

**'Socializing Transgender'**

**Social Care and Transgender People in Scotland**

**A Review of Statutory and Voluntary Services and  
Other Transgender Experiences of Social Care Support**

**A Report to the Scottish Government**

**Based on a Thesis Submitted for the Degree of Doctor of Philosophy**

**to the**

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## **Executive Summary**

Support for transgender people has mainly focused on medical treatment, usually through assistance during the gender reassignment process. A paucity of knowledge of social care services to transgender people in Scotland led to this research, which was commissioned by the Scottish Government under an ESRC 1 + 3 research award. Three questions underpinned the online surveys and interviews, firstly exploring assistance relating to transgender identity and status, secondly considering additional support to transgender people within their relationships and their communities, and thirdly looking at the nature of dedicated and generic services in Scotland.

### **Key Findings**

- Dedicated social care provision was found to be often limited to adults during transition to a binary gender role (with limited policy and staff guidance, funding and training opportunities). Support to non-binary transgender adults, ethnic minority groups, transgender children and young people, and family members including partners and parents, was limited.
- A range of sources of assistance, including transgender support groups, gender specialists, GPs, counsellors/psychiatrists and social care staff, were found to provide varying levels of support to transgender people with gender identity and transition issues, family support, documentation, transgender linked mental health problems and long-term health issues.
- Approximately half of transgender respondents indicated that social work advice and support would be valued for each of the above concerns, and that additional support would also be valued regarding making plans for the future, conflicts with family, friends, colleagues or neighbours, social isolation, social rejection, and with developing a more confident community presence.
- There is limited planning, guidance, training and policy development to facilitate access to generic services by transgender people.

### **Implications for Policy and Practice**

#### **Dedicated and Generic Social Care Provision**

- The development of formal and informal liaison between statutory and voluntary organisations is likely to be beneficial at both national and local levels to improve existing services, to clarify levels of additional need for transgender people and their families,

nationally and locally, and to develop new networks and services to meet these needs, bearing in mind that many voluntary organisations appear under-funded or non-funded.

- Most voluntary sector staff/volunteers appear to have had little or no training. Joint training with statutory sector staff might serve to develop and improve joint working relationships. Gaps in policy statements and staff guidelines which might ensure greater consistency of support locally and nationally were also highlighted.
- Where levels of local transgender support need may be small, statutory and voluntary organisations from nearby council areas of Scotland may be better able to plan for and provide dedicated/specialist services by pooling resources.
- Limited dedicated G.I.C. support to transgender children and young people, and their parents and families in Scotland, suggests that a Scottish source of advice and assistance, including consideration of predictors and outcomes, and of appropriate hormonal and surgical interventions would be a valuable additional national resource.
- With an ageing population, the specific needs of older transgender people are likely to become more apparent: the vulnerability of transgender people in old age may perhaps be exacerbated by the additional burden of stigma-related isolation, as well as by generic issues associated with old age, such as illness, disability and dementia.
- Planners, managers and social care workers need training to better understand the complex nature of transgender, if needs-appropriate generic support services are to be made welcoming to transgender people. A greater awareness is needed of the different barriers which might affect transgender access across the range of generic social care services.
- Service providers need to be made more aware of equalities guidance and the potential indicators and consequences of binary-gender based prejudice and of implicit and explicit transphobia by both staff and by other service users. In addition, implications for the legal status and the confidentiality of transgender people need to be respected, in line with current legislation including the Gender Recognition Act and Equal Treatment Directive (UK Government, 2004).

### **Transgender Identity and Status**

- There is a need for social care support with gender and transgender identity issues prior to, during, and following transition, which may also include understanding of sexuality. This may perhaps be achieved through an individually assigned care worker within a G.I.C. team.
- Targeted social care support may need to reflect differing underlying associations between biological sex, age, transition status and mental health for MtF and FtM individuals, as well

as perceived differences in the value of support from G.I.C. specialists, transgender groups, GPs, counsellors and psychiatrists, and family and friends, by MtF and FtM people.

- A significant number of respondents identified with non-binary transgender identities, indicating a need to acknowledge such a choice of categories within transition support, and within the G.R.C. application, by the inclusion of a legal category of transgender.
- Putting together a 'how to change documentation' pack, together with a 'how to apply for a gender recognition certificate' pack might be most appropriately undertaken within the network of support groups, perhaps under the auspices of the Scottish Transgender Alliance.

### **Relationships and Communities**

- Pro-active support to families of transgender people needs to be systematically provided, to enable the development of a positive dynamic, sustaining the family and the transgender individual, prior to, during and following transition, not least because the degree and quality of family support appears to be a significant factor in prognoses for MtF and FtM individuals.
- Focussed social care support may enable transgender individuals to maintain a community presence through work and leisure activities prior to, during and following transition, through the input of 'allies', and, where funds allow, through Self-Directed Support, to reduce the risk of social isolation and consequent mental health difficulties.
- Goal directed social care support might also address cultural competence and empowerment, for example in promoting a better understanding of the language and social skills which underpin same-sex friendships for women and men, and those which affect relationships between women and men.
- Social care support may also be needed to assist a transgender person in evolving strategies to deal with name errors, improper pronouns, distancing, overt prejudice, harassment and transphobia from relatives, friends, colleagues, neighbours, acquaintances etc.

### **Summary Statement**

It is proposed that there is a need for a re-balancing of the historical systematic 'medicalization' of transgender by a process of 'socializing transgender', through advocacy work seeking greater understanding and acceptance of transgender people, through the adoption of a transgender legal status in Scotland, and through the provision of a range of additional, focused, social care support to transgender people, prior to and during the major life changes of transition, and beyond.



## Glossary of Terms Used in the Report

These necessarily simplified working definitions are based on reference to a range of texts.

**Bi-gender, a-gender, poly-gender, fuzzy gender, androgyne, gender queer, gender outlaw etc.:** Terms used to describe a wide range of people whose self-perception of their gender identity does not conform to the binary gender norm and who may adjust their gendered behaviour accordingly.

**Biological Sex:** The state of biological variables that can be described as either male-typical, female-typical or intersex, (e.g. genes, chromosomes, gonads, internal and external genital structures, hormonal profiles).

**Cross-dresser:** A person who dresses in the clothing of the opposite gender often for pleasure, but who may also cross dress to entertain others, but usually without the intention of permanent migration to that role.

**Gender:** The state of being male, female or transgender either self-perceived or perceived by others.

**Gender Dysphoria:** A condition where there is a marked difference between a person's expressed and/or experienced gender, and the gender others would assign to them, continuing for at least six months, causing clinically significant distress, and/or impairment in social, occupational or other important aspects of life.

**Gender Identity:** The sense or self-perception of belonging to either of the binary male or female gender categories, or to a transgender category.

**Gender Reassignment/Confirmation:** The transition process by which a transsexual person confirms their internal sense of gender identity, through the external reassignment of bodily characteristics and gender role, often with the assistance of hormonal and/or surgical intervention.

**Gender Role:** A short hand term for a blend of forms of self-expression (e.g. mannerisms, styles of dress, activities) that usually convey to oneself and others one's membership of a binary gender or transgender category. Such a multiplicity of forms of expression may fall within a wide range of binary masculine or feminine stereotypical behaviours within society, but, within a transgender role, may be combined in unusual, or non-standard ways.

**Intersex:** A person whose development and differentiation of sex characteristics *in utero* is atypical, and who was born, for example, with a blend of both male and female internal and/or external genitalia.

**Migrator:** A sub-division of transgender: a person, more commonly known as transsexual, who seeks to live permanently in the opposite binary gender role to that in which they were initially raised.

**Oscillator:** A sub-division of transgender: a person who undertakes cross-dressing but for whom this always implies the intention to return to their original gender.

**Real-life Test/Experience:** A required period (usually one year) during which a transsexual lives full-time in their preferred gender role usually prior to an application for gender reassignment surgery.

**Sexuality:** A person's sexual orientation or preference.

**Social Care:** The provision of paid or voluntary support necessary for the advocacy, welfare, maintenance and protection of someone, by a family member, friend, neighbour or colleague or by a group, or organisation within the community, informally, or linked with a formally assessed need.

**Transcender:** A sub-division of transgender: a person who seeks to move beyond binary gender categories.

**Transgender:** A person whose self-identity does not correspond to the gender linked with their biological sex and/or their initial gender role or who does not conform unambiguously to conventional notions of male or female binary gender categories.

**Transphobia:** Dislike of, or prejudice against transgender or transsexual people, which may be expressed through often subtle forms of discrimination or through more overt acts of rejection including verbal and physical abuse.

**Transsexual:** A transgender person who wishes to or who seeks to resolve their gender dysphoria through gender reassignment/confirmation, in order to live permanently in the opposite binary gender role.

**Transvestite:** See 'cross-dresser' which is increasingly preferred as a descriptive for those who undertake oscillating gender behaviours.

**Trans-man, Trans-male, Transgender male/man, Transsexual male/man, FtM etc.:** Terms used to describe a transsexual person who is migrating or has migrated from their original female gender to live permanently in a male gender role.

**Trans-woman, Trans-female, Transgender female/woman, Transsexual female/woman, MtF etc.:** Terms used to describe a transsexual person who is migrating or has migrated from their original male gender to live permanently in a female gender role.

## Introduction

The notion of gender (*the state of being male or female, either self-perceived or perceived by others*) underpins the umbrella term 'transgender', which is itself sometimes used interchangeably with the term 'transsexual', an identifier for a group of people who form only a proportion of the transgender population. Because the term 'transsexual' might be linked by many with notions of 'sex change' and contains the suffix 'sexual', it is also important to distinguish gender from sex (*the state of biological variables that can be described as either male-typical or female-typical*), and sexuality (a *person's sexual orientation or preference*).

The overall aim of the research was to address the paucity of knowledge of social care service provision to transgender people in Scotland, and to explore the types of services that are available, that are needed and that might be developed to good effect in the future. There were three main objectives addressing different aspects of the overall aim of the research, to firstly explore existing dedicated and generic social care services, secondly social care issues relating to gender identity and gender status, and thirdly social care issues relating to family and friends, work and the wider community. These three objectives are integrated within the three research questions:

### Research Question One

What types of dedicated/specialist and generic social care services are/might be requested, made available to, or received by transgender people in Scotland, through which statutory and voluntary commissioning and provider organizations, transgender networks, and/or individuals seek to meet the assessed and/or perceived needs of transgender people?

### Research Question Two

To what extent do/might social care services from the statutory and voluntary sectors assist transgender people in understanding and resolving issues of gender identity and gender status as individuals with binary, transgender, complex or ambiguous gender identities?

### Research Question Three

To what extent do/might social care services from the statutory and voluntary sectors assist transgender people with resolving difficulties within their relationships with family and friends, at work and within their wider communities?

## The Transgender Surveys

A study was undertaken with a transgender support group based in the N.E. of England to pilot the questionnaire and to consider the potential value of focus groups within the forthcoming research

methodology. Two main methods were subsequently used in the main research with respondents living in Scotland: online surveys and online interviews. Three online surveys were undertaken, two with transgender people, and one with service providers/commissioners, offering the opportunity to collate both descriptive and analytical data from service users and service providers. Additional asynchronous, semi-structured online interviews were undertaken, to supplement the survey data, with ten transgender people and nine service providers/commissioners.

In order to reach as many transgender people as possible, it was necessary to target them directly, and to do this the support of the Scottish Transgender Alliance (S.T.A.) was sought, a voluntary organisation based in Edinburgh but with nationwide connections to individuals and transgender groups in Scotland, to circulate information about the research, and to circulate the web addresses of the two questionnaires for transgender people.

Forty seven questionnaire responses were received for the first survey of transgender people (survey one) together with twenty nine questionnaire responses to the second survey of transgender people (survey two). Ten transgender people took part in online interviews by self-selecting to be interviewed at the end of the first survey.

### **Transgender Survey Attribute Data**

Attribute data for the respondents to surveys one and two indicate a wide span of ages, home circumstances, employment status, gender identities and gender descriptors, suggesting a broad range of participants. However, no transgender participants aged under 16 (an age group which consists of 17% of the Scottish population) and very few transgender people aged 66 or over, took part in this research. Their participation would have provided valuable insights and knowledge into the experiences of two age groups at different polarities in their transgender experience. Every one of the forty seven people who took part in survey one was of white origin, suggesting that transgender people from other ethnic groups may not, or may be unable to, access mainstream 'white' services.

47% of participants of survey one, and 38% of participants of survey two were living alone, compared to 34% of households across Scotland which contain only one person (the percentage of adults living alone across Scotland will therefore be rather less than 34%).

Biological males outnumbered biological females in the age groups 46 to 55 (by 9:1) 56 to 65 (by 6:0) and 66 and over (by 6:1). Biological females outnumbered biological males in the age group 16 to 25 (by 6:1) (survey one). Similar ratios were found within survey two. Participants currently in a male

role outnumbered those in a female role, within the age groups 16 to 25 (by 5:2) and 26 to 35 (by 4:2). As might perhaps therefore be anticipated, participants in a female role outnumbered those in a male role within the age groups 36 to 45 (by 4:2) and 46 to 55 (by 9:2). Similar differences in the age groups of transgender participants in male or female current roles, were also found in a cross tabulation of current gender role and age groups for survey two.

53% (twenty five) of the forty seven respondents to survey one had a degree or postgraduate qualification. The percentage of biological males (who were more likely to be living in a female role) with a degree, postgraduate or professional qualification was 36%, and of biological females (who were more likely to be living in a male role) was 22%. There is little difference between the percentages of men and women (27%) with these qualifications nationally.

Employment is also relevant within this section, for the sense of status it brings: twenty three (43%) of the forty seven participants to survey one were employed or self-employed consisting of fourteen (54%) biological males and five (34%) biological females. These figures are somewhat less than the national percentages of 58% of men and 49% of women, though figures for unemployment (five: 9%) are fairly comparable with the national average of 7%.

24% (thirteen) of forty seven participants in survey one described themselves as long-term sick or disabled compared to a national average of 5% who are 'permanently sick or disabled'. Almost a third (seven) of the twenty three people living alone, and over a third (eleven) of the thirty one in the age groups 36 to 45, 46 to 55 and 56 to 65, described themselves as long-term sick or disabled, as did 20% of biological males and 27% of biological females.

### **The Service Provider Survey**

The survey of service providers was circulated to each member of the Association of Directors of Social Work (A.D.S.W.) Contracts Officers group which has members located in or liaising with every local authority in Scotland. The members of this group are also responsible for liaising with private and voluntary providers of social care support in their local Region of Scotland.

The twelve public sector questionnaire respondents and eight interviewees came from organisations based in twelve of the thirty two unitary authorities across Scotland. Although mainly focussed around the more densely populated central belt, and in particular within Edinburgh and Glasgow, which together account for just over a fifth of the population of Scotland, representation was also included from the north-east, west, south-west and south-east of Scotland.

The eight voluntary sector questionnaire respondents came from approximately a third (eight of twenty six) of the organisations on the S.T.A. circulation list. These were also based in a range of regions across Scotland, but were mainly focussed around the more densely populated central belt.

### **Data Analysis**

Data analysis of the survey and interview research findings was influenced by grounded theory, in the identification of sub-themes and themes and in hypothesising and theorising, prior to, concurrent with and following the main research process. In addition to the main questionnaire data from the transgender surveys, five sets of two way cross tabulations were systematically undertaken across all survey responses, by age, biological sex, gender identity, current gender role and home circumstances, together with additional three way cross tabulations, for both surveys one and two. Juxtaposition and alignment of data from each of the surveys with extracts from the interview responses was also an essential part of the data analysis process and the synthesis of the data.

The findings from the research were summarised and considered in the light of other academic publications on the subjects covered, within a thesis which was duly submitted to the University of Edinburgh, assessed by Viva, leading to the award of PhD in July 2015. Names of participants in the research have been changed within both the original thesis and within this report. The gender of their name at the time of the survey has been reflected in the substitution of a similarly gendered name.

## **Transgender and Social Care**

### **Statutory and Voluntary Sector Social Care Provision**

#### **Background Information**

Mitchell and Howarth found 'no large scale surveys or research that focused specifically on the ... social care needs of the trans population' (2009: 62). However some knowledge of social care to transgender people has been evidenced, mainly within wider LGBT studies. For example, Lienert et al in a scoping report on end-of-life care for elderly gay, lesbian, bisexual and transgender people noted a 'pattern of modifying behaviour due to fear of discrimination or prejudice (which) "would seem to be well grounded" given the evidence of actual experiences of discrimination and violence against GLBT (sic) people in many health and aged care settings' (2010: 8).

Cartwright et al report separately on Lienert et al's thought-provoking survey outcomes, noting that 'respondents identified in this study as being at particular risk in relation to receiving adequate care and treatment at the end of life included those who: were not open about their sexuality to any significant others; nominated a gender other than female or male; were in a relationship other than single or partnered; were grieving the loss of a partner; had less than Year 10 education; had incomes of less than \$20K per annum; or were in poor or fair health. People in such socio-demographic groups may require more support than others to talk about, and plan for, their end-of-life care' (2010: xvii).

Addis et al in the most extensive meta-analysis of one hundred and eighty seven papers or chapters on the health, social care and housing needs of older lesbian, gay, bisexual and transgender adults, found that 'the main themes that emerge from the review were isolation (and that) the health, social care and housing needs of LGBT older people is (sic) influenced by a number of forms of discrimination which may impact upon ... provision and access' (2009: 647).

#### **Summary of Key Research Findings**

##### **Dedicated Service Provision**

Two of the key research findings relating to dedicated/specialist services concerned the limited provision or commissioning of such services by statutory organisations, and their limited awareness of local voluntary sector transgender service provision. Linked with this, and perhaps underpinning the low provision/commissioning rates, was a limited statutory awareness of additional local

transgender service need. Voluntary sector funding varied from self-funded/local authority/lottery funding to none at all.

Compensation for limited statutory sector services came from rather more extensive voluntary sector social care provision, which was apparent mainly through group meetings and social/online support, although work on transgender rights and equality were also evidenced. In addition, talks to other agencies, online leaflets, websites, etc. were used for advocacy by some transgender groups.

However, not all transgender people have access to local support groups because of their limited availability. This was highlighted by half of the voluntary sector respondents and three of the statutory sector respondents. For those who are able to attend such groups, it seems that other transgender people may become close confidantes and, within such a relationship, the expression of need is likely to remain informal and largely based on trust: two transgender respondents said that they also offered individual support to those less experienced than themselves, both within and outwith transgender support groups.

Most local support, even from within the voluntary sector sample, was provided to transgender adults; there was only a little evidence of transgender children/young people receiving support. Family members, including partners/children of transgender adults and parents of transgender children/young people also appeared to receive limited local support. In addition to these gaps in the service, telephone support was identified as a necessary additional service, perhaps reinforcing the importance of anonymity: a person seeking initial advice and support about the possibility of being part of a marginalized, abused and stigmatized group, might prefer the lack of personal identification that telephone contact offers, whilst still seeking levels of individualized, personal empathy that online forums may struggle to emulate.

### **Generic Service Provision**

The apparent inadequacy of equality impact assessments to reflect service provider awareness or planning for the needs of transgender people suggests that many generic services are ill prepared to meet their needs, despite evidence of some initiatives to improve awareness: one example of good initiative indicated an increased awareness of transgender need when training was targeted at staff working at 'points of access'.

There also appeared to be very limited awareness of current transgender usage of generic services. Bauer et al suggest, in recognising that 'trans people represent one of the most marginalised groups in our society' that 'care providers lack of preparation for working with trans patients (sic) stems in



part from inaccurate current estimates of the size of trans populations'. The absence of knowledge about transgender populations and transgender need evidenced by Scottish local authorities within the current research appears to fall into what Bauer et al call 'informational erasure' which 'encompasses both a lack of knowledge regarding trans people and trans issues and the assumption that such knowledge does not exist' (2009: 349, 352, 354).

In relation to the current research it is important to recognise the honesty with which some statutory representatives admitted such a lack of knowledge and the constructive suggestions which were made to try to address both gaps in knowledge and gaps in services (for example the notion of smaller local authorities working together to meet the needs of local transgender people). The appendix to this report indicates estimates of the numbers of transsexual individuals who might be present in each Scottish Council Area, and these figures support the notion of local councils and voluntary services co-working to provide dedicated services and, as appropriate, to better develop guidance and policies on transgender accessibility to generic services.

### **Staffing and Training**

There were very few dedicated/specialist staff employed to meet transgender service needs within either the statutory or voluntary sector samples and the voluntary sector services sample in particular appeared largely reliant on transgender volunteers.

Limited transgender-specific training opportunities were available to staff/volunteers in both the voluntary and statutory sector samples, which may perhaps be linked with transgender workers' largely voluntary status, and with low levels of specialist transgender services within the statutory sector. However two voluntary sector staff were very experienced, with access to transgender literature, training opportunities, conference attendance etc.

Greater awareness of transgender need by the voluntary sector was suggested by their plans to meet transgender-specific training needs in the future, to a greater degree than statutory sector respondents. However there were some training initiatives for transgender issues that were also apparent within the statutory sector sample.

### **Policy Statements and Staff Guidelines**

There was limited evidence of transgender guidelines/guidance to staff and/or transgender policy documents for dedicated/specialist and/or generic services, within both the statutory and voluntary sector samples.

It seems that most equality policies are generic and generalized, although a small number of examples were found of individuals who were working within statutory agencies seeking to ensure the wellbeing of transgender people accessing generic services.

The notion of life history was raised by one interviewee who, after indicating concern about ‘a lack of understanding by practitioners re. the fluid nature of gender, and a rigidity about biological sex – i.e. you are either a man or a woman’, explained that, in relation to protecting other clients of domestic abuse/sexual violence services, ‘some service providers may feel that whilst a transgender woman presents physically as a woman, their core values are related to their biological sex and gendered early years.’ She went on to explore how ‘traditional service models in this field would be promoted as "women only services", designed and delivered by women for women, based on an understanding of women’s status in relation to men, and (are) often based on a patriarchal view of the world ... transgender women may feel that they are not able to access (services), if key messages relate to the differences between men and women and refer to the socialisation of men/boys, notions of masculinity, femininity, (etc.) which may portray an inability for anyone born and raised as a man, to then be able to avoid implicit male attitudes, views etc.’

It seems that the power of the binary may hinder some transgender people’s access to generic services or their ability to fully partake in gendered activities within such services. However, Tolley and Ranzijn in a ‘study of heteronormativity amongst staff of residential aged care facilities’ found that ‘increased exposure to gay and lesbian people was directly related to ... (increased knowledge) and also to reduced heterosexism’ (2006: 83). It is likely that a similar reduction in transphobia might be found as carers’ knowledge of transgender identities increases through targeted training and experience.

### **Service Development/Potential Additional Support: Transgender and Social Care**

Bauer et al suggest that ‘the perception that trans-people are rare reinforces an erasure of trans communities and the continuing treatment of trans people as isolated cases (leading to their) cumulative invisibility’ (2009: 354). Recognising that creative cross-service provision can make a real difference to the lives of even small numbers of transgender people in a local area might significantly counter-balance the effects of such erasure. But other opportunities may exist for transgender people to seek empathetic, personalised social care services, for example through self-directed support, which, whilst not directly referred to within either the comments of service providers or transgender people, is an established and potentially valuable alternative to mainstream social care

in Scotland, though, if funding is available, this can only be provided through a statutory authority after initial, detailed financial and needs assessments.

The range of support which may be purchased includes care options to enable a client to continue to live in their own home, 'such as help with having a bath or getting washed and dressed', but it may also be used to assist individuals to take part in activities elsewhere, for example, 'out of the home it could support you to college, to continue in employment or take a job, or to enjoy leisure pursuits more ... you might arrange for a personal assistant ... to help you attend local classes, go swimming, or be a volunteer helping others. It could also be used to provide a short break (respite)' (SDS Scotland, 2013). It is not difficult to envisage the potential for a very wide range of personalised assistance for a socially isolated transgender individual.

A further advantage of the SDS Scotland scheme (2013) is that the client can opt to set up a contract for support for themselves, rather than leaving this to the funding body, thereby enabling potentially much greater control over both the care and support that they receive, and the way that they arrange with support staff to provide this care and support. Such a self-controlled support scheme may enable transgender people to employ carers who are sympathetic to the anomalies and nuances of gender which transgender status highlights.

The development of formal and informal liaison between statutory and voluntary organisations is likely to be beneficial at both national and local levels to improve existing services, to clarify levels of need for transgender people and their families, nationally and locally, and to develop new networks and services to meet these needs. Such liaison needs to take into account that at least some voluntary organisations appear to be underfunded or not funded at all, making development of new or existing services (for example to extend group or family support services or to provide telephone support) potentially very difficult.

Most voluntary sector staff/volunteers appear to have had little or no training; joint training with statutory sector staff might also serve to develop and improve joint working relationships. Gaps in policy statements/staff guidelines which might ensure greater consistency of support locally and nationally have been highlighted. Where levels of local transgender support need may be small, statutory and voluntary organisations from nearby council areas of Scotland may be better able to plan for and provide dedicated/specialist services by pooling resources.

Although no children or young people under the age of sixteen participated in the research, the transgender related social care needs of young people and their families have been highlighted, not least by the absence of G.I.C. support to this age group in Scotland which suggests that transgender

children and young people, and their parents and families, are likely to struggle to find suitable support locally. A Scottish source of advice and assistance, which includes consideration of predictors and outcomes, and the availability of hormonal and surgical interventions which may be appropriate, would be a very valuable resource.

With an ageing population, the specific needs of older transgender people, and the consequent issues which these might raise for service providers, are also likely to become more apparent, particularly because, as Hartley and Whittle (2003) indicate 'those who were previously excluded may well be those who already have significant needs due to age, health, disability or social status' (quoted in Witten and Whittle, 2004: 512). The vulnerability of transgender people in old age may be exacerbated by the additional burden of stigma-related isolation, as well as by generic issues such as illness and disability associated with old age, including dementia.

Lastly, it is important to ensure that the needs of all transgender people are planned and provided for, whilst recognizing that the need for support for migratory transsexual people has been most evident within this research. It seems that there may be much work to be done in enabling planners, managers and social care workers to better understand the complex nature of transgender, if needs-appropriate generic support services are to be made welcoming to transgender people. A greater awareness is needed of the barriers which might affect transgender access to generic social care services, and these need to be carefully examined within individual service areas as part of equality reviews: barriers to accessing welfare benefits advice by a transgender person, for example, are likely to be rather different from those which affect their access to residential care for the elderly.

Whilst recognizing that the involvement of transgender volunteers who themselves have undertaken or considered transition will probably result in empathy from shared experience that is less likely within a care worker/client relationship, there may be potential for clarifying and adopting policy statements and staff guidance between statutory staff and these volunteers, so that a common agenda might be agreed and implemented, underpinned by shared aims and values. Existing policy documents (such as NHS Greater Glasgow and Clyde's transgender policy, 2010) might serve as a useful reference or starting point for some organisations. As with dedicated service provision, it is suggested that generic statutory staff development may be facilitated alongside voluntary sector representatives, by joint training, workshops, seminars and conferences.

It may be helpful too for staff from the voluntary and statutory sectors not only to liaise and work together to facilitate access to generic services, but also to develop awareness within service provision of a more flexible approach to gender and to the range of transgender presentations: the

needs of a transitioned FtM elderly person, who has not undertaken genital surgery but who passes easily as a man when clothed, are likely to be somewhat different to those of a transitioned MtF person, who has had full genital surgery, but has difficulty passing as a woman. Equality impact assessments need to be altered accordingly.

The range of physical conditions recorded by ten respondents included deafness or partial hearing loss, learning difficulty such as dyslexia, and developmental disorder such as Asperger syndrome. Some of these respondents, whilst under the primary care of their GP, may benefit from generic social care provision as appropriate for each of these disabilities for which the person's transgender status should, in theory have little or no relevance, although concerns have been noted that being transgender may affect the quality of social care that is provided (Lienert et al, 2010).

Service providers therefore need to be made more aware of equalities guidance and the potential indicators and consequences of binary-gender based prejudice and of implicit and explicit transphobia by both staff and by other service users. Staff working with transgender people should also be made aware of the implications for legal status and the confidentiality of transgender people in line with the Gender Recognition Act and Equal Treatment Directive (UK Government, 2004).

# Gender and Transgender Identities

## Gender and Transgender Categories

### Background Information

The term transgender may have little universal meaning outwith the boundaries of academia, policy makers, direct service providers and the world of transgender (and perhaps LGB) people too, although at least one transgender subcategory should be familiar, having received much media attention in recent years.

Ekins and King (2006) distinguish between three main categories of transgender, based upon a person's observable gender related behaviour. They use three descriptive terms to define these categories - oscillation, migration, and transcendence:

Cross dressers who move 'to and fro between male and female polarities, across and between the binary divide' are described as *oscillators* by Ekins and King (2006: 97), whose descriptor fits with Brierley's important overview of male to female cross dressing which always implies the intention to return to the original gender - 'transvestism (is) a condition in which there is a relatively stable feminine gender persona, in the context of (a) desire to preserve male heterosexuality' (1979: 8/12, 16). As Oram (2007) explains, cross-dressing may also be as much a female to male activity.

*Migrators*, unlike oscillators, are much more visible to services, and are perhaps better known by the more common term transsexual. These individuals appear to share 'a passionate, lifelong, ineradicable conviction' (Morris, 1974: 15) present, (even if not always discernible to others), from early childhood, to be accepted as a member of the opposite gender so that their journeys across the binary gender divide are usually an expression of a desire to live permanently in the opposite binary gender role, with the assistance of hormonal and/or surgical interventions. However, not all transsexual people wish to alter their bodies in such a permanently significant manner, and not all seek to live within binary conceptions of gender.

The notion of living outwith binary gender categories links with Ekins and King's third concept, that of *transcenders*. Garfinkel's (1967) first two rules for 'our natural attitude towards gender' that there are only two genders, and that one's gender is invariant, are here seriously questioned, for transcendence involves subverting or moving 'beyond the binary divide' (Ekins and King, 2006: 181). Bornstein, in her book 'Gender Outlaw', notes that 'transgressively gendered ... people break the

rules, codes and shackles of gender' (1994: 98,135). Although many of the examples given, particularly in her second book (Bornstein and Bergman, 2010), appear to bend or break only one or more 'rules, codes or shackles' without, in most cases, apparently 'transcending' far beyond the binary, such a notion appears to mix stereotypical or identifiable behaviours from either side of the binary in a novel or unusual, rule-breaking mix.

That the dilemma of gender dysphoria in children cannot be readily explained within performance based theory has been argued by Kennedy and Hellen who noted that 'although transgender children are subjected to considerable and sustained pressure to conform to gender roles assigned at birth ... in defiance of this they still develop a transgender identity' (2010: 39). Thus, although the separation of gender role and identity is no longer widely recognised within much of current gender theory, it has been retained within the underpinning theory of this research as it appears to reflect the early experience, motivation for reassignment and subsequent transition of many transgender individuals, including participants to the present research.

### **Summary of Key Research Findings**

Biological males outnumbered biological females by a ratio of 2:1 (survey one) and 6:5 (survey two) compared to a national ratio of 12:13. Biological females (and those who described their gender identity and current gender role as male) were more likely to be in younger age groups than biological males (and those who described their gender identity and current gender role as female) for both survey one and survey two.

69% of participants to survey one identified with male (24%) or female (45%) gender identity categories; 31% of participants identified with transgender (20%) or 'other' (11%) categories. 59% of respondents to survey two identified with binary categories (21% male, 38% female) whilst 41% identified with transgender (14%) or 'other' categories (27%). There was a slightly greater likelihood for participants in younger age groups to describe themselves as transgender, while the term transsexual was less often chosen by biological females (6%) than biological males (14%) (survey one). Four respondents to survey one, in the age groups 46 to 55, 56 to 65 or 66 and over, (8%) saw themselves as falling within the category of 'cross-dresser, transvestite, drag queen, sissy or similar'.

The gender dysphoria that many transgender people feel very early in their lives (Whittle 2000: 19) is readily apparent from the memories of childhood of two of the participants to this research, one of whom, Abigail, spoke about not really recognising the boy she saw in the mirror. Another interviewee, Amy, indicated that she had been aware of her gender dysphoria from the age of

seven, but it was only after suicidal thoughts that a visit to a GP began to help her to understand these feelings within the context of transsexuality.

One respondent, Andrew, stated simply that he always knew he was different and another, Abigail, similarly explained that she had always felt different. One participant, Suzie, spoke of gender confusion, while a survey respondent thought that their gender identity was very possibly male but that it was complicated. The variance in these quotes suggests that there is a broad range of self-perceived difference, from doubt and uncertainty about one's gender status and the nature of the gendered relationship between oneself and others, to certainty that the nature of the problem lies in being 'trapped' in the wrong body.

Within the respondents to survey one, for example, of the twenty five participants who described themselves as biologically male, thirteen described their gender identity and current gender role as female, while the remainder described their gender identity and gender role in combinations of male, female, transgender and 'other'. Similarly, eight of the thirteen participants to survey one who described themselves as biologically female described their gender identity and current gender role as male, while the remainder described their gender identity and current role in combinations of male, female, transgender and 'other'.

The maintenance of an initial gender role – individually nuanced perhaps, but apparently concordant with the multiplicity of behaviours which may be construed as 'normal' for one's biological sex, prior to transition - varied in duration from fourteen years to seventy two years, with a mean of 34.3 and a median of 34.5 years. This suggests that the dilemma of a conflict of gender identity with gendered behaviour and appearance may be a long-term factor in many transgender people's lives (though, as this research also indicates, trending towards a shorter duration in FtM transgender people who appear more likely to transition at an earlier age).

Such a conflict resulted in some participants taking a long time to understand their gender dysphoria: one interviewee, Andrew, explained that he did not understand that he was transgender until he was thirty nine, after seeing a documentary of a FtM person on TV. Several respondents commented about the difficulties of finding useful information online and one, Ciaran, spoke of being confused by the limited information available.

Gender dysphoria appeared particularly difficult to cope with during adolescence: one interviewee, Suzie, said that she found the idea of puberty and its drastic effects on her future life to be both very confusing and upsetting.



Some respondents indicated that gender identity issues were not always resolved within the binary. One interviewee, Abigail, commented that she had never had a female or male identity and that she felt like she belonged neither to men nor to women.

Such a statement is supported by the 20% of respondents who, when offered the choice of a range of gender descriptives with which they identified, indicated a preference for the term 'transgender' alongside the 7% of respondents preferring options including bi-gender, a-gender, and poly-gender over more binary based options. These figures support the notion of transgender or 'other' gender identities which were identified with by participants of surveys one and two (nine and four respectively) and those who chose the 'other' category (five in survey one and eight in survey two), preferring terms such as 'third gender', 'inter-gender or gender queer', 'gender fluid', and 'poly-gender' to describe their gender identity. Similar identification with the notion of a current transgender role was indicated by participants of surveys one and two (seven and three respectively), or as 'other' (three and four respectively).

Some research participants felt that gender transition offered the possibility of altering at least one or more criteria of their biological sex, beyond the markers of social category (West and Zimmerman, 1987: 132). The survey participant who explained that their biological sex was female at birth, but that, having subsequently undergone gender reassignment from female to male, he no longer considered it accurate to say that his biological sex was simply female, raised a key aspect of gender transition: that it may alter some of the defining aspects of biological sex. More specifically, one interviewee, Josie, suggested that, having been on hormones for some twelve years, the chemical make-up of her body had significantly changed. The feminising and masculinising effects of the regular use of oestrogen in MtF transsexuals and of testosterone in FtM transsexuals are well documented (Seal 2007: 157/190).

One interviewee, Sarah, explained that she viewed 'transsexual' as a process that she went through, rather than as an identity. However another interviewee, Amy, was disappointed when she was not viewed as a woman after transition, making it clear that she did not undertake transitioning to be seen as a transsexual. In this situation it seems that, despite the difficulties of the journey to date, some migrators may still be viewed (by some others) as essentially belonging to their original biological sex and, by implication, to their original gender (particularly so perhaps, in the case of some MtF transgender people: Whittle, 2000, 49/50).

The research participants provided many examples of the profound conundrum at the heart of their gender dysphoria: how to resolve a gender identity/role conflict within a society that expects and

reinforces conformity to the binary. Lack of experience of the gendered behaviour which corresponds with perceived gender may partially explain problems in passing, though these may also be linked with secondary sexual characteristics (including breast development or vocal change) developed at puberty. It seems that for some transitioned transgender people, seeking to resolve a conflict of gender identity through transitioning may result in trading the deeply distressing personal dilemma of gender dysphoria for a similarly distressing, but more publicly evident conflict which centres on their gendered behaviour and appearance.

Perhaps one of the most striking outcomes of this aspect of the research is the degree to which some participants showed a willingness to carefully consider their status in relation to sex and gender, and to continue reconsidering this, as physical and social changes linked with transition became apparent. The clichéd notion that transitioned transgender people adopt very stereotyped binary gender behaviour and appearance may be correct for some, particularly during the transition period, but the research findings indicate a much greater flexibility of self-perception within participants' transgender identities.

It is the flexibility of these category choices which informs one of the recommendations from the research. The choice of gender category through the G.R.C. process is currently restricted within the binary. It is suggested that it is also important to recognize the importance of transgender categories to 30% to 40% of research respondents too, leading to the proposal of a legal category of transgender as an alternative to the binary categories currently recognized in Scotland, concordant with the recent WPATH statement on Legal Recognition of Gender Identity (Green, 2015).

Transgender groups were rated as the most highly valued source of support re gender identity issues by over a third (seventeen of forty seven) of respondents to survey one. However, transgender groups were rated less likely to meet their needs by MtF rather than FtM individuals regarding understanding their gender identity or transgender status.

Whilst over a quarter (thirteen) of people rated gender specialists at a G.I.C as their most highly valued source of support re gender identity issues, nine respondents rated them as the least valued source of support. There were no significant differences in the way FtM or MtF respondents perceived this source of support.

Eight of the ten respondents in a current male gender role and with a male gender identity, rated family members in the three highest categories for support with gender identity issues, (with just one respondent rating family members in the three lowest categories for such support). Conversely, of the sixteen respondents in a current female gender role, and with a female gender identity, just

six rated family members in the three highest categories, with seven respondents rating them in the three lowest categories.

Similarly five of the ten respondents in a current male gender role and with a male gender identity, rated close friends in the three highest categories for support with gender identity issues (with just one respondent rating close friends in the three lowest categories for such support). Conversely, of the fifteen respondents in a current female gender role, and with a female gender identity, just six rated close friends in the three highest categories for support with gender identity issues, with five respondents rating them in the three lowest categories.

A little over a third (ten of twenty eight) of respondents to survey two said that they would greatly value advice, information and support from a suitably trained and experienced social or care worker on gender identity issues even though most of these had already transitioned to their preferred gender role. Nine of these respondents were in the age groups 36 to 45 and 46 to 55. Seventeen of twenty eight respondents had either received such support in the past or were receiving it at present, from a social care or other source.

Five of the twelve of those currently in a female gender role, and four of the ten of those currently in a male gender role would value such advice and support greatly. A three way cross tabulation with current gender role and gender identity indicated that all five of those in a female role who would value support greatly, described themselves as having a female gender identity. Similarly three of the four people currently in a male gender role who also said they would value such support greatly, had a male gender identity. These findings suggest that transition may not necessarily bring resolution to one's personal sense of gender identity or of being transgender.

## **Gender Transition**

### **Background Information**

Support for many transgender people has historically been mainly within a medical model to the migrating transsexual individual, during their relatively brief transitional period across binary roles. Such limited support is unlikely to meet the range of needs linked with social care and status which may be apparent before, during (and perhaps long after) gender reassignment. Binary gender transition is reinforced within legislation through the UK Gender Recognition Act 2004, within which 'one's acquired *gender* becomes the *sex* in which one is recognised in law ... in the terms of the Act *gender* refers to *female* and *sex* refers to *woman*' (Whittle and Turner, 2007: 3, 5, 16/18, italics

original). A transitioned person in the UK, on receiving a gender recognition certificate, thus becomes legally not only their 'new' gender, but their sex also now matches this gender, backdated, if desired, to their date of birth. This accommodation is valuable to transsexual people who had previously viewed themselves as perhaps having been 'a man living in a woman's body' or 'a woman living in a man's body', but does not reflect those transgender people who perceive their gender as being located outwith the binary.

Kennedy and Hellen note 'that children start to understand gender identity between ages 3 and 4, and that this develops over the next two years as they also become aware of social interpretations of gender as an "invariant" category' (2010: 28). It seems that this may be the stage too, at which transgender children recognise their difference. Whittle explains that 'transsexual people will, without exception, say that they have always known that something was wrong' (2000: 19). It is therefore not unusual (though apparently not 'without exception' – see Connell, 2010) to find transgender people whose earliest memory is of the discord of being transgender. Kennedy and Hellen note the subsequent 'tension between societal expectations of gendered behaviour and ... people (who) are unable to conform to gender norms' (2010: 38), referring to transgender people's restricted ability to express what they may perceive as their 'real' gender identity, to others at least, leading perhaps to consequential secretive cross dressing and non-conformist gender expression.

It might be speculated that transgender children are able to maintain a dual identity in their heads – their hidden transgender identity in constant conflict with their overtly requisite social role. However, *active* adoption of this overt role is also apparent from transgender narratives, whereby individuals have sought to emulate and achieve societal assimilation within the binary gender role linked to their biological sex, until it seems, the pressure of gender dysphoria requires release and/or resolution: to continue to live within the daily routines and lifestyle of the 'wrong' gender for their self-perceived gender identity is likely to be a source of great discomfort and unhappiness linked with 'a lifelong sense of insecurity in (their designated gender) role' (Barrett, 2007: 20, 23).

For many transgender people, surgery and/or hormones appear to offer the gateway or 'hoops' through which entry to their preferred gender role might be attained. Whittle explains that 'when Benjamin published the first major textbook on the subject, *The Transsexual Phenomenon*, in 1966, gender reassignment was still the subject of extensive social stigma both publicly and in the medical world. Over 40 years later, some of that stigma remains, but it is widely accepted that the only successful treatment for transsexual people is hormone therapy and surgical reassignment' (2010).

There is however an emergent transgender movement against the expectation that transitioning transsexuals will re-form their bodies as fully as possible to reflect the 'natural' male or female body. It is now increasingly recognised that some FtM transsexuals do not wish, for example, to have an artificial penis, or may want to retain their womb, to give birth at a later stage, or that some MtF transsexuals may wish to retain their penis for later sexual pleasure, or because they see it is an essential part of themselves. These individual choices of course, reflect a growing recognition that the transgender body does not have to (and indeed cannot) conform fully to the 'norm'.

Nonetheless, passing (not being identified as transgender within society in one's adopted gender role) appears to be an important underlying source of concern to many transgender people, as implied within the S.T.A. report of transphobic harassment from strangers ... '*who perceived* (respondents) to be transgender' (Morton: 2008: 11, italics added). Concerns about being 'read' as transgender occur frequently within the transgender literature, with an underlying assumption that it is most transgender people's intention to 'pass' within their preferred gender. As Namaste suggests: 'transsexuality is about the banality of buying some bread, of making photocopies, of getting your shoe fixed. It is not about challenging the binary sex/gender system' (2011: 25).

In addition, a dilemma faced by many transsexual people within society is that they lack a 'history' in their preferred gender role (and indeed that they bring with them, consciously or unconsciously, their 'history' in their original gender role). Bradley expands de Beauvoir's quote (1949, reprint 1997: 295), to argue that 'one is born with a body that is immediately ascribed a male or female identity (usually on the basis of fairly unambiguous physiological evidence, the possession of a penis or a vagina) but one becomes a man or a woman through social interactions within a set of cultural understandings of femininity and masculinity' (2007: 21). The absence of a lifetime of experience of such social interactions and cultural understandings is likely to result in some difficulty in adapting to and feeling at ease within the very different gender role to which one transitions, despite a life of wishing for such a transition, or feeling 'trapped' within the wrong body.

The notion of a lack of history is not however simply a matter of adjusting to or passing within gender divided social conventions. If, for example, one has lived through the formative gendered years of childhood, adolescence and early adulthood, in a male role before transitioning, and benefitted from this, the loss of such benefits may not only result in significantly altered status within society, but may affect self-esteem and self-perception, perhaps making adaptation to a post-transition role more difficult. Similarly, someone who began life living as a girl or woman who then transitions, may be somewhat taken aback or, initially at least, made uncomfortable by the new

status which he gradually acquires alongside his acceptance as a man, bringing into clearer focus the lesser authority which was available to him previously as a woman.

The recent publication of the Scottish Protocol for Gender Reassignment for Transsexual Patients is a valuable step towards a nationally consistent service. The protocol identifies the main steps in the reassignment process, with some recommendations for timescales. Common options for MtF and FtM transsexuals are identified and an appendix to the protocol explains these, together with additional procedures which are not exclusive to gender reassignment. An appendix also covers services for children and young people, for whom G.I.C. services are not however available in Scotland, and who are therefore referred to the Tavistock Centre in London (Scottish Government, 2012).

Detailed information on the numbers of transsexual people in Scotland undertaking reassignment came from Wilson et al who sought information from GP practices, of which 73% responded, representing 4,105,872 patients. 'A total of 273 patients with gender dysphoria were identified, representing 8.18 patients per 100,000 population aged over 15 years'. They found that 'sixty five (24% of these patients) were undergoing hormonal treatment without surgery, and ninety five (35%) had undergone gender reassignment surgery' (1999: 991).

### **Summary of Key Research Findings**

Of the twenty four participants who described their original gender role as male (survey one), seven also described their current gender role as male, while twelve described this now as female, four as transgender and one as 'other', indicating that just under a third of those with an original male gender role had not, at the time of the questionnaire, transitioned to a female role. Of the thirteen participants who described their original gender role as female, five now described this as male, with eight describing this as currently female indicating that almost two thirds of those with an original female gender role had not transitioned to a male role.

Three of the six participants who described their original gender role as transgender now described their gender role as male, while three remained transgender.

Two participants were 'happy to spend some time in the opposite gender role' but didn't want to do this permanently (indicating that just 4% of participants in the survey saw themselves as 'oscillators'), while five (11%) described themselves as 'other'.

As noted above, the mean (median) number of years that survey one respondents had lived in their original gender role was 34.3 (34.5) years, suggesting that most transitioned participants had not done so until their mid-thirties. The mean (median) number of years that survey one respondents had lived in their current gender role was 7.3 (5) years, suggesting mainly limited life experience within transitioned gender roles.

Transgender groups were rated the most highly valued source of support for helping to undertake a transition by fourteen of forty (35%) respondents to survey one, although FtM respondents were more likely to rate transgender support groups in the three highest categories than MtF individuals. The findings also indicated that FtM individuals were more likely to find sources of support during transition from friends, family or support groups and less likely to need G.I.C. support or support from counsellors or psychiatrists compared to the very different, almost converse situation for MtF people.

A quarter (ten of forty) people rated gender specialists at a G.I.C as their most highly valued source of support in undertaking a transition, but almost the same number of respondents, nine, rated them as their least valued source of support. Relatively brief periods of support from a G.I.C., the waiting time for a first appointment, and the length of time between appointments, were unfavorably commented on.

Lastly, more GP's appear in the three highest importance columns than the three columns of lowest importance, although twice as many GP's were rated of least importance (eight) in helping to make the transition as those who were rated of highest importance (four) perhaps evidencing Whittle et al's finding that 21% of GPs did not want to help transgender people (2007: 16).

69% (thirty of forty three) of family members received no advice or support about the respondent's transition, with limited evidence of support to respondents' spouses, partners and children (survey one). No-one within the families of 80% of respondents in the age groups 36 to 45 and 46 to 55 had received support, though this percentage fell to 53% of families of respondents aged 16 to 25 and 26 to 35.

Despite low overall response rates to this question, transgender support groups were still rated as of the highest importance as a source of advice and support regarding helping family members to come to terms with a gender transition, by approximately a third of respondents (five of fourteen). Other family members, close friends, gender specialists, GPs and counsellors or psychiatrists received mixed ratings from both high to low importance.

Ten of twenty seven respondents to survey two said that their partner or other family members would greatly value advice, information and support to better understand about the respondent being transgender/transitioning. No one was currently receiving this support but four respondents said that family members had received such support in the past, from a social care or other source.

Ten of twenty seven respondents to survey two also said that they would greatly value advice, information and support to understand/address family differences and disagreements re transgender issues. Just one person's family was currently receiving such support, and one respondents' family had received such assistance on this issue in the past.

Survey respondents and interviewees described greatly varying levels of support from within their families, with frequently painful memories of conflict at the time of transition. Issues described included difficulties for partners, family divisions, rejection by close family members, including a parent or sibling, the 'loss' of family relationships, and the 'loss' to a parent of a daughter, the effect of religion, and conflict associated with the public airing of 'family business'.

Almost two thirds (twenty of thirty three) of respondents to survey two said that they would value advice, information or support from a social or care worker greatly (thirteen) or a little (seven) now that they were no longer receiving G.I.C. support. A further three way cross tabulation indicated that four respondents currently living in a male gender role, six in a female gender role (all ten of whom had a 'matching' gender identity) and two in a transgender role said that they would value this support greatly. These respondents had spent a range of periods in their current gender role, varying from 1 year, 1.5 years, 3 years, 4 years (3), 6 years, 8 years, 14 years, 20 years and 24 years (one respondent did not answer this question), suggesting that the need for support was, for most, no longer just centred around transitional issues and the transition period.

37% (ten of twenty seven) of respondents to survey two said that they would greatly value advice, information and support from a suitably trained and experienced social or care worker in making plans for the future including perhaps for a gender transition. Of the ten people who said that they would value this advice greatly, six were currently in a female role, three in a male, and one in a transgender role. A three way cross tabulation indicated that seven of these ten people (five of those in a female role and two of those in a male role) were already living in an opposite gender role to their biological sex, suggesting that either transitional issues were still in evidence, or that plans for the longer term future remained rather uncertain.

Some indicators of biological sex (including secondary sexual characteristics) may be transformed to a greater or lesser degree for MtF and FtM transgender people by hormonal changes which may



promote at least some of the secondary sexual characteristics of the person's opposite biological sex. These may be particularly noticeable in the 'breaking voice' and beard growth of the FtM person, or the breast growth of the MtF individual, so that these processes may well become aids in reducing visibility. Given the complexity of the physical process of changing gender, it is perhaps unsurprisingly that one interviewee, Kay, (who was still awaiting G.I.C. support) expressed concern about how, and in what order, to undertake such a transformation. Genital reconstruction can also be very successfully undertaken for MtF individuals, though rather less successfully for those who are FtM. Nonetheless, surgery to construct a penis was still important for some research participants and one interviewee, Ciaran, further reinforced the importance of the notion of presumed sex category when he explained that having a penis would give him more confidence if people tried to tell him that he wasn't a 'real' man.

The complexities of transitioning from one binary gender role to another, in the absence of any history in an opposite gender role, were simply stated by one interviewee, Abigail, who commented on the huge implications of transition, on every aspect of her life. The gender transition process concentrates mainly on re-embodiment, with much less apparent consideration for the social implications of such a journey. This was readily demonstrated by many of the comments by survey respondents and interviewees about advice and support which would be valued in assisting with social assimilation within networks of family, friends, acquaintances, colleagues, neighbours, and the wider community.

Two thirds (twenty eight of forty four) of respondents had completed a real life experience as part of gender reassignment, but six people (five of whom were in the age groups 16 to 25 or 26 to 35) had undertaken gender reassignment without undertaking a real life experience.

37% (ten of twenty seven) of respondents to survey two said that they would greatly value advice, information and support from a suitably trained and experienced social or care worker during a gender role transition or the 'real life test', while ten others said that they did not need such support. In total, ten of twenty eight respondents had either received such support in the past, or were currently receiving it, from a social or care worker, or from another source.

Of the ten people who would value advice and support greatly during a gender transition, six were currently in a female role, three in a male, and one in a transgender role. A three way cross tabulation indicated that five of the six people in a female role and one of the three in a male role had actually already made the transition from the opposite binary role, suggesting perhaps that the

transitional process is a long and complex process for which advice and support may be needed for some time after the initial 'transformation' and adoption of the opposite binary role.

## **Gendered Documentation**

### **Background Information**

Whittle suggests that 'for transsexual and transgender people who commence living permanently in their preferred gender role the changing of one's documentation is a crucial part of the transition process' (2008: 2). Pragmatically, changing documentation is an essential part of the 'real life test' unless the transgender person is to face daily discord between gender presentation and gender attribution in everyday life, and gender status within a range of legal documentation. The issuing of a Gender Recognition Certificate (GRC) may make any future name changes more straightforward, but a transgender person needs to live in role for a full two years before an application for a GRC can be considered.

### **Summary of Key Research Findings**

Transgender support groups were rated as of the highest importance by over half of participants to survey one (eighteen of thirty three) as a source of advice regarding helping to change documentation. However, 44% (twelve of twenty seven) of the respondents to survey two said that they would greatly value advice, information and support to help change documentation. 58% of biological males (seven of twelve) and 60% of biological females (six of ten) said that they would value this information either greatly or a little. Two respondents were currently receiving such support from a social or care worker, and six had received support with documentation in the past.

Twenty seven (57%) respondents to survey one had changed their gender role to match their gender identity although only thirteen (28%) had applied for and received a Gender Recognition Certificate, while two more had an application in progress. Twelve (30%) participants (who had undertaken gender reassignment) had not applied, and nine further participants (19%) were in the process of transition.

A three way cross tabulation between current gender role, gender identity and applications for a G.R.C. indicated that of the ten people living in a male role who described their gender identity as male, six had applied for and received a G.R.C. Conversely and rather surprisingly only three of the

sixteen people living in a female role who described their gender identity as female had made an application, two of whom had been successful, and one of whom had an application pending.

55% (fifteen of twenty seven) of respondents to survey two said that they would greatly value advice, information and support with applying for a Gender Recognition Certificate: 58% of biological males (seven of twelve) and 70% of biological females (seven of ten) whilst 70% of those currently living in a male role (seven of ten) and 50% of those living in a female role (six of twelve) said that they would value this information either greatly or a little. Two respondents were currently receiving such help from a social or care worker and two have received such assistance in the past.

There was mixed feedback about the value and 'honesty' of the Gender Recognition Certificate:

**Abigail:** 'I have to live as a woman: with a female passport, a female NHS number, and a gender recognition certificate. With that comes a birth certificate that states I was born "(current female name)" on my birth date, and born female. And this is very lovely to have, very important too. But at the same time I know it is a lie'.

### **Service Development/Potential Additional Support : Gender and Transgender Identities**

Research question two addressed transgender social care support for issues of gender identity and gender status. The help that respondents sought for gender identity issues appeared to be based upon an affirmation of their perspective of their gender dysphoria, together with assistance to clarify what could be done to resolve this: 'if there had been a trained social worker I could have talked to I would have done so' (*Andrew*).

Some transgender people appear to have valued the possibility of exploring issues of gender and transgender identity, for a broader perspective of their own position. Exploring matters of identity within a series of discussions with a trained and experienced care worker, may not only help someone to better understand their current situation, but also to better visualise and realise their future gender role.

Lev offers a developmental model of transgender emergence, which breaks down into six stages consisting of 'awareness', 'seeking information – reaching out', 'disclosure to significant others', 'exploration – identity and self labelling', 'exploration – transition issues/possible body modification' and 'integration - acceptance and post-transition issues' (2006: 268). This developmental model might provide a valuable framework through which a care worker may be able to identify where a

transgender person has reached in coming to terms with their gender dysphoria, and where the priority for focus of supportive work might be best located. The research findings on developing a more confident community presence for example, suggest that post-transition integration or acceptance may be elusive for quite a significant number of transgender people. While Lev's model is clearly aimed at migratory transsexual people, the early stages of the process may also have relevance to aiding the personal development of other transgender people too.

Because 'the vast majority of respondents reported major psychological distress before transition' (Wilson et al, 2005: 28/29) many transgender people may be in a poor psychological state at this crucially vulnerable period of their lives, as they embark on such an intense and emotionally complex process. As Connell has noted: 'people in gender transition are grappling with such complex, disturbing and difficult issues that few have much energy to spare' (2010: 17).

In addition to more general discussion and support on the nature of gender and transgender identity, consideration of some of the social roles and skills of the gender of transition may form a valuable basis for a series of discussions with a care worker, prior to or during a transition, for, as one respondent, Sarah, noted, such a process can take years. If a transgender person is to gradually feel comfortable in their preferred gender role (particularly perhaps, though not exclusively, if their view of this role falls within one of the binary categories) thinking about and discussing how they might use language, how they would like to appear in public, and how transition is likely to affect their social role and status within their family, their network of friends and colleagues, as well as within wider society, may not only assist with the transitional process, but may also enable a more realistic appraisal of possible outcomes. The choice of some transgender people to live non binary conforming lives may however challenge support services which base their support on the notion of living within the binary, whilst further stretching the resources of these transgender people for whom role models are likely to be very limited.

It has already been noted that, while preparing for the great personal and social upheaval of transition, a transgender person has to simultaneously negotiate the process of changing documentation. One suggestion was that 'a pre-prepared mail pack, or pdf could be sent to them explaining the mechanical and bureaucratic process, who to get in touch (with) and when'. Given the lead role that transgender support groups in Scotland have played to date in supporting individuals in changing documentation, it seems reasonable to suggest that the task of putting together a 'how to change documentation' pack, together with a 'how to apply for a gender recognition certificate' pack might be most appropriately undertaken within this network, perhaps under the auspices of the Scottish Transgender Alliance, with due reference to the guidelines

included within Whittle's 2008 paper, and with necessary amendments to take into account any Scottish anomalies.

Concerns are also raised in regard to the G.R.C., in relation to the absence of a 'transgender' option for those people who do not feel comfortable with male or female designators. Advocacy by social work and other supportive organisations might assist in this too becoming an option in the future.

Future research may clarify whether there are underlying links between biological sex, age, transition status and mental health for transsexual individuals, as is suggested by associations noted within the current research. This may strengthen an argument for targeted social care support to the pre-transition or transitioning MtF or FtM transgender person at different times in their lives.

A need for post-transition support is, however, also indicated by the current research. The possible inclusion of an individually assigned care worker within a G.I.C. based support team during and following a gender transition might also be usefully explored. This was an idea initially raised within the pilot study focus group (bearing in mind that, although approximately a quarter of respondents to survey one rated G.I.C. input as their most highly valued support with gender identity (thirteen) and transition (ten) issues, only slightly lower numbers (nine and nine respectively) rated this as their least valued support). There was also a tendency for those who transitioned to a female role to rate G.I.C. support as more valuable than those who transitioned to a male role.

The potential for addressing the difficulties of social isolation, which may affect transitioned individuals is discussed later in this report. A potential role for the care worker may also be to facilitate regular 'safe' trips for the transgender person into the community through personalized volunteer support, *prior to, during and following* transition, to reduce such later isolation.

Although not featured within the research findings, transgender children and young people and their families are likely to have their own unique social care needs, complicated by rapid bodily and mental development associated with puberty, and exacerbated by the absence of local gender identity clinic support in Scotland. In addition to the absence of G.I.C. support and treatment within Scotland to transgender young people, it is important to note that no guidelines are included in the Scottish Protocol regarding treatment options for children and young people nor indeed diagnostic procedures which might be followed. There is also an absence of guidance on the prescription of anti-androgens or progestins to delay puberty, which might be suitable and/or made available or the timescales under which these might be expected to be made available (for example relating to the onset of puberty and adolescence), or on the prescription of androgens or oestrogens.

Ageing too brings its own complications to the social care of transgender people; it might be hypothesised that assistance from a care worker may be necessary regarding likely increased isolation, to find empathetic and sensitive carers, to advocate on behalf of transitioned older person's needs and rights and, it might be reasonably suggested, to monitor the care that is being provided, to ensure that being transgender does not lead to abuses of respect or privacy (see for example the meta-analysis by Addis et al (2009)).

## Transgender and Society

### Transgender Acceptance and Rejection

#### Background Information

Historically, particularly over the last sixty years, there has been a growing public awareness of transgender and/or transsexual people, ever since Christine Jorgensen 'made *sex change* a household term' in 1952, (Meyerowitz, 2002: 51, italic original), through the serialisation of Jan Morris's (1974) biography in a Sunday broadsheet in the mid-1970's, through public exposés in the tabloid press, feminist controversy within the broadsheet press or the inclusion of a trans-woman in Coronation Street (albeit played by a non-trans actor). The new millennium has seen an increasingly common 'reality or docu-drama' approach to the lives of transgender people on television, including 'My Transsexual Summer' which looked at the experiences of seven trans-men and trans-women, aged from twenty two to fifty two, meeting over a series of residential weekends to discuss their ideas and experiences and 'to overcome some of the multiple challenges of being trans in day-to-day life' (Channel Four, 2011). The recent inclusion of a transgender actor in the Netflix series 'Orange is the New Black' was widely recognised as a major step forward in the public perception of transgender.

Notions of gender power, status and inequality are deeply relevant to an understanding of transgender, for, partly linked with gender inequality, the transition of transsexual people is likely to have a significant effect on their status with others. The non-acceptance of transgender people through rejection, which may be evidenced by transphobia and hate crime, appears to be linked with transgressing the norms of the gender binary, provoking discomfort and even disdain in others. It appears that a deficit in information on transgender issues may reinforce both misunderstanding and ignorance and may be the precursor of prejudice, discrimination and transphobia. These may be expressed through discrimination or acts of rejection, including sexual or physical violence, as experienced by transgender people (in the main, by transsexual people), within close relationships, local communities and wider society. For example, the findings of the Scottish Transgender Alliance (S.T.A.) survey of seventy one transgender people in Scotland in 2007 indicated that 62% of respondents had suffered harassment from strangers, mostly in 'the form of verbal abuse, with 31% experiencing threatening behaviour, 17% experiencing physical assault and 4% experiencing sexual assault' (Morton, 2008: 11/18).

A more recent survey for the Scottish Transgender Alliance, a UK based online survey of mental health and transgender people, in which 889 people took part, lists wide ranging examples of apparently endemic transphobia: 'over 90% (of participants) had been told that trans people were not normal, over 80% had experienced silent harassment ... 50% had been sexually objectified or fetishised ... 38% had experienced sexual harassment, 13% had been sexually assaulted, and 6% had been raped ... over 37% had experienced physical threats or intimidation ... 19% had been hit or beaten up ... 25% had to move away from family or friends ... over 16% had experienced domestic abuse, and 14% had experienced police harassment (McNeil et al, 2012: 88).

Evidence of such attitudes within the close relationships of transgender people was demonstrated by the Scottish LGBT Domestic Abuse project which identified eight behaviours which it termed transphobic. These included for example, being stopped from expressing one's gender identity through appearance and/or through use of name and pronouns, being stopped from sharing information with others about one's trans background or identity, or being made to feel shame, guilt or wrong about one's trans background or identity. 73% of forty five respondents said that their partner or ex-partner had carried out at least one of the eight identified transphobic behaviours (Roch et al, 2010: 15).

Discrimination towards transgender people has also been evidenced within health services. Whittle et al report that '21% of respondents' GPs did not want to help transgender people', and 'in 6% of cases ... they actually refused to help them' (with transgender matters). In addition '17% of respondents had experience of a nurse or doctor ... who did not approve of gender reassignment and hence refused services' (for non-transgender issues). 'Accessing healthcare was the ... third highest sector where trans people encountered discrimination and inequality' and 'many local health authority funding refusals or refusals for care (were) from individual health service workers who expressed personal prejudice about gender dysphoria' (2007: 16, 43/45).

A number of female academic feminists have taken an extremely critical view of transsexualism. As Connell notes in her review of transsexual women and feminist thought, 'transsexual women are a small group who have been subject to fierce and extended scrutiny ... (which) ... includes a feminist literature that exposes a troubled and often antagonistic relationship between feminism and transsexual women'. For example, Connell notes that 'Daly (1978) attacked transsexuality as a "necrophilic invasion" of women's bodies and spirits' (2012: 857, 860), while Raymond's (1980) book 'The Transsexual Empire' was the forerunner of a 'politically progressive ethical condemnation of transsexualism' (Stryker and Whittle, 2006: 131). They went on to suggest that although Raymond's



book 'did not invent anti-transsexual prejudice ... it did more to justify and perpetuate it than any book ever written'.

Whittle suggests that 'Raymond's thesis ... discredited for a long time any academic voice that ... (the transgendered community) ... might have, in particular with feminist theorists' (1996: 207). The recent publication by Jeffreys which is described on its cover as a 'provocative and controversial book ... (which) ... offers a feminist perspective on the ideology and practice of transgenderism, which the author sees as harmful' (2014) and which contains praise by Raymond as a book of 'exceptional courage, clarity and scholarship (which) interrogates the dogma of transgenderism', suggests that such discussions and arguments are far from resolved.

The early internalisation of self-directed transphobia in transgender people themselves, is noted by Hellen who comments that 'as transgendered children become more aware of how socially unacceptable they may be, the more likely it will be that, rightly or wrongly, they will suppress or at least conceal their gender identities' (2009: 84).

### **Summary of Key Research Findings**

Seven of twenty seven respondents to survey two said that they would value support from a social or care worker greatly to address differences /disagreements with friends. Numbers saying they would value this support greatly tended to rise with age up to the age group 46 to 55. 42% (five of twelve) of biological males but only 10% (one of ten) biological females said that they would value such support greatly.

One person was currently receiving such support from a social/care worker, and four had received this in the past. Only two of twenty seven respondents to survey two said that they had not experienced transgender related differences/disagreements with friends.

Ten of twenty seven respondents to survey two said that they would value support greatly to address transgender related differences /disagreements with neighbours, colleagues etc. Numbers saying they would value this support greatly, again tended to rise with age up to the age group 46 to 55. The numbers of biological males (50%: six of twelve) and biological females (20%: two of ten) who would value this information greatly were again quite different.

Two people were currently receiving such support from a social/care worker, and four had received this in the past. Just three of twenty seven respondents to survey two said that they had not experienced transgender related differences /disagreements with neighbours, colleagues etc.

Almost a half of respondents to survey two said that they would value support from a social or care worker greatly (twelve of twenty seven) to address the consequences of social rejection/abuse. Once again, numbers saying that they would value this support greatly, tended to rise with age up to the age group 46 to 55. Seven of twelve (58%) of biological males but only two of ten (20%) biological females said that they would value such support greatly. Just two respondents said that they had not experienced social rejection: they were both living in a female role, one of these described her gender identity as female, the other as 'other'.

One person was currently receiving such support from a social/care worker, and three had received this in the past.

Almost half (twelve) of twenty seven respondents to survey two said that they would value support greatly to establish a more confident community presence with 66% (eight of twelve) biological males and 20% (two of ten) biological females saying that they would value such support greatly. Once again, numbers saying they would value this support greatly tended to rise with age up to the age group 46 to 55.

One person was currently receiving such support from a social/care worker, and two had received this in the past.

(It should be noted in each of the series of statistics shown above, that including those who would value each area of assistance 'a little' reduced the differences between biological males and biological females considerably).

Non-acceptance or failure to pass successfully in a transitioned role sometimes resulted in very punitive responses. One interviewee, Ciaran noted that he was verbally abused and even assaulted more than once. Another, Lucy described how she was spat at, beaten up, and refused service in shops because of her gender change, and even had excrement pushed through her letterbox. There were also examples of less abusive, but nonetheless disabling responses, for example where participants lost contact with relatives because of their transgender status, sometimes at the expense of other family relationships: Luke spoke of how his mother in particular found his transition very hard, particularly in view of the rejection from his mother's brother and his wife, who now ignore him at family gatherings. Another interviewee, Sarah, explained that with the exception of her mother, her family appeared not to want acknowledge her as a family member.

Such experiences provide very negative feedback to transgender people, very different from the feedback which the majority of people who grow up in a gender role which matches their gender identity are likely to receive. Nonetheless, there was no suggestion from any participant, either as

survey or interview respondents, that they felt that they had made a mistake in undertaking a transition to align their gender identity and gendered behaviour and appearance.

## **Transgender and Mental Health/Disability**

### **Background Information**

Brierley's detailed exploration of treatments for cross dressing including ECT, behaviour (usually aversion) therapy, and classical conditioning (to reward normalised behaviour) (1979: 159/194) indicate that few of these treatments have been viewed as successful and/or appropriate in the long-term, although Barrett comments that transvestism would still 'probably be reasonably familiar to any general practitioner or psychiatrist' (2007: 31) perhaps because of psychological conditions such as guilt, anxiety, stress or depression, linked with 'the need to keep gender oscillations secret' because 'cross dressing is still a stigmatised activity' (Ekins and King, 2006: 103/128). Brierley also comments that 'there is no evidence whatever beyond the conviction of certain practitioners that ... psychotherapy (is) of general significance in reducing/eliminating transvestism', not least because a 'large proportion of transvestites ... choose never to reveal their transvestism' because 'most transvestites ... do not conceive themselves as in need of medical help' (1979: 18/26, 163).

The value of psychotherapeutic treatment for transsexuality has also been seriously questioned, because, as Morris notes: 'patients with gender disorders do not want therapy ... they want surgery'. Nonetheless he goes on to argue that 'gender patients both require and deserve psychotherapeutic input in order to be able to clarify their motivations for seeking gender reassignment treatment' (Morris, in Barrett, 2007: 91, 100). Age of treatment for transsexuality is currently subject to significant debate, and ongoing treatment and research in Holland in particular indicates notable success in clarifying and addressing the needs of transgender adolescents prior to puberty, including the use of puberty blocking hormones where appropriate (Cohen-Kettenis and Pfäfflin (2010).

Kennedy and Hellen note that 'there is evidence that, as a result of (the imposition of the performance of a gender identity which is not their own) and subsequent internalized transphobia, many ... (transgender) children achieve well below their abilities at school, leave school early, are more likely to self-harm or attempt suicide and are more likely to suffer from mental health issues in early adulthood'. They suggest that the effect of living a life that 'is about concealment, suppression, stigmatization, fear, isolation, doubt and repression' (2010: 25) may lead to 'many

years of their lives unnecessarily having to deal with feelings of guilt and shame' and may result in 'substantial underachievement in all areas of their lives' (2010: 40).

Bockting et al stress the holistic and wide ranging nature of mental health when they comment that it 'is intrinsically connected to cultural, physical, sexual, psychosocial and spiritual aspects of health and that for individuals seeking help relating to gender concerns, the clinician must be knowledgeable about gender and sexual identity development, transgender 'coming out', crossdressing, gender dysphoria, gender transition and the common concerns and reactions of loved ones'. They note the intense pressures which may affect 'many transgender individuals (for whom) the daily trials of living in a transphobic society constitutes ongoing trauma' commenting that some transgender individuals 'described life as a daily humiliation' (2006: 35/36).

Whittle et al note that 64% of females who become trans men later in life initially faced more harassment and bullying at school (not just from their fellow pupils but from school staff including teachers) than natal males with a female identity (44%) (2007: 63), but that these additional difficulties for trans men gradually dissipate. As Whittle et al explain 'whilst the ... trans man will experience some social problems in the first year or so of transition, these often fade away as they quickly come to look physically very masculine ... on the other hand many ... trans women will face difficulties for many years of their life as they struggle with the limitations of medicine and surgery to facilitate their passing as an ordinary woman in their day to day life' (2007: 8). Indeed the NHS/Glasgow University 'Scottish Transgender Survey' found that 'FtM respondents seemed on average, to enjoy better mental health' than MtF respondents (Wilson et al, 2005: 28).

That support via the family might help to counterbalance stresses associated with being transsexual is suggested by Ryan et al (2010: 205) who note that family acceptance predicts greater self-esteem, social support and general status. However, Whittle et al found a tendency for higher levels of familial support to be available for trans-men than for trans-women (2007: 69). The NHS/Glasgow University 'Scottish Transgender Survey' found that 'experiences surrounding gender transition ranged from remarkable levels of support to total rejection and threats of violence ... family support was often lacking at times of most need ... problems with families were almost universal' (2005: 2). In addition the NHS/Glasgow University study found that 'many respondents had lost all their pre-transition friends. Problems with friendships seem to be greater for MtF respondents than FtM participants' (2005: 27).

Although the NHS/Glasgow University survey found that 'the vast majority of respondents reported major psychological distress before transition' there was a noticeable difference following the

transition process, for 'scores on the mental health scales ... suggest that operative intervention improved mental health'. However, the 'single most important health issue is the lack of provision of appropriate mental health services for trans-people' (Wilson et al, 2005: 28/29). Similarly the S.T.A. survey of 2012 found that '70% of their participants were more satisfied with their lives since transitioning and only 2% were less satisfied (for reasons linked with) poor surgical outcome, loss of family, friends and employment, everyday experiences of transphobia and non-trans-related reasons. However this same survey found that '70% of respondents felt that they had lost or missed out on something as a result of being trans, transitioning, or expressing their gender identity (including) jobs and a career, money, reproduction, home, childhood and youth, sports and leisure opportunities, equality and respect, family life, relationships and dating, happiness, friendships, intimacy, social life, personal development, education and qualifications' (McNeil et al, 2012: 87/89).

Further evidence of mental health issues which affect transgender people comes from Kenagy, who in a study of 182 transgender individuals in Philadelphia in 1997, found that 30% had attempted suicide (2005: 19). Similarly Morrow in a discussion of social work practice with LGBT adolescents, indicates that 'an alarming 30% to 40% of GLBT (sic) youth have attempted suicide ... in comparison to (an attempted) suicide rate of 8% to 13% for presumed heterosexual youth' (2004: 95). McNeil et al found that 84% of participants had thought about ending their lives at some point, with more than one in four (27%) having had these thoughts in the week previous to completing the survey and almost two thirds (63%) during the year prior to the survey.

Although McNeil et al found that 'suicidal ideation and actual attempts reduced after transition, with 63% thinking about or attempting suicide more before they transitioned and only 3% thinking about or attempting suicide more post-transition' (2012: 89), Dhejne et al, in their 'long-term follow up of (three hundred and twenty four) transsexual persons undergoing sex assignment surgery' in Sweden, found 'substantially higher rates of ... death from ... suicide, suicide attempts, and psychiatric hospitalisations in sex-reassigned transsexual individuals compared to a healthy control population' (2011: 7).

Kuiper and Cohen-Kettenis are particularly explicit in their advocacy for the notion of social support or 'psychosocial guidance in addition to medical guidance' for issues other than those directly related to gender dysphoria. They explain that 'many transsexuals undergoing SRS (especially MtF's) lose their jobs, their relationships with (part of) their families, their partners (if any) and children, and their friends. Many are forced or feel forced to move away from their familiar environment ... social adaptation is not always easy. Not infrequently, significant others are lost, social isolation ensues, and a sense of existential loneliness is experienced. It is understandable that such a

situation saps the emotional strength of the person. Although the new situation appears to reduce the gender problems experienced, the loss situations unfortunately mar the process of sex reassignment in many cases' (1988: 455).

### **Summary of Key Research Findings**

71% of participants of survey one (thirty of forty two) did not perceive their day to day activities as being limited by a mental health problem or disability linked with being transgender. However 19% (eight of forty two) of respondents to survey one said that their day to day activities were limited a lot, and a further 10% (four of forty two) said that their activities were limited a little, because of such a problem or disability.

Of the twenty seven people who had changed their gender role to match their gender identity, five described their day to day activities as limited 'a lot', (none were limited 'a little') while, of the nine people who were in the process of such a change, two found their day to day activities limited 'a lot' and one 'a little'.

Three way cross tabulation indicated that, of the five people who had transitioned and were limited 'a lot' by transgender related problems, two said that they had a male gender identity and had transitioned to a male role four and fourteen years previously, and two cited a female gender identity and had transitioned to a female role six and twenty four years previously, suggesting that such limitations were not simply a feature of the difficulties of the period around transition itself, or that they were necessarily related to gender role/identity.

Counsellors or psychiatrists were rated as of the highest importance by over a third of respondents (eight of twenty) to a question regarding the value of sources of advice and support regarding a health problem or disability linked with being transgender.

A three way cross tabulation indicated that all four of the respondents in a current male gender role, and with a male gender identity, rated close friends in the three highest categories for support with health problems linked with being transgender. Conversely none of the four respondents in a current female gender role and with a female gender identity rated close friends in the three highest categories, while three of the four respondents actually rated them in the three lowest categories.

Similarly, a further three way cross tabulation indicated that three of the four respondents in a current male gender role and with a male gender identity, rated family members in the three highest categories for support with health problems linked with being transgender, (with the remaining

respondent rating family members in the three lowest categories for such support). Conversely, three of the four respondents in a current female gender role and with a female gender identity, rated support from family members in the three lowest categories.

47% of participants of survey one, and 38% of participants of survey two were living alone. A three way cross tabulation of current gender role, home circumstances and gender role preference (survey one), indicated that eleven of the twelve people living alone in a female role had changed their gender role to match their gender identity, while only one of the four people living alone in a male role, had done this.

41% (eleven of twenty seven) of respondents to survey two said that they would greatly value advice, information and support from a suitably trained and experienced social or care worker to help address social isolation linked with being transgender. Six of twelve respondents currently in a female role said that they would value this advice greatly compared to three of ten respondents currently in a male role. 58% of biological males (seven of twelve) and 20% of biological females (two of ten) said that they would value this information greatly. Nine of twenty seven respondents had either received such support in the past, or were receiving it at present, from a social or care worker, or from another source.

(It should again be noted that including those who would value each area of assistance 'a little' reduced these differences between biological males and biological females considerably)

Just two of twenty nine participants said that they had not experienced social isolation linked with being transgender.

Eighteen of forty seven (37%) respondents to survey one said that they had a long-term mental health condition, and fifteen of forty seven (32%) said that they had a long-term illness, disease or condition, but just seven of forty one (17%) respondents said that they were receiving support for such long-term problems. The percentage of biological females with a mental health condition (41%) was higher than that of biological males (24%). Five respondents currently living in a male gender role, seven in a female gender role and five in a transgender role said that they had a mental health condition.

The percentage of biological males with a long-term illness (24%) was the same as that of biological females despite the biological male to female ratio being 2:1 (26:13). However, just one person in a male gender role, but nine people in a female gender role, and two each in a transgender or 'other' gender role said that they had a long-term illness suggesting that a higher proportion of biological females with long-term illness were pre-transition.

These were very high numbers when compared with the S.H.S. (Scottish Government, 2013) figure of 5% who are 'permanently sick or disabled'. Because of this, although this series of questions attempted to separate transgender related difficulties from apparently non-transgender related disabilities, it seems that at least some may be gender identity/ transphobia/transition related, with implications for both social and health care.

Biological males with mental health conditions tended to be in an older age group (46 to 55) than biological females with mental health conditions (16-25).

GP's were rated as of the highest importance as a source of advice and support regarding long-term physical or mental ill health, disability or problems related to old age, by almost half of respondents (nine of twenty one), with mainly positive ratings indicated by both those who had transitioned to a male or a female gender role. Counsellors or psychiatrists also received mainly positive ratings by both those in a male or female gender role.

A three way cross tabulation indicated that each of the three respondents in a current male gender role and with a male gender identity rated close friends in the three highest categories for support with long-term health issues. Of the nine respondents in a current female gender role and with a female gender identity, four rated close friends in the three highest categories, with the remaining respondents rating them in the three lowest categories.

Of the seven main categories of social care services indicated, seven participants were receiving or had received welfare benefits and homelessness advice, and eleven participants were receiving or had received support relating to mental illness, physical or learning disability, or to domestic or societal abuse. Five of nineteen social care service users said that their transgender status was affecting the quality of their social care. Five further respondents were unsure of this (survey one).

Six respondents (all biological males, mostly in older age groups) to survey one provided social care support to others. Five of these were living currently in a female role, and one was living in an 'other' role.

### **Service Development/Potential Additional Support: Transgender and Society**

The research findings on family responses to a family member coming out as transgender or transitioning, vary widely from 'I do have a very supportive family' (*Andrew*) to 'I don't think they want to even acknowledge me as a family member' (*Sarah*). From the perspective of support to



others, it was not uncommon to find that 'none of my family received support' (*Ciaran*). In this section, ideas are explored for how services to families might be developed and improved, using the social care literature for models of service provision.

Murgatroyd and Woolfe suggest that working with a family is very different from working with an individual because 'families have their own dynamics, their own structures and strategies and their own 'games' by which the contributions of the individuals within the family are mediated' and, in discussing 'the role of a helper in a family crisis' they suggest that 'an event ... may be perceived as a crisis by one family but as a hiccup or a non-problem by another family'. Most families learn from earlier experiences and develop 'anticipatory coping skills' but for the family faced with the news that one of their members is transgender (or has changed or is changing gender role imminently), there may be little time to adjust and to use existing coping resources (1985: 5, 119, 126).

Brown and Rounsley explain the background to such a crisis when they describe how 'most transsexuals reach the point where their gender dysphoria dominates their lives to such an overwhelming extent that daily functioning becomes difficult if not impossible ... debilitating depression often sets in ... they cannot ignore or deny their gender dysphoria any longer: something has to change'. They describe how 'the news is especially hard for family members and close friends to accept – they are usually profoundly confused and distressed ... the old rules no longer apply' (2003: 5, 96).

Lev suggests that 'a few clinicians have noted that families of transgender people move through a (four) stage process that is as predictable as the one Kubler-Ross outlined in her work with patients addressing issues of death and dying'. The four stages are described as 'discovery and disclosure' (usually involving a sense of shock, betrayal and confusion), 'turmoil' (a time of intense stress and conflict), 'negotiation' (including adjustment, compromise, and recognition of new limits of gender expression), and 'finding balance' (being ready to integrate the transgender person back into the normative life of the family – which may or may not involve transition at this stage) (2006: 267, 269). By helping a family to recognise these four stages a care worker might be able to identify where the family has reached in coming to terms with the presence of a transgender member, and to clarify how best to assist them, as a group and as individuals, to progress their acceptance of new developments.

That family support will vary according to the individual family member's relationship with the transgender person is another factor which social care support may need to address. The support needs of the partner of a transgender adult or of the parents of a transgender child or adult are

likely to be rather different from each other. Similarly the needs of siblings, and of members of the more extended family such as grandparents, aunts and uncles, cousins, nephews and nieces may vary (additionally perhaps according to the gender or age, and other factors including religion, of the family member and transgender person).

Whilst consideration of family needs has been dealt with generally so far, it is important to consider the needs of partners of children of a transgender person separately, for they are likely to be the most vulnerable close relations, and their needs, coping mechanisms and the long-term effects of transition on their relationships have been inadequately researched to date.

The research findings indicated that the need for partners to receive information and their own separate support too is likely to be a factor prior to, during and post-transition. Cohen et al note that 'the process of adjustment for spouses of GLBT people involves three general stages: shock, anger and confusion (prior to) reintegration' (although these stages perhaps pre-suppose a lack of openness from the transgender partner about their gender identity earlier in the relationship, which may not always be the case). 'Intimate partners of transgender people go through a complex process of making sense of their partner's gender transitions (sic). In the case of transsexuality, the expectations and conceptions that intimate partners hold concerning the identity of their transsexual partners are deeply challenged as they see their physical and other transformations' (2006: 164/165). Cohen et al quote Davis (2002) who notes that 'those who lived with their partners during the pre-transition period found the transition process confusing. Thus they frequently continued to see their partner in their gender of birth, or in some unique combination of masculine or feminine characteristics ... intimate partners must also re-examine their own sexuality in light of the revelation of their partner's transsexuality ... ultimately while some relationships dissolve, many non-transsexual partners remain involved as co-parents, non-intimate partners, or intimate partners' (2006: 165). In addition, Benvenuto explains how 'outsiders' question the sexual orientation of a transgender person's partner, (2012: 236), so that a potentially painful examination of one's sexuality may be both personally and publicly undertaken.

The sexuality of the transgender person may also be an issue for themselves too: Lombardi and Davis suggest that self-acceptance as a non-traditional man or woman (2006: 358) and forming (or adjustment within existing) intimate and family relationships are also important stages in post-transition acclimatization (2006: 358). Sexuality may form part of this exploration of intimacy, given the questioning of sexual orientation that gender role transition may bring to the transitioned individual. In addition to seeking to resolve gender dysphoria through gender reassignment,

Coleman et al (1993) suggest that 'transgender individuals go through a second developmental process, for sexual identity'.

Barrett notes the distinction between heterosexual (biologically male) transsexuals and 'a rather smaller proportion of' homosexual transsexuals, whose pre-transition sexual paths differ considerably (and whose post-transition prognoses are likely to differ somewhat too. He compares these experiences with biologically female transsexuals for whom 'most have either no history of sexual relations with males, or report a single episode of such sexual interaction' and whose 'relationships with other women can be subdivided into those with heterosexual and homosexual women' (2007: 19, 22/27). The NHS/Glasgow University 'Scottish Transgender Survey' found that 'none of the transmen had been married or had children, but two thirds of the transwomen had been married and half had children' (Wilson et al 2005: 2).

From a child's perspective, Brown and Rounsley suggest that 'the impact (of disclosure of transsexuality in a parent) is largely dependent on their parents and possibly the immediate family. If adults in their environment are bitter or hostile about the situation, angry at the transsexual, and secretive, as if shielding others from some despicable or criminal act, children are without a doubt negatively affected. They can become depressed, anxious and conflicted'. They note that 'as a rule, prepubescent kids can handle the transition well as long as the other parent and family members don't undermine the transsexual parent (but that) if kids are adolescents ... it can be more difficult to deal with'. That fear of losing friends, or being the focus of gossip, or of embarrassment or shame might also extend to a sense of anger and depression suggests that particular care needs to be provided by supportive professionals, of whom care workers may well be most experienced in family work, to ensure that the nature of a child's relationship with their transsexual parent is a potential topic for advice, discussion and support if needed (2003: 190/192).

Much of the above discussion has centred round the scenario of an adult transsexual person 'coming out' to their family, reflecting the findings of the research. However, before closing this section it is also important to recognize that some transgender children and young people make their condition known whilst still living at home and that there may be limited local support, exacerbated by the lack of G.I.C. support for them in Scotland. Brill and Pepper note the developmental stages of the transgender child, including the trauma of puberty and describe a process of family acceptance, 'from crisis to empowerment' (2008: 39/59, 64/71) which bears some similarity to that outlined by Lev above, and which might be valuable as a basis for social support to a transgender child and their family.

Similarly, within a detailed 'summary of recommendations for the clinical treatment of transgender and gender variant youth' Mallon includes a section on 'supporting transgender emergence in adolescence' which might also form a useful framework for social work support, (2009: 179/180). This, together with a comprehensive chapter which considers social work practice with transgender and gender variant children and youth (Mallon and DeCrescenzo, 2009: 65/86), provides a thoughtful account of the likely issues facing a transgender child, their family and their care worker, containing a section of recommendations or implications for practice which ends with the sobering thought that 'practitioners must accept the reality that not everyone can provide validation for a transgender child or teen. Some will simply not be able to understand the turmoil and pain transgender children and youth experience. In these instances, practitioners must be prepared to advocate vigorously on behalf of these youths' (2009: 79/82,). However, follow up studies suggest that 'compared with the adult group ... adolescents function better psychologically (Kuiper, 1991). In addition, they appear to have far fewer social problems and they receive much more support from their families and friends' (Cohen-Kettenis and van Goozen, 1997: 270).

A care worker may also be able to assist a transgender person by offering advice if their friends struggle with their being transgender or transitioning. It may be possible to assist the person in understanding how gender-orientated are many friendship based relationships and activities, and, if possible, to facilitate discussion with friends about how transition might affect the gender based nature of friendship, rather than undertaking direct intervention/conciliation per se to resolve such difficulties.

It may also be possible to assist a transitioned person in better understanding the nature of same-sex friendships for women and for men. Brown and Rounsley suggest 'women are more likely to maintain emotionally intimate and intense friendships with other women, whereas male friendships with other men are generally ... less intimate. As a result, a FtM transsexual who has been accustomed to having several very intimate friendships may suddenly feel quite lonely in the male world of friendship' (2003: 140). Conversely, a MTF transsexual may initially find it difficult to build up new relationships with women because they lack many of the experiences which women discuss together, perhaps compounding difficulties related to limited learning of female interactional skills too (Tannen, 1995).

One of the possible roles which a care worker may be able to take with a transgender person who is having problems with their colleagues or neighbours over being transgender or transitioning, may be to assist the person in evolving strategies to deal with a wide range of possible behaviours which they may encounter, including 'name slip ups, use of improper pronouns, distancing ... even

harassment' (Brown and Rounsley, 2003: 157), rather than undertaking direct intervention or conciliation per se to resolve difficulties. Understanding the difficulties which neighbours, colleagues and acquaintances perceive in dealing with what is likely to be a unique situation to them too, may indicate possible strategies which might be explored and adopted.

As has already been noted, not all individuals, particularly in rural Scotland, have access to a local transgender community even if online support can be found. Possible social care support might be provided here through 'affirmative practice' in building upon a goal orientated 'framework of cultural competence and empowerment practice' (Morrow and Messinger, 2006: 460, based on the work of Solomon (1976)). Although this notion of cultural competence and empowerment is likely to be a difficult one for many newly transitioned transgender people who, in the space of a few days or weeks seek to appear gender competent within their transitioned role, a structured approach to affirmative practice may form the basis of mid to long-term plans for those who have begun to establish themselves in this role, and for whom the support of the G.I.C. is no longer an option.

It is not difficult to visualize a role for a trained and experienced care worker in supporting a transgender person on these wider issues, particularly in the absence of other support systems, by developing pro-active strategies to cope with a lack of understanding in others, or with the discrimination, harassment, bullying and other forms of transphobia described by research participants. Regular discussions with a care worker may also help a transgender person to gradually address an ongoing sense of loss linked with being transgender or with undertaking transition, while recognizing that GPs in particular are likely to continue to provide the main sources of support for the transgender person's physical and mental health, with the additional input of psychiatrists and counsellors for these latter issues.

The role of the care worker in building up self-image and self-confidence is likely to be a slow one, but a facilitative role in developing a greater community presence for a transgender person, for example in taking on a (part-time) job, or in social or further educational activities, will also be an important aspect of such work too. A care worker might also be able to find an 'ally': Messinger quotes Washington and Evans (1991: 196) who, in relation to gay, lesbian and bisexual people, define an ally as 'a person who is a member of the dominant or majority group who works to end oppression ... through support of, and as an advocate for, the oppressed population' (2006: 468). To this notion of advocacy might be added the dimension of accompanying the transgender person on early excursions when they are at their most vulnerable. It may be possible for the ally to advise on matters of dress, demeanour etc., if the non-transgender ally is of the same gender as that to which a transgender person is transitioning/has transitioned. Indeed it is also possible (based on

Comstock's findings regarding the effect of a companion on violence to gay men and lesbians), that the presence of a male or female ally may reduce discrimination and displays of transphobia to a transgender person (1992: 65).

Self-consciousness and uncertainty about appearance and behaviour may affect self-confidence and ability to relax in public and 'be oneself'. Indeed the notion of 'who' one is, is probably more of an everyday issue at transition than at any time since adolescence. Facilitated supported social interactions may provide welcome opportunities to practice newly acquired social skills appropriate to the transitioned gender. However additional social care support may be required to assist with coping with persistent transphobia, societal rejection or social isolation. It is not difficult to visualize a role for a trained and experienced care worker in supporting a transgender person to cope with harassment, bullying and other forms of transphobia by developing pro-active strategies, to counteract the 'daily trials' noted by Bockting et al (2006: 70) and which may limit day to day activities significantly, by facilitating 'safe' trips for the transgender person into the community.

The care worker role might be mainly to link a transgender person with an ally/volunteer, and to offer support to both, individually or together, as social ventures are planned, undertaken and evaluated. The support of an ally in social situations may therefore be of importance in the development of a (post transition) gender role (and, reflecting the notions of performativity expounded by Butler (1990), it may also aid the consolidation of some transgender people's sense of themselves as male, female or transgender – or at least their success in masculine or feminine patterns of behavior). It may be possible that funding for an ally's expenses may be undertaken through a self-directed support scheme as outlined in more detail above in the section on transgender and social care.

Avis in the context of interviewing has described succinctly 'a construction of character that conveyed confidence and credibility' (2002: 195). Even if, at times, this may feel reminiscent of the 'act' they used to perform in their former gender, the very act of performing confidently may have a significant effect on both a transgender person, and on those with whom they interact.

## Discussion and Conclusion: The Socializing of Transgender

Hird, in an article on a 'Sociology of Transsexualism', suggests that 'it is the possibility of transcending sex and gender altogether that offers, from a sociological perspective, the most interesting possibilities' (2002: 591). A similar point of view is expressed by McKenna and Kessler who suggest that transcending gender is 'of greatest importance to gender theorists like us who are interested in the possibility, both theoretical and real, of eliminating gender' (2006: 349). Namaste, however, takes a very different, pragmatic perspective: 'transgender discourse is utopian and one profoundly informed by privilege: it assumes that one already has a job, housing and access to health care (it is only) when all of these things are in place, then it is perhaps possible to move through the world in some kind of genderless state, or some state beyond gender' (2011: 28). The importance of work, home and health is expanded on by Abbott, who quotes Morris in her perception of the apparent ubiquity of gender issues confronting transgender people: 'there seems to be no aspect of existence, no moment of the day, no contact, no arrangement, no response, which is not different for men and women' (2000: 140).

The research findings have indeed shown that some respondents have been willing to, or have needed to explore fundamentally their concepts of sex and gender, as a way of coming to terms with their own sense of identity, of finding a place, a status, which reflected their sense of themselves as usually quite different from how they had been perceived in the past. The research explored the potential role of carers within statutory and voluntary sectors, and formal and informal networks, in assisting transgender people, and in particular migrating transsexual people, to find such a sense of identity, such a social role and status, such a niche in which to live.

The evidence from the research aids in understanding the difficulties in finding such a coherent sense of being, by considering current social care concerns, and the sources (and gaps) in social care support to transgender people across four key areas: transgender support groups; G.I.C. support; GPs, counsellors and psychiatrists; and family and friends.

Transgender groups play an important role currently in supporting individuals, for, as the research indicates, they were rated as the most highly valued source of support regarding gender identity and transition issues by over a third of participants. Surprisingly perhaps, this support was rather more likely to be valued by respondents with a male gender identity than those with a female gender identity. It should also be noted that group support was recognised as being a necessary additional service in many parts of Scotland by both voluntary and statutory sector respondents. Transgender

groups were also rated as of the highest importance by over half of respondents for assistance with changing documentation.

It might be anticipated that G.I.C support would be most appreciated for gender and transition related issues. However, such support received very mixed evaluations, with only slightly more respondents rating G.I.C. staff as of highest importance as of lowest importance. A tendency was also apparent for those with a female gender identity to value G.I.C. support more highly than those with a male gender identity.

Counsellors and psychiatrists also tended to be rated as of highest importance for support with transition issues by those with a female gender identity, rather than by those with a male identity. They were also rated very highly for support with a health problem or disability linked with being transgender by over a third of respondents. GP's were rated most highly by almost half of respondents with more generic long-term physical or mental health issues, disabilities or problems linked with old age.

Family and friends tended to be rated more highly for support with gender identity and transition issues by those with a male gender identity, than by those with a female gender identity. No clear single source of support to families was apparent, though five respondents rated transgender support groups highly for this. Support from family members and close friends tended to be more highly rated by those with a male gender identity than by those with a female gender identity.

Around a half of respondents said that they would value social care support with addressing concerns and difficulties across a wide range of transgender related social issues, including aiding an understanding of gender identity and being transgender, during a gender role transition, support to family members and to help address discord with family/friends/colleagues/neighbours, to change documentation and to apply for a G.R.C., to address social isolation and rejection, and to aid community integration.

Further analysis and comparison of these responses demonstrates moderate, strong or very strong correlations between each of these social care issues for which assistance would be valued, though low respondent numbers prevent meaningful correlation data from being calculated in all cases. An average of 76% of respondents who said that they would greatly value advice on one issue said that they would also value advice on other issues.

It seems that some of the sources of social care support noted above may be ideally placed to meet at least some of these social care needs for some individuals, but few sources of social concern appear to be adequately addressed for most transgender people. There is a demonstrable need to



supplement current medical, statutory and voluntary sector contributions to transgender care for many of the transgender people who live and undertake transition in Scotland.

The gaps in social care within the support provided during a largely medically monitored transition process, appear to reflect a continuing emphasis on the medical aspects of transgender. By this process the symptoms of gender dysphoria appear to have become indicative an illness that is then, to a greater or lesser extent, 'cured' by surgical intervention, creating a body reflecting as closely as possible that appropriate to an individual's gender identity. An increasing sense of the inadequacy of medical practice to counterbalance the effects of genes and hormones, particularly in the embodiment of post-pubertal, migrating, transgender people, has subsequently led some to question the primary role of medicalization in providing a resolution for gender dysphoria. Namaste, affirms that 'transsexuals have also objected to a strictly biomedical approach to health at (the gender clinic), one neglecting the important social dimensions of gender transition' (2011: 30).

Although Pfäfflin and Junge's follow-up review 'of approximately two thousand persons who have undergone sex reassignment surgery' concluded that 'gender reassigning treatments are effective and that positive ... desired ... effects outweigh continuously ... negative or non-desired effects', they also noted that the results with (FtM people) are, on average somewhat more favourable than those with (MtF people)' (1998: 1, 39). Similarly Kuiper and Cohen-Kettenis report that 'virtually all FtMs and almost 80% of the MtFs describe integration as good or very good by their own standards (1988: 446). Overall, outcomes of follow up studies suggest that being older, MtF, and/or previously heterosexual puts individuals more at risk of loneliness and isolation post-transition, leading to a more likely need for support, than those who are younger, FtM, and/or previously homosexual.

Of particular relevance to the present research, are many of the findings by Kuiper and Cohen-Kettenis relating to a positive correlation between subjective post-transition well-being, and ten variables: 'employment, acceptance by family, partnership, sense of loneliness, satisfaction with relations in general, gender role behaviour, integration of new gender role in day to day life, general satisfaction with sex life, certainty about one's own gender identity, and suicidal attempts' (1988: 452). To these might be added coping with the consequences of ageing and of ethnicity.

Dhejne et al's recent follow-up study concludes that gender reassignment will still leave some transgender persons facing 'substantially higher rates of overall mortality, death from cardiovascular disease and suicide, suicide attempts, and psychiatric hospitalisations ... compared to a healthy control population' (2011: 7). They conclude that 'improved care for the transsexual group after the sex reassignment should therefore be considered' (2011: 7). Such studies provide

compelling evidence that social care should take its place alongside medical care to address and compensate for social factors which may underlie post-transition difficulties.

Dietert and Dentice, in an article exploring 'Growing up Trans: Socialization and the Gender Binary' discuss the difficulties within relationships of interviewees as children, with their mothers, fathers and peers, as they sought to express their feelings about their gender, while experiencing 'mainstream social constructions of gender (which) demand conformity by adhering to only two choices of gender identity' (2013: 24). That the findings of much of the present research into social care support suggest that gender role socialization in adult transgender people may be similarly difficult and potentially disruptive to close relationships, further evidences the need for targeted advice, support, consideration and understanding within the post-transition adult socialization process.

A further role of social care agencies might also be to include information sharing and advocacy on a wider scale to promote a greater awareness of the needs of transgender people. Indeed, Burdge argues that it is the responsibility of 'social workers to target society's traditional gender dichotomy for change' (2007: 243).

It is therefore concluded that a combination of social care support and advocacy on behalf of transgender people, working towards the socializing of transgender on both an individual and a generic level, is necessary to supplement and counterbalance the medicalization which has dominated the treatment of transgender since the middle of the last century. This would not replace medical support of course, for the need for surgical intervention is likely to remain for many, and perhaps most, migrators, but it is proposed that care services should also supplement medical support through social care assistance to individual transgender people during the socialization phase of transition and beyond, through the planning, development, funding and provision of the wide range of additional social care support to individual transgender people that is suggested within the service development sections of this report, and by supporting the establishment of a transgender legal status separate from male and female categories, as a further step towards a greater understanding and acceptance of transgender people in Scotland.

As one interviewee commented:

**Lucy:** 'I think a trained social worker would be a good step as a means of de-medicalizing our condition. It is something that should be out in the community and not in a doctor's surgery. It is all about life skills and choices'.

## **Appendix: Estimated Scottish Transsexual Population by Council Area**

A comment by one of the statutory sector survey respondents within the research findings had indicated that 'we don't even know how many transgender people are within our population'. Another comment had suggested that 'given that I work in a small authority with a small population ... it would be beneficial for 3/4 authorities to work together to provide dedicated specialised services for transgender people and their families'.

This appendix explores evidence that the population of Scotland might contain sufficiently small numbers of transgender people to justify such a pooled approach to service provision.

Taking the estimates of incidence and prevalence of transsexual people in Scotland of between 429 (one in 12,225) and 1,051 (one in 5,000) individuals, using the parameters of Wilson et al's (1999) survey data based on doctors' knowledge of transgender patients who had presented with gender dysphoria, and the 2009 GIRES figures (Reed et al, 2009: 4) based on estimated prevalence taking into account those who had undertaken transition in the U.K., and using the population of Scotland of 5,254,800 at June 2011 (General Register Office 2012a), it is possible to estimate the numbers of transsexual individuals who might be present in each Scottish Council Area.

These figures suggest that estimates of very small numbers of transsexual people living in some Council areas may indeed support a notion of pooled resources within neighbouring statutory and voluntary agencies. That many of the transsexual people in Scotland may be found in the larger cities is statistically likely: Glasgow City with a population of 598,830, and Edinburgh with a population of 495,360 in 2011 (General Register Office, 2012a) together might account for approximately 20% of the overall transsexual population of Scotland (estimated at some 90 to 219 individuals) – perhaps more if some people have migrated to these cities in search of anonymity or for the support of transgender groups and/or gender identity clinics.

It is of course not known how many additional individuals across Scotland maintain privacy about their gender dysphoria or do not seek support during transition, nor is it known how many other transgender people there are in Scotland who are not transsexual. Whilst this evidence appears to support the notion of voluntary and statutory organisations in adjacent, smaller Councils working together to develop and provide services, it is also important not to underestimate the potential need for additional services to transgender people in Scotland, particularly if, as may be likely, the incidence of visible transgender people continues to rise (Gires, 2011).

### Table of Estimated Scottish Transsexual Populations by Council Area

Extrapolation from Estimated Incidence of Transsexuals from Wilson et al\* (1999) (1 in 12,225) and Estimated Prevalence from Reed et al\*\* (2009) (1 in 5000)

	Population	Estimated Transsexual Population (based on Wilson et al*)	Estimated Transsexual Population (based on Reed et al**)
Aberdeen City	220,420	18	44
Aberdeenshire	247,600	20	50
Angus	110,630	9	22
Argyll and Bute	89,590	7	18
Clackmannanshire	50,770	4	10
Dumfries/ Galloway	148,060	12	30
Dundee City	145,570	12	29
East Ayrshire	120,200	10	24
East Dunbartonshire	104,570	9	21
East Lothian	98,170	8	20
East Renfrewshire	89,850	7	18
City of Edinburgh	495,360	41	99
Na h-Eileanan Siar	26,080	2	5
Falkirk	154,380	13	31
Fife	367,370	30	73
Glasgow City	598,830	49	120
Highland	222,370	18	44
Inverclyde	79,220	6	16
Midlothian	82,370	7	16
Moray	87,260	7	17
North Ayrshire	135,130	11	27
North Lanarkshire	326,680	27	65
Orkney Islands	20,160	2	4
Perth and Kinross	149,520	12	30
Renfrewshire	170,650	14	34
Scottish Borders	113,150	9	23
Shetland Islands	22,500	2	5
South Ayrshire	111,560	9	22
South Lanarkshire	312,660	26	63
Stirling	90,770	7	18
W./Dunbartonshire	90,360	7	18
West Lothian	172,990	14	35
<b>TOTAL SCOTLAND</b>	<b>5,254,800</b>	<b>429</b>	<b>1051</b>

(Source: General Register Office, 2012a Scotland: Mid-2011 Population Estimates)

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