender identity and aversion to expected gender role behaviours;
2. sex and gender discomfort has significantly increased with the onset of puberty;
3. the family consents and participates in the therapy.

Biological males should be treated with LHRH agonists (which stop LH secretion and therefore testosterone secretion), or with progestins or anti androgens (which block testosterone secretion or neutralise testosterone action)

Biological females should be treated with LHRH agonists or with sufficient progestins (which stop the production of estrogen and progesterone) to stop menstruation.

*Partially Reversible Interventions.* Adolescents may be eligible to begin masculinizing or feminizing hormone therapy as early as age 16, preferably with parental consent. In many countries 16-year olds are legal adults for medical decision making and do not require parental consent.

*Irreversible Interventions.* Any surgical intervention should not be carried out prior to adulthood, or prior to a real-life experience of at least two years in the gender role of the sex with which the adolescent

identifies. The threshold of 18 should be seen as an eligibility criterion and not an indication in itself for active intervention

*Extract from WPATH SOC Sixth Version*

## **Teenager set to become Britain's youngest sex-change patient**

A 16-year-old boy is set to become Britain's youngest sex-change patient after surgery costing £10,000 was approved by the NHS.

By Amy Willis

Published: 1:42PM GMT 24 Jan 2010

Bradley Cooper, who calls himself Ria after his pop idol Rihanna, has been dressing as a girl since he was 12.

He has been told that surgery to give him breasts and change his genitalia will be funded by his local NHS trust in Hull, East Yorkshire and should happen within 18 months.

He told The News of the World: "People might think I'm too young to make such a huge decision but I know my own mind and this is what I want.

"I've known for years I'm a woman. I think and act like a woman, not a man. In my mind I'm a woman, so all I need now is the operation."

"I know people might say horrible things like the money could be better spent on other things. But this is my life, and it won't be worth living unless I have that operation.

"I don't want years of misery. I want it done as soon as possible so I can be the person physically that I am on the inside."

His mother Elaine, 40, added: "People can have their own beliefs on whether they think this is a good use of NHS money but I just want what will make my child happy."

Currently the youngest British person to have a sex-change is Angel Paris-Jordan, of Wigton, Cumbria, who had the operation shortly before her 18th birthday in 2002.

The youngest person in the world to have a sex-change is Kim Petras from Germany who was 16 when she had surgery. She had been undergoing hormone therapy from the age of 12.

Kim is now a model and pop-singer.

Perhaps they have finally looked at the SOC, as laid out above

## **VII. Requirements for Hormone Therapy for Adults**

**Reasons for Hormone Therapy.** Cross-sex hormonal treatments play an important role in the anatomical and psychological gender transition process for properly selected adults with gender identity disorders. Hormones are often medically necessary for successful living in the new gender. They improve the quality of life and limit psychiatric co-morbidity, which often accompanies lack of treatment. When physicians administer androgens to biologic females and estrogens, progesterone, and testosterone-blocking

agents to biologic males, patients feel and appear more like members of their preferred gender.

**Eligibility Criteria.** The administration of hormones is not to be lightly undertaken because of their medical and social risks. Three criteria exist.

1. Age 18 years;
2. Demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks;
3. Either:
  - a. A documented real-life experience of at least three months prior to the administration of hormones; or
  - b. A period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months).

In selected circumstances, it can be acceptable to provide hormones to patients who have not fulfilled criterion 3 – for example, to facilitate the provision of monitored therapy using hormones of known quality, as an alternative to black-market or unsupervised hormone use.

In selected circumstances, it can be acceptable to provide hormones to patients who have not fulfilled criterion 3 – for example, to facilitate the provision of monitored therapy using hormones of known quality, as an alternative to black-market or unsupervised hormone use.

**Readiness Criteria.** Three criteria exist:

1. The patient has had further consolidation of gender identity during the real-life experience or psychotherapy;
2. The patient has made some progress in mastering other identified problems leading to improving or continuing stable mental health (this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis and suicidality);
3. The patient is likely to take hormones in a responsible manner.

**Can Hormones Be Given To Those Who Do Not Want Surgery or a Real-life Experience?** Yes, but after diagnosis and psychotherapy with a qualified mental health professional following minimal standards listed above. Hormone therapy can provide significant comfort to gender patients who do not wish to cross live or undergo surgery, or who are unable to do so. In some patients, hormone therapy alone may provide sufficient symptomatic relief to obviate the need for cross living or surgery.

**Hormone Therapy and Medical Care for Incarcerated Persons.** Persons who are receiving treatment for gender identity disorders should continue to receive appropriate treatment following these Standards of Care after incarceration. For example, those who are receiving psychotherapy and/or cross-sex hormonal treatments should be allowed to continue this medically necessary treatment to prevent or limit emotional lability, undesired regression of hormonally-induced physical effects and the sense of desperation that may lead to depression, anxiety and suicidality. Prisoners who are subject to rapid withdrawal of cross-sex hormones are particularly at risk for psychiatric symptoms and self-injurious behaviors. Medical monitoring of hormonal treatment as described in these Standards should also be provided. Housing for transgendered prisoners should take into account their transition status and their personal safety.

## VIII. Effects of Hormone Therapy in Adults

The maximum physical effects of hormones may not be evident until two years of continuous treatment. Heredity limits the tissue response to hormones and this cannot be overcome by increasing dosage. The degree of effects actually attained varies from patient to patient.

**Desired Effects of Hormones.** Biologic males treated with estrogens can realistically expect treatment to result in: breast growth, some redistribution of body fat to approximate a female body habitus, decreased upper body strength, softening of skin, decrease in body hair, slowing or stopping the loss of scalp hair, decreased fertility and testicular size, and less frequent, less firm erections. Most of these changes are reversible, although breast enlargement will not completely reverse after discontinuation of treatment.

Biologic females treated with testosterone can expect the following permanent changes: a deepening of the voice, clitoral enlargement, mild breast atrophy, increased facial and body hair and male pattern baldness. Reversible changes include increased upper body strength, weight gain, increased social and sexual interest and arousability, and decreased hip fat.

**Potential Negative Medical Side Effects.** Patients with medical problems or otherwise at risk for cardiovascular disease may be more likely to experience serious or fatal consequences of cross-sex hormonal treatments. For example, cigarette smoking, obesity, advanced age, heart disease, hypertension, clotting abnormalities, malignancy, and some endocrine abnormalities may increase side effects and risks for hormonal treatment. Therefore, some patients may not be able to tolerate cross-sex hormones. However, hormones can provide health benefits as well as risks. Risk-benefit ratios should be considered collaboratively by the patient and prescribing physician.

Side effects in biologic males treated with estrogens and progestins may include increased propensity to blood clotting (venous thrombosis with a risk of fatal pulmonary embolism), development of benign pituitary prolactinomas, infertility, weight gain, emotional lability, liver disease, gallstone formation, somnolence, hypertension, and diabetes mellitus.

Side effects in biologic females treated with testosterone may include infertility, acne, emotional lability, increases in sexual desire, shift of lipid profiles to male patterns which increase the risk of cardiovascular disease, and the potential to develop benign and malignant liver tumors and hepatic dysfunction.

### *Extract from WPATH SOC Sixth Version*

*I have always been interested in the situation of the possible development of benign pituitary prolactinomas, as mentioned above and also in the following part of the SOC which states A pretreatment prolactin level should be obtained and repeated at 1, 2, and 3 years. If hyperprolactemia does not occur during this time, no further measurements are necessary.*

The reason for my interest in this area, is that I was found to be making Prolactin at 4.5 times that of a genetic woman. I was also thought to have a prolactinoma, but

thankfully that was not the case. I was continually told by certain people that men do not make prolactin, which is totally wrong.

My endocrinologist recognised the problems of possible interaction with oestrogen, so we had to get the prolactin levels down, before I could go onto oestrogen. He called it a stress hormone

One interesting side to this problem, which they think was caused when I had two heart attacks in 1988, was the fact that it was decided to get me “Back to being a man” by administering bromocriptine to lower the prolactin, and testosterone to fetch it to the required levels. I found out that prolactin is very useful at lowering testosterone. I had one course of this procedure, and was hospitalised on 4 occasions due to the bromocriptine making me violently sick and having to be re-hydrated. At the end of the course, the desired effect was accomplished, so I had to come off the testosterone. As soon as this happened, the levels went back to previous, very high prolactin, and virtually nil testosterone. I was asked to go back on the course a second time, which I declined, as it was mind blowing, plus the fact it was achieving what I had always wanted, which was a body change as well as a mental one.

Perhaps now you can understand why I am so interested in the prolactin, prolactinoma situation. Over time, several people have noticed that their prolactin has elevated, the longer they are on oestrogen. I find it quite unforgivable, that many of us are not tested for prolactin, as is the requirement in the SOC

### **The Prescribing Physician's Responsibilities**

Physicians have a wide latitude in what hormone preparations they may prescribe and what routes of administration they may select for individual patients. Viable options include oral, injectable, and transdermal delivery systems. The use of transdermal estrogen patches should be considered for males over 40 years of age or those with clotting abnormalities or a history of venous thrombosis. Transdermal testosterone is useful in females who do not want to take injections. In the absence of any other medical, surgical, or psychiatric conditions, basic medical monitoring should include: serial physical examinations relevant to treatment effects and side effects, vital sign measurements before and during treatment, weight measurements, and laboratory assessment. Gender patients, whether on hormones or not, should be screened for pelvic malignancies as are other persons.

For those receiving estrogens, the minimum laboratory assessment should consist of a Pre-treatment free testosterone level, fasting glucose, liver function tests, and complete blood count with reassessment at 6 and 12 months and annually thereafter. A pre-treatment prolactin level should be obtained and repeated at 1, 2, and 3 years. If hyperprolactemia does not occur during this time, no further measurements are necessary. Biologic males undergoing estrogen treatment should be monitored for breast cancer and encouraged to engage in routine self examination. As they age, they should be monitored for prostatic cancer.

*Extract from WPATH SOC Sixth Version*

If we have to in later life, pay to have any of the above surgeries involved, many of which are invasive and hurtful and at great cost. To just clear the beard is going to take over 300 hours at some where between \$80.00 and \$120.00 per hour, unless you can arrange a better price. In many cases this will be the equivalent, or more than having Sex Affirmation Surgery. Also, the on going cost of professional meetings, hormones and drugs, without other items that may be required in the aid to pass and be accepted as female. The list appears endless and pretty soon you realise just what the cost is likely to amount to.

For many of us this is true, but there are many who over time learn what to say by rote, in order to be accepted and complete our transition from Male to Female (MtF). Many see this transition as a magic panacea for all their perceived ills. This is quite wrong, as they could be in a much more invidious situation with no family, no roof, no friends and no job. How are they now to live and pay for costs involved in this immense journey of transition?

Many do not understand that by changing the body via hormones and surgery does not of itself negate all of those inherent problems. You still have to live and earn your keep, but what you have accomplished is to exacerbate your problems, as now you are out there, learning and living as a female. This is a hard task, as you have not had access to the training in being female that is imparted by your mother, sisters, aunts and friends. This now means that we have to embark on a crash course in 'becoming female'. There is much to learn, so it is of great importance that, if you can you seek out a genetic female who is willing to guide you down this path. There are many areas of concern, but a very important one is feminine hygiene. Sure there are others, but many tend to miss this very important area, and concentrate on dress, make-up and trying to attract a man.

So you have undergone surgery, and find that it is not really what you expected it to be after, so what is the answer? This can also lead to a catastrophic situation. You have been accepted and had surgery after learning what to say E.G.:- Finch and Kane et al who after several years of living as a woman, found that it was not what they expected, so they go back to being male. This is no easy course, as the initial procedures are irreversible, so when you finally realise what you have done, is wrong for you, many then hit out and blame every one around them. I have on several occasions questioned if I had done the right thing in undergoing surgery. My answers have always been the same to myself that I have. I view this as a healthy approach to my situation. The true numbers of those who are in this position who do de-transition are not known. There are several who have written their stories, but most do not declare how they survive after this turn around. They will have to go back onto testosterone, have a double mastectomy and perhaps a phalloplasty. Not what they originally visualised.

Many of us do realise that we can never be fully female, or complete as we tend to call it. We cannot menstruate, become pregnant, give birth or suckle a baby, although many of us have those feeling and wish it were possible. Most do come to terms with this fact, but some really do think that after surgery this will all happen. I have been asked if it is possible to have all the above after surgery.

After my surgery in November 2001, I had a bad case of 'post op blues', which lasted for about two months. I managed to overcome this with the help of my daughters and lady

friends. One big help was the two hours I spent with my reverend from the Spiritualist Church, who after 45 minutes said that I was grieving. I thought she meant for my wife who had died in a car crash in 2000, but she said, "No, you are grieving for the male you have virtually killed off, in order to become Kathy"

### **XIII. Post-Transition Follow-up**

Long-term postoperative follow-up is encouraged in that it is one of the factors associated with a good psychosocial outcome. Follow-up is important to the patient's subsequent anatomic and medical health and to the surgeon's knowledge about the benefits and limitations of surgery.

Long-term follow-up with the surgeon is recommended in all patients to ensure an optimal surgical outcome. Surgeons who operate on patients who are coming from long distances should include personal follow-up in their care plan and attempt to ensure affordable, local, long-term aftercare in the patient's geographic region. Postoperative patients may also sometimes exclude themselves from follow-up with the physician prescribing hormones, not recognizing that these physicians are best able to prevent, diagnose and treat possible long term medical conditions that are unique to hormonally and surgically treated patients. Postoperative patients should undergo regular medical screening according to recommended guidelines for their age. The need for follow-up extends to the mental health professional, who having spent a longer period of time with the patient than any other professional, is in an excellent position to assist in any postoperative adjustment difficulties.

#### ***Above is an Extract from WPATH Sixth Version***

The above is sadly lacking in many instances. There is no medical response in an emergency that Trans people can call upon, where mental problems are the issue. We need emergency support, in order to stop a small problem, blowing out of all proportions, because there is no backup when needed.

I feel that this is very important after surgery, and especially in cases like mine, as above.

Many, who succeed to full transition, then go into "Stealth" as they do not want anyone to know of their previous background. By this, I mean living full time as a woman before surgery and of course after it. This can be a blessing or a vast problem waiting to arise, especially if they have constructed a whole new background history, in order to cover the fact they were male originally. If at some stage this new background is questioned and their former life comes out, then the damage done could be irreparable. This may lead to all the frustration and depression returning and leading to possible shame at the hands of others. People are so unkind when they find out your true story, because they feel they have been duped. The pressures that ensue are now multiplied, as it was bad enough thinking that this might happen, and now it has. The forces at work may lead this person to think suicide, as a preferable way to living with the problems that have now surfaced. They feel that they have lost the cover that they carefully built over time and have come to a possible outcome that they cannot face.

To add to the frustration and depression with the continual problems of assessment and costs, we are now faced with the laws that require us to be over 18, single (read divorce)

and have had surgery in order to amend our documentation. The problems that we face immediately are the facts that there are various ways of interpreting the ways we are required to alter in order to fulfil these requirements. Many documents can be amended before surgery, but there are catches to this too. In the case of Medicare and Private health they will offer you a new card in your new name, but the details on screen when scanned are those of your previous self. This will not be corrected until after surgery

If we are to retain the current criteria that exists, that being the requirement of the “Alteration or removal of a person’s reproductive organs” in order to qualify for amended documentation, they must have undergone sex affirmation surgery for the main documentation concerned, that being, birth certificate, passport, health insurance central records (Medicare) and for those born offshore, residency status, citizenship and passport. It becomes even worse as we delve deeper into what we can and cannot amend.

Many psychiatrists over time have learnt about GID/Transsexualism, much of it, we believe from us, as there appears to be little if any training in this subject. The problem that we now face, is the fact that many trusted psychiatrists are approaching retirement, as others in the fields of endocrinology and surgery. At present, there seems a definite lack of wanting to take over when they do retire, by people in these fields. It is to be hoped, that those who do take an interest in us, will do so not as an adjunct to their practice, but out of a sincere feeling, that we are an interesting challenge and the need for help and understanding is of paramount importance to us, if we are to feel that we are being helped in our journey, and are not there just as a cash cow.

Psychiatrists are the ones who we have to rely on to determine our future health and happiness. Perhaps this is why they have gained the name of “Gatekeeper” as they can either help us become our true self, or deny that to us.

They are required to determine not just our mental stability (as per the SOC), but to also determine how we approached the problem of GID/Transsexualism. The questions relate to whether we played with dolls and were more attracted to playing girlish games and being happier in the company of girls. From my point of view, I did not have this approach, as I was an only child, and the only girls I came into contact with, were my cousins and at school. Perhaps living during the Second World War blitz had some impression on this?

They were interested in if I sat to pee and did I spend time tucking? Yes I did, but the question that I have posed to several psychiatrists, including Professor Milton Diamond, is, if I never saw a naked female, why did tucking seem so natural as it conveyed to me, what should be between my legs, and not that horrible thing that existed. The immense stress this caused me to endure was terrifying, when I think back on it, as are some of the other outcomes.

The personal accounts of transsexual people and their clinicians further demonstrate that surgical considerations often represent, quite literally, a matter of life or death

Kotula D. (2002) In *The Phallus Palace*, W.E. Parker (consulting editor) Alyson Publications, Los Angeles

*Delays in the 'system', whether clinical or financial, cause a great deal of stress, While the inability to access timely treatment may also be a cause of suicidal feelings. As well as suicide, a number of other risks are identified:*

*Stress leads to a number of trans people to self-harm and even to attempt suicide.... These feelings may occur at any time, but they are often associated with the realisation that it is impossible to continue life in the pre-transition role. For some, the choice is stark: either the gender issue is addressed, or there is no future... Through frustration or anxiety, or both, some trans people self-harm by cutting their arms and legs and, occasionally, their offending sex characteristics, such as breasts (trans men) or the penis and scrotum (trans women). Alcohol and other substance misuse may also be a factor, especially where there is family breakdown and social isolation*

GIRES et al. (2008) Guidance for GPs, other clinicians and health professionals on the care of gender variant people; document issued by the Department of Health (UK)

As you can see, there are far worse things that can happen, that I did not encounter.

If we complete the assessment successfully, we are allowed to progress to the stage of hormones (Oestrogen) and drugs (Aldactone or Androcur) I have to add here that if placed on Androcur, you will be listed as a "Sexual Deviant" and that stays on your records. How will that be dealt with under the auspices of the E-Card?

As previously mentioned, I was glad that I went to an endocrinologist because of my prolactin problem. He recognised that we had to adopt a careful path, and this took over two years of careful balances between Oestrogen and Prolactin, before my balances were considered to be correct. In this time I had grown breasts and my body shape had altered, I was very emotional and wept easily at something I was reading, or watching.

The next step was to approach a surgeon who would perform sex affirmation surgery. To be allowed to have surgery, I had to have letters from the psychiatrist and endocrinologist before the surgeon would consider performing surgery on me. As I had a heart condition, I had to have a complete check up by my cardiologist a week before the operation to ascertain that I was fit to undergo surgery. The night before, I had an ECG to establish that I was still fit enough to go ahead.

Surgery of itself, is between 4.5 and 5.5 hours with anaesthetic being administered during this time. This causes a longer time for full recovery, as it takes time for these dosages to work out of the system. This is of course how each individual recovers. I was offered an epidural and 95% pain free, which was true. I only suffered some minor pain due to bruising and swelling, but a Panadol took care of that.

There can be complications after that may need further surgery to correct the problem, or as in my case, post op blues. Also you have the forthcoming use of the dilation kit, in order to open the neo vagina and keep it open to the depth that has been acquired. This can be uncomfortable, and can cause problems due to granulation and bleeding when dilating. There can be other problems, such as necrosis, when part of the penile inversion, or colon extension dies. Sometimes it has been known for the neo clitoris to

lose sensation and suffer necrosis and even for labia to die, or not take. Some, or all of this will mean further surgery.

After surgery, you now have to face, not just the task of recovery and feeling very weak and tired for many weeks, OK, I know that some sail through, but that is not the usual take on the situation. You now have to come to terms with the new body structure and the fact that you will sit and walk differently, as there no longer is that lump between your legs. Feminine hygiene is now a must and it is most important that you keep yourself clean and fresh. This will also add to your confidence knowing that you will present in a wholesome fashion. If you do not look after your hygiene, you run the risk of infection, and thrush is not a nice thing to have, and I am not talking about a bird!

After surgery, you now have to think about not just physical recovery, but the monetary one as well. If you are in private health cover, then this means that some or all of the cost of bed and theatre have been covered. You can now claim refunds from Medicare and private health. The bulk comes from Medicare, with the gap being made up by private health. You can also claim rebates against the cost of surgeon and anaesthetist. If you are not in Private health, you can still claim against Medicare for their refunds. If you are working, then you should be able to claim against your tax, anything over \$1500.00 dollars, at 20 cents in the dollar. Please check this with an accountant.

## LAW

The laws governing the Trans community are an absolute shambles. In order for us to understand them and how to go about using them in order to amend documentation, they need to be enacted at Federal level, so that we have consistency of word and law that is easily understood. Currently, Federal laws can be over ruled by State and Territory laws that need to be repealed, or at the very least, updated. We currently have to deal with 9 governments, plus government departments and agencies. Add to this the fact that they have a tendency to approach the same subject in very different ways.

South Australia requires you to apply to a magistrate in order to obtain a recognition certificate in order to be able to register the reassignment of sex and must wait one month before they can produce said recognition certificate to the registrar in order to amend their birth certificate.

### Interpretation

*Corresponding law* means—

- (a) a law of another State, or of a Territory, of the Commonwealth; or
  - (b) a law of another country,
- declared by the regulations to be a corresponding law;

*equivalent certificate* means a certificate under a corresponding law that corresponds to a recognition certificate under this Act;

## Recognition certificates

A recognition certificate is a certificate, issued under this Act, that identifies a person who has undergone a reassignment procedure as being of the sex to which the person has been reassigned

I take it that this means that an amended birth certificate can now be issued.

Western Australia you must apply to the Board in order to receive a recognition certificate. The person applying can appear at the hearing. In order to have a recognition certificate issued, then one or more of the following must apply.

- The reassignment procedure was carried out in the State
- The birth of the person to whom the application relates is registered in the State
- The person to whom the application relates is a resident of the State and has been so resident for not less than 12 months

## Effect of recognition certificate

- 1 A recognition certificate is conclusive evidence that the person to whom it refers--
  - Has undergone a reassignment procedure; and
  - Is of the sex stated in the certificate
- 2 An equivalent certificate issued under a corresponding law has the same effect as a recognition certificate under this Act

Does this mean that a gender recognition certificate from the UK is acceptable?

You can now apply for your birth certificate to be amended via the Registrar

We now have 2 different approaches to the same situation, and this can cause problems.

If we now go to Victoria and New South Wales, then we are confronted with yet another approach to the same situation. Both require you to have undergone sex affirmation surgery and be single (read divorced, as do the above 2 States).

(a) To have statutory declarations by 2 doctors, or by 2 medical practitioners registered under another State, verifying that the person the subject of the application has undergone a sex affirmation procedure

(b) such other documents and information as may be prescribed by the regulations..

- If born in either State, you can apply for alteration of the sex in the birth register
- If born outside of either State but resident for at least 12 months, you can apply for a Recognised Details Certificate (RDC) acknowledging their name and sex.

This can be extremely useful if born off shore, as you can use the RDC in order to amend documents in your country of birth, if offered.

Currently, the other States and Territories do not offer this facility, which is very frustrating.

As you can imagine, trying to work through and understand these legislations, is akin to walking in a mine field. There is so much difference between the 8 States and Territories that many just give up and settle for a name change and a change on the driver's licence.

Currently, we could move to any of these 4 States and reside there for the required period and then apply for a recognition certificate/RDC and be given one, if we meet the criteria. The only snag is, what is the reaction if we offer these certificates to the State or Territory where we reside, will they be accepted?

## MARRIAGE

All States and Territories require us to be single (Read Divorced) in order to amend our birth certificate. I cannot come to terms with this, when the Federal Government sent me this reply; plus answers from the passport office and centrelink on this subject.

Letter from the Federal A-G dated 19-01-2009

While the reforms do not expressly address the sex or gender diversity of specific individuals, they ensure that same-sex de facto couples and their families are recognised and have the same entitlements as opposite-sex de facto couples. A transgender individual who remains married after surgery will not be deemed to be no longer married as a result of the reforms. The effect of the reforms is that such an individual will receive the same treatment regardless of whether they are considered to be a member of a same-sex or opposite-sex couple. (My highlighting)

Letter from the Federal A-G dated 17-03-2009

In relation to your letter of 24 January 2009, I would like to clarify the Government's position. I can confirm that the Commonwealth Same-Sex discrimination law reforms will have no effect on the *Marriage Act 1961*. The Marriage Act provides that a marriage must be between a man and a woman. This is consistent with current Government policy and there are no plans to change the Marriage Act to allow for a marriage to be solemnized between same-sex couples.

Gender re-assignment surgery has never, of itself, changed the status of a marriage which was valid at the time of solemnization. It has always been the case that a validly solemnized marriage would continue, irrespective of whether one of the parties subsequently underwent gender re-assignment surgery. The same-sex reforms due to come into force on 1 July 2009 do not change that position.

Add this from the Passport Office, and you begin to understand how confusing we find the legislation

## **Exceptions - Full validity passport to be issued in new gender**

### **Married Applicants**

Applicants who claim that they are unable to obtain an amended cardinal document because they are married should provide the following documentation (note, this only applies to RBDM documents as DIAC will amend its records for married persons):

- A statement from the relevant RBDM/Gender Reassignment Board that they have met all requirements for their reassigned gender to be recognised, except that they are married **or** medical evidence as set down in the relevant state or territory Registry of Births, Deaths and Marriages;
- Evidence of living in the character of the other gender such as driver's licence, medicare card, centrelink card, rates notices (or other PIDS documents);
- Original birth certificate;
- RBDM name change certificate;
- Marriage certificate;
- Statutory declaration stating that marriage has not been annulled.

And this from Centrelink

Dear Ms Noble

I refer to your recent enquiry about Centrelink's policy in regard to the introduction of the Government's same-sex reforms.

From 1 July 2009, a couple who are legally married and not living separately and apart from one another on a permanent or indefinite basis, despite one of the members of the couple having undergone gender re-assignment surgery, can be assessed in the same way as any other legally married couple.

I hope that this answers your question. Please contact me if I can be of further assistance in this matter.

Yours Sincerely,

Manager  
Cleveland Customer Service Centre  
Ph 3383 0130

If the Federal Government state what is in the above letters and are responsible for the Marriage Act 1961, how can this be over ruled at State and Territory level? The spouse was the biggest loser, when we were deemed to be a same sex couple, as they had done nothing, other than stay with their partner. We fought this for over 2 years, before we arrived at the current situation.

If this is the Federal Government stance on remaining married after sex affirmation surgery, then why are we still required to divorce at State and Territory level, in order to

amend our birth certificate? Surely the one law, being the Marriage Act 1961 should be adhered to by the States and Territories, as it is a Federal Law. The attached gives some idea as to the situation in the EU.

Germany: Forced divorce of trans people declared unconstitutional

by Justus Einfeld

On 23 July 2008, the German Constitutional Court declared the provision in the German Transsexual Law (Transsexuellengesetz TSG) which requires forced divorce of transsexuals unconstitutional. The TSG requires that transsexuals who legally want to change their gender marker on their birth certificates have to be unmarried (though a registered partnership was no hindrance). This part of the law has just been declared unconstitutional and may not be used until the German government proposes a new solution. The German government has a deadline of 1 August 2009 to come up with a new law. Earlier the Constitutional Court declared that a retrieval of a legal change of names in the case of a marriage after the name change was also unconstitutional.

This is a major victory for the trans community in Germany and abroad – as well as for the broader LGBT community. After Austria in 2006, Germany is the second country without same-sex marriage that abolishes the forced divorce rule for transsexuals.

### CHANGE OF NAME

All States and Territories allow those born in, or resident in that State or Territory to do a change of name. The law has been tightened as per the attached.

Requirements have been tightened because of legislation amendments. So that if you were born in Australia or born overseas and Adopted in Australia, you must now apply to the State or Territory in which you were born or adopted to do a change of name. This also assists the Registry of Births, Deaths and Marriages where Trans people are concerned, as it is noted on the person's birth registration.

If born off shore, then you will need to apply to the State or Territory in which you are a resident in together with evidence of residency. Residency requirements do differ, so you will need to contact your State Registry to ascertain their specific requirements.

If a Queensland born/adopted person has legally changed their name interstate they may, if they wish, make application to the Registry Office in Brisbane and have the change of name noted on their birth registration.

The above has been verified by the Queensland Registry of Births, Deaths and Marriages

They will allow you to amend our driver's licence, but this would be dependent on the change of name. If born in NSW and have changed your name there, but now reside in

Queensland, you must apply for an amended driver's licence in Queensland, if you intend to drive there. Sort that out. It's even more confusing.

### BORN ON SHORE

For those born in Australia, they have to contend with differing laws within each State and Territory, and the requirements placed on them by each.

The three usual ones are

- Over 18
- Single (Read Divorced)
- Have undergone a sex affirmation procedure.

This means that anyone who dares to stay married after surgery cannot amend their birth certificate, so because of this, you could not amend your passport. However, this changed, thanks to Grace Abrams, after winning her appeal against the Passport office, so allowing those who stayed married after surgery, to be able to amend their passport on a case by case basis. Thank you Grace, this allowed us to have other items altered as well

### Administrative Appeals Tribunal

#### DECISION AND REASONS FOR DECISION [2007] AATA 1816

ADMINISTRATIVE APPEALS TRIBUNAL )  
No 2007/0955 GENERAL ADMINISTRATIVE DIVISION

Re

GRACE ABRAMS

You can of course change your name under the tightened rules, as well as your driver's licence, and many other of the myriad items that we have to amend (About 40 plus)

### BORN OFF SHORE

Those born off shore must change their name in the State or Territory in which they reside. Residency maybe required to be confirmed, as per the piece from Queensland RBDM.

This is very important that Residency be established, as you entered the country as a permanent resident as male, but are now female. To achieve this change of detail you have to contact the Department of Immigration and Citizenship, the Immigration FOI department in order to change your details of name, which will be back dated to the time of arrival in Australia as a permanent resident.

The following from the department is very useful.

## RESIDENCY

*In the interests of assisting Trans community members who wish to make applications the Department of Immigration and Citizenship has provided the following summary of documentary requirements for some specific applications.*

*To apply to have departmental records amended under Freedom of Information provisions a person must make an application Form 424C - Request for amendment or annotation to personal records under the Freedom of Information Act 1982. There is no application fee for this application. Please note: all cases are assessed on a case by case basis.*

- *Recognised Details Certificate, issued in Australia by Office of Births, Deaths and Marriages (RBDM) in States or Territories,  
OR*
- *Equivalent overseas document,  
OR*
- *Evidence such as surgeon's and/or psychiatrists statement*
- *Change of Name Certificate, if applicable, issued in Australia by RBDM (as no previous names are recorded on the RDC)*
- *Evidence of when and how you arrived, such as entry stamp in passport or details of ship or flight.*

*Australian temporary or permanent residents may be required to provide evidence of their status to State or Territory authorities in the form of a certificate of evidence of resident status. You must make this application on a Form 164 - Certificate of evidence of residence status (also known as a form 283) and pay a \$100.00 application fee. This certificate is not required for citizenship application purposes.*

*Note: the surgeon's statement would contain information such as confirmation that the person has undergone a full gender re-assignment procedure. The psychiatrist's statement would provide confirmation that the person is living as their chosen gender of identity, has undergone hormone treatment and shows no intention of reverting to their original gender*

## CITIZENSHIP

*It is desirable that the evidence of Australian citizenship reflects the person's new identity. Australian citizens applying for new evidence of citizenship should apply on Form 119 – Application for evidence of Australian citizenship and pay \$55.00 application fee. The following documentation should be provided in addition to those that are required for all applications:*

- *Recognised Details Certificate, issued in Australia by Office of Births, Deaths and Marriages (RBDM) in States or Territories,  
OR*
- *Equivalent overseas document,  
OR*

- *Evidence such as surgeon's and/or psychiatrists letters*
- *Original citizenship certificate (which is to be cancelled and retained by the department)*
- *Change of Name Certificate, if applicable, issued in Australia by RBDM (as no previous names are recorded on the RDC)*

*Note: the surgeon's statement would contain information such as confirmation that the person has undergone a full gender re-assignment procedure. The psychiatrist's statement would provide confirmation that the person is living as their chosen gender of identity, has undergone hormone treatment and shows no intention of reverting to their original gender*

*So this equates to non-surgery*

*Neither Residency or Citizenship show sex on the documents.*

## PASSPORTS

### **Travelling for the purpose of gender reassignment**

People travelling overseas for the specific purpose of gender reassignment surgery may be issued with:

- a full validity passport which indicates their gender at birth as recorded on their birth certificate or citizenship record (as confirmed by DIAC), or
- a limited validity passport (LVP) in their intended gender with sufficient validity to meet return travel needs up to a maximum validity of 12 months, whichever is the lesser, or
- a Document of Identity, with a maximum validity of 12 months and the gender field left blank.

### **Limited Validity Passport (LVP)**

Applicants issued with a LVP in the intended gender are required to:

- Provide appropriate medical evidence from a registered medical practitioner, including that gender affirmation surgery is scheduled to take place.

Sign a statement acknowledging that difficulties crossing international borders may still be encountered due to the fact that the gender in the passport does not match the physical gender of the client, and that the passport has been issued in the intended gender at the client's request

Note - The LVP may be replaced gratis with a passport valid for the remainder of the 10 year period in reassigned gender only when the applicant submits a cardinal document reflecting the changed sex, evidence of a change of name registered with RBDM as well as other usual passport requirements

### **Document of Identity**

Applicants issued with a Document of Identity in these circumstances should be advised in writing that:

- Australian Documents of Identity are widely, although not universally, recognised as a valid travel document and the applicant should check with the relevant country's diplomatic representative, prior to their departure from Australia, as to whether a Document of Identity will be accepted for entry to and exit from that country.

Note - For LVPs and DOIs, the applicant must acknowledge the following in writing

- Their receipt of the letter from DFAT; and
- Their agreement to the issue of a Document of Identity.

### **Change of Name**

All applicants who have undergone gender reassignment and wish their passport to include a new name must provide the normal RBDM change of name/revised birth certificate to support the change of name. Applicants travelling for the purpose of gender reassignment surgery and who request a different name on the travel document must provide the normal RBDM name change documentation to support the change of name, before it can be included in a travel document.

### **Full validity passports issued in new gender**

Applicants must provide

- For applicants born in Australia – a birth certificate from their state/territory RBDM showing the gender of reassignment;
- For applicants born overseas – a revised citizenship certificate to reflect their new identity, or given current citizenship certificates no longer record a person's gender, formal evidence from DIAC that it has accepted the reassigned gender and amended its citizenship records to reflect the new gender.

### **Exceptions - Full validity passport to be issued in new gender**

#### Married Applicants

Applicants who claim that they are unable to obtain an amended cardinal document because they are married should provide the following documentation (note, this only applies to RBDM documents as DIAC will amend its records for married persons):

- A statement from the relevant RBDM/Gender Reassignment Board that they have met all requirements for their reassigned gender to be recognised, except that they are married *or* medical evidence as set down in the relevant state or territory Registry of Births, Deaths and Marriages;
- Evidence of living in the character of the other gender such as driver's licence, medicare card, centrelink card, rates notices (or other PIDS documents);
- Original birth certificate;
- RBDM name change certificate;
- Marriage certificate;
- Statutory declaration stating that marriage has not been annulled.

Applicants who have not completed gender reassignment

Applications will be considered on a case by case basis by the APO where an applicant claims they are unable to obtain an cardinal document in their preferred gender because they are unable to complete gender reassignment surgery due to a pre-existing medical condition or because the surgery in the applicant's case carries a higher than normal risk, with the result that completion of the surgery in the

applicant's case is considered by a relevant medical practitioner to be dangerous or life threatening. The following documentation should accompany the application:

1. Documentary evidence that the applicant has approached the relevant body in their State or Territory seeking recognition of their change of gender, and the body's written advice as to why it has declined to recognise a change in gender.
2. A statement from the client's medical practitioner providing the following information:
  - confirmation that hormone therapy treatment has been on-going for at least two years.
  - evidence of any initial surgery completed (e.g. mastectomy)
  - details of the pre-existing health condition and advice why surgery carries a higher than normal risk
  - confirmation that completion of sexual reassignment surgery would be dangerous or life-threatening for the particular applicant.
3. Documentary evidence from the client confirming that they live in the community in their reassigned gender, e.g. driving licence, Medicare card, credit card.

#### Other

Other cases will be considered on a case by case basis by the APO. (Note - This exception policy would generally be used for children who are indeterminate sex and unable to undergo surgery due to their age).

Applicants who claim that they are unable to meet requirements because of unique circumstances, including a failure to meet the requirements of the relevant state or territory legislation or by DIAC, should provide the following supporting documentation,

- Statement (B11) of reason why the applicant cannot meet requirements;
- Medical practitioner's statement, where relevant, providing reasons for the applicant's inability to undergo gender reassignment;
- Evidence of living in the character of the other gender such as driver's licence, medicare card, centrelink card, rates notices (or other PIDS documents);
- Original birth certificate;
- Name change certificate;
- Passport Office Manager's recommendation.

#### HEALTH INSURANCE COMMISSION (HIC)

HIC central records, is applicable to all who are either born on or off shore. You must notify them after surgery, so that their central records are amended to show, not just your new name, but new sex. You have been given a new Medicare card and private health care card, if in it, but the details when scanned are those of your old self. After central records have been amended, then your new details show when scanned.

Add to this, the plethora of other documents to be amended, and the fun really begins.

We now have to be aware of those that can be changed before surgery, and those that can only be changed after surgery. The main ones are those after surgery and are as follows.

- Residency ? Non-Surgery
- Citizenship? Non-Surgery

- Passport
- Health Insurance Commission central records
- Birth Certificate

Complicated, you had better believe it. They call us complex, but in truth it is the system.

## Summary

We have discussed the personal, social and medical challenges that face transsexuals. If government at all levels is to provide proper help for these, their own citizens, why is there not far more improved cooperation between the Federal and State departments?

We have come to expect inconsistency when dealing with Governments at all nine levels within Australia. What is upsetting is that we are having different interpretations from within the same department. DIAC has given me interpretations that are totally different to my friends when applying for the same documentation to be amended. I was given to understand that because of the current situation in regard to terrorism it was imperative to receive an amended Certificate of Residency status (CERS). However that does not appear to be the case from the wording of the letter to my friend, but does state: If you have not made a valid application and if you are still in Australia after that date (word/ no date) you will *become an unlawful non-citizen on date* (again word but no date). It appears that our fears of inconsistency concerning this matter are well founded.

I would like to again state that we need to follow what the UK ID Card department is doing. They are setting up a series of ways that Trans people can access what details are required, and this will be in the following formats ,Quote "We will produce a specific guidance booklet that address the needs of the trans community when filling in the application form. It will be important that Trans applicants refer to these notes when filling in their identity card application forms. We will make this booklet available online as well as making them available on request by telephone and distributing them amongst Trans community groups."

It now appears to us that the oft quoted word *complex* appears to be a cop out by all Governments in Australia. I would contend that we are made to appear *complex* because Governments refuse to listen to us and our needs when it comes to amending documentation. If we were to be consulted when laws and wording are being considered that affect us, it would be only an act of courtesy to request not just our requirements, but that we are invited to take part in these consultation.

On the 17 March 2009 the Australian Human Rights Report into Trans issues was released. We sincerely hope that within the 'Documentation section' that these problems have been, or are being addressed.

After all of this, is it any wonder that most are so confused, that they are totally unaware if they are legally recognised, or not.

Some States and Territories offer recognition certificates, or Recognised Details Certificates, whilst others offer nothing. Add to this that those certificates may or may not be recognised in other States and territories, and most will not accept certificates from abroad. Again this is muddled, because some federal government offices will accept certificates from abroad.

Too often we are told we are “Too Complex”. Sorry, but it is not us, but the myriad of systems that we are required to deal with. They are so complex and convoluted, that I challenge any lawyer to understand what we have to come to terms with, if we wish to amend documentation. We are not trained in the legal system, but some now must come to terms with these myriad requirements thrust upon us, by many people who really do not understand, that by doing so, they are condemning those who are unable to cope, to be never fully legally recognised in their new sex. Because of the frustration and stress this may even commit them on the path of suicidality, as it is all too much to contemplate. These laws need to be enacted at Commonwealth level, with the States and Territories acting as their agents. This, hopefully would lead to Nation wide laws, not the jumble that we now face, because of 9 Governments all enacting laws that do not gel with each other.

The general public think we are Gay, but that could not be further from the truth. We maybe Gay, but sexuality does not come into our equation. We are gender orientated, and only look at our sexuality after surgery. We may then become one of five options. Heterosexual, Gay, Lesbian, Bi-sexual or even A-sexual.

I am more concerned with the fact that the Gay, Lesbian and Bi-sexual community do not have to suffer the requirements that we in the Trans community have to. That being that they do not have to change or amend every piece of documentation, or declare themselves, as we do.

We on the other hand are branded from day one. We are expected to ‘live in role’ and endure the ‘real life experience’ as part of our assessment and acceptance as a Transsexual person, in order that we can prove that we can cope with our new life. Analogy; Take a 6 foot, broad shouldered male, with a heavy five o’clock shadow and put him in a dress and heels and watch what ensues. This is what we are expected to do. Is it any wonder that we are abused, bashed or raped.

I can only hope that the future will be more kindly and understanding of the whole Trans community, and that those coming through will enjoy more understanding and peace, than is currently the situation.

Yours Sincerely, Kathy Anne Noble.  
President, Changeling Aspects  
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