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The University of Edinburgh
School of Social and Political Science

'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 Thesis Submitted for the Degree of Doctor of Philosophy
to the
University of Edinburgh

by

Kate Norman

June 2015

Declaration Page

The work contained within this thesis has been undertaken by myself and is entirely my own.

No part of this thesis has been submitted for any other degree or professional qualification, with the exception of extracts within the literature review and methodology sections which were originally included within the research proposal for this thesis, submitted in 2010 to the School of Social and Political Science, University of Edinburgh, for my MSc (Research).

Kate Norman

26.06.15

Abstract

A paucity of knowledge of social care services to transgender people in Scotland led to this research. Medical and social care services take very different approaches to the needs of migratory transgender people. The research design involved online questionnaires and interviews with statutory service commissioners and providers, and with voluntary organisations and transgender people themselves. A framework of three research questions underpinned the research, firstly looking at the nature of dedicated and generic support services in Scotland, secondly exploring assistance relating to transgender identity and status, and thirdly considering additional support to transgender people within their relationships and their communities. Data analysis was influenced by grounded theory in the development of themes and sub-themes which structured the research findings.

The research findings indicate limited planning, guidance, training and policy development to facilitate access to generic services by transgender people. Dedicated service provision was found to be often limited to adults during transition whilst transgender children and young people, and family members including partners and parents, received limited support. A range of alternative sources of support, 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, transition, family support, documentation, transgender linked mental health problems and with long-term physical or other mental ill health issues. Approximately half of transgender respondents indicated that social work advice and support would be valued for each of the above categories, 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.

The thesis concludes with a proposal 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 and the adoption of a transgender legal status, and through the provision of the wide range of additional social care support to transgender people noted above, particularly during the socialization phase of transition and beyond.

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The research was aided by the support and cooperation of the Scottish Transgender Alliance who gave feedback on the draft versions of the questionnaires, and who facilitated their circulation to transgender people and transgender organisations across Scotland. Particular thanks are due to James Morton and Nathan Gale for their assistance in these matters. I must also acknowledge the support of the members of Tyne Trans who assisted in the pilot study which preceded my research in Scotland. I am very grateful to Lesley Horne who facilitated the circulation of the questionnaire to each Scottish local authority via the A.D.S.W. Contracts Officers Group, and who, together with Andrea Beavon, gave valuable feedback on the draft version of this questionnaire. Thanks are also due to Joanna Smith, whose conversations over the five years of the PhD have aided me in maintaining momentum and focus, and whose positivity helped to counter some of the seemingly unreasoned and unreasonable criticism of transgender people which I have encountered.

I am very grateful to the forty seven transgender people who completed survey one, to the twenty seven transgender people who completed survey two and to the twenty people who completed survey three on behalf of statutory and voluntary agencies. I am also deeply grateful to the nine people who contributed interview material from the statutory and voluntary agencies, and to the ten transgender people who took part in online interviews. Each of these contributors remains anonymous of course despite often offering very personal and thoughtful insights which enhanced the research findings considerably.

ai i miei due cari figli che sono vicini a me a tutto quello che faccio...

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Glossary of Terms Used in the Thesis

These necessarily simplified working definitions are based on my own understanding of the meaning of each term, with reference to a range of texts. In most cases the complexity of their potential meanings is explored more deeply within the literature review and within the research findings.

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 or female-typical (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, or for reasons associated with fetishism or exhibitionism or to work in the role of the opposite gender, but usually without the intention of permanent migration to that role.

Gender: The state of being male or female, 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 their 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, usually 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 fit 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 sexual development and differentiation *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 (see Ekins and King: 2006).

Negator: A sub-division of transgender: a person who seeks to erase their former gender characteristics (physical and behavioural) in order to 'ungender' (see Ekins and King: 2006).

Oscillator: A sub-division of transgender: a person who undertakes cross-dressing but for whom this always implies the intention to return to the original gender (see Ekins and King: 2006).

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 gender reassignment surgery.

Sexuality: A person's sexual orientation or preference.

Social Care: The provision of paid or voluntary support necessary for the welfare, maintenance and protection of someone, by an individual, group, or organisation within the community.

Transcender: A sub-division of transgender: a person who seeks to move beyond binary gender categories (see Ekins and King: 2006).

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 the 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 violence.

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' above.

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

Introduction

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 some transgender subcategories should indeed be very familiar to many, having received much media attention in recent years.

Many transgender 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 initial journeys across the binary gender divide are usually part of a desire to live permanently in the opposite binary gender role, with the assistance of hormonal and/or surgical interventions. They are perhaps better known by the more generally used term transsexual, but the significant attention which they have received in recent decades from the media should not overshadow other transgender people who live largely 'hidden' lives within society, perhaps privately cross-dressing, but with however, no intention of living permanently within an opposite gender role, or bending gender rules to reflect their own personal sense of a gender identity which may not fit within conventional binary norms.

Medical perspectives, and the medicalization of transgender diagnoses and treatments have tended to dominate consideration of many transgender matters from the early 1950's to the present day, even as groups and individual transgender people began to question the authenticity of a medical diagnosis and treatment for their condition, in particular from the latter part of the twentieth century onwards. As indicated within this thesis' literature review, health service provision to transgender people tends to centre around those transgender people who are planning to, undertaking, or who have recently undertaken gender transition, within a medical model which largely eschews social care support.

There appears to be very little evidence of whether and how social care services support transgender people who are preparing for or undertaking a gender based transition or those who have received assistance with reassignment in the past but who are still perhaps adapting to its long-term consequences. In addition little is known of those transgender people who do not seek hormonal and/or surgical treatment at all but need social care support as age or disability takes its toll, in order to remain as independent as possible.

Preparations for this research began within the research proposal which formed the basis of my MSc (Research) (Norman, 2010). This research proposal originally sought to explore 'transgender people's experiences of health and social care provision in Scotland', but following further consideration of the paucity of evidence relating to how social care services are provided to transgender people, it was decided to restrict and concentrate the research to 'social care and transgender people in Scotland'.

It has therefore been the central purpose of the research described in this thesis to identify and evaluate both social care needs and support networks for transgender people across Scotland. This has been carried out through three online surveys and nineteen online interviews, with commissioners/service providers and with transgender people themselves, clarifying support that is currently in place to meet identified needs, and identifying gaps where transgender people's social care needs are being inadequately met within current service provision.

The thesis begins with a detailed review of a wide range of relevant literature which considers the nature of transgender and its place in modern society, within current notions of biological sex, gender, gender identity and gender roles. That transgender people may be the subject of transphobia and hate crime is also explored, within a discussion which considers why the gender binary plays such a powerful role in alienating those who do not conform to such a normative factor, affecting both how people behave, and how they think about both themselves and others. Additional information on legislative perspectives, reassignment surgeries and the Scottish Protocol for gender reassignment, and follow up studies on transitioned transgender people, is contained within separate appendices to the thesis, together with comprehensive summaries of all the research findings.

The chapter on the methodology of the research explores the reasons for undertaking the mixed research methods of online surveys and interviews, within a consideration of values and ethical issues underpinned by a constant sense of reflexivity.

The overall aim of the research was to address the paucity of knowledge of social care service provision to transgender people in Scotland, with the objectives of clarifying the types of services that are available, needed and might be developed to good effect in the future. Three research questions elucidate the key objectives of the research, firstly looking at the nature of dedicated and generic support services in Scotland, secondly exploring

assistance for transgender issues linked with gender identity and status, and thirdly considering support to transgender people in addressing relationship difficulties with family and friends, at work and within their wider communities.

Because the majority of the transgender respondents to the surveys and interviews which formed the framework of the research described themselves as transsexual, or described their experience of or need for gender reassignment, much of the material within the research findings chapters centers round this group of transgender people, although where possible and appropriate, the needs of other transgender people are also reflected

That social care may be provided by organizations, through paid members of staff, through volunteers and by friends and family, is reflected in those aspects of the research which sought to understand if and how health and social care organizations, transgender networks and family and friends provide care and support to transgender individuals. Proposals for service development and additional support to transgender people are incorporated within the discussion chapter, which also reflects on how transgender individuals themselves might seek more empathetic and personalized support within currently available service structures.

The thesis concludes by proposing a re-balancing of the historical systematic 'medicalization' of transgender by a process of the 'socializing' of transgender, through advocacy work seeking greater understanding and acceptance of transgender people, and through the provision of the wide range of additional social care support to individual transgender people that is suggested by the research findings, during the socialization phase of transition and beyond,.

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Introduction

The first section of this review of the literature relating to research into social care and transgender people addresses a number of theoretical concepts, beginning, perhaps most essentially, with the term 'gender' itself. The notion of gender 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 ask whether, why and how gender is distinct from sex and sexuality. The notion of intersex is also explored, because of the additional understanding it brings to the nature of sex itself.

The social status of transgender people, including their non-acceptance through rejection which may be linked with transphobia and hate crime, is considered within the second section of this review by exploring the reasons why transgressing the gender binary appears to so often provoke discomfort and even disdain in others.

As noted within the introduction to this thesis, support for many transgender people has mainly been within a medical model and this is reflected within the third section of this literature review. That medical interventions for transgender people do not meet all of transgender people's needs is an implication of the subject of this research, and so this literature review also explores research into social care provision to transgender people too.

Gender, Transgender, Sex, Intersex, and Sexuality

Sex and Gender

The notion of gender, the state of being male or female, has been addressed by a wide range of researchers and writers, some of whose thoughts and ideas are explored in this initial section of this literature review. However, as Jackson and Scott note, 'prior to the 1970's ... for the most part sociologists studied the world of men, as if men constituted the whole of society (which) not only rendered women invisible, but also concealed the gendered characteristics of men's social locations, activities and identities' (2002: 1) and that 'women were absent not only from sociological research but also from the contexts in which such research was undertaken' (2002: 28).

Connell suggests the need for an integrated approach to the study of gender, moving 'across conventional boundaries between academic disciplines' and drawing on 'a spectrum of the human sciences, from psychology and sociology to political science, cultural studies, education and history' (2009: xiv). Whilst it is not possible within the available space to fully consider the extensive literature on gender, from, for example, psychological, sociological and feminist perspectives, a range of such sources and concepts has been touched on, where it is believed that these aid an understanding of both gender and, as importantly, notions of transgender which underpin this thesis. This exploration attempts to clarify the differences between gender as an external perception or attribution ('that person is (or appears to be) female') or as an inner identity ('I am (or I think that I may be) female'), and whether being a 'man' or a 'woman' is the same as being 'male' or 'female', beginning therefore by comparing notions of sex and gender.

Bradley notes that writers in the 1960's, and in particular Stoller in his book 'Sex and Gender' (1968), originally made the distinction between gender ('socio-cultural aspects of being a man or woman') and sex ('the base of biological sex differences') (2007: 15, quoting Andermahr et al, 2000). Byne, from a clinical perspective, details Stoller's distinction further when he suggests that 'sex refers to the state of biologic (sic) variables that can be described as either male-typical or female-typical in normatively developed individuals (e.g. genes, chromosomes, gonads, internal and external genital structures, hormonal profiles)' (2007: 65/66). The validity of such an apparently straightforward distinction between the

sexes, and indeed this apparently straightforward distinction between gender and sex remain, however, much discussed.

Byne concurs with Bradley's perspective that gender refers to 'factors related to living in the social role of a man or woman' whilst adding that gender also refers to the *social categories* of man or woman, boy or girl (2007: 65/66, italic added). Connell notes the advent of the use of the terms 'sex role', 'male role' and 'female role' in the 1940s leading to a large increase in sex role research by the 1970's so that 'sex role theory rapidly became the theoretical language of feminist reform'. She also notes ensuing disenchantment with the concept of 'sex roles' 'because they missed the significance of power in gender relationships' (1987: 30, 33, 34), by substituting 'a theory of norms' which led to 'an abstract view of the differences between the sexes' with a 'dependence on biological dichotomy' (1987: 50, 51, 53).

Herdt reflects Rubin's (1975) view that the exaggeration of sex differences suppresses equality between the sexes, explaining that creating 'a taboo against the sameness of men and women ... dividing the sexes into two mutually exclusive categories ... thereby *creates* gender' (1996: 55). Elsewhere, Connell notes the 'careful critique' by Pringle (1992) which raises the concern that 'the masculine, was consistently more highly valued than' (the feminine) (2009: 58) whilst Bradley argues that 'the usage of the term (gender) has been persistently bound up with power relations between women and men' (2007: 4) and that Millett, Mitchell and Rubin in the early 1970's each linked 'the concept of gender to a theory of inequality and oppression of women. This was the theory of patriarchy' (Bradley, 2007: 16) although this term is now less widely used, in recognition of the narrowness of its definition (Jackson and Scott, 2002: 11).

Richardson refers to Delphy's (1993) view that 'gender is understood as a hierarchy that exists in society, where one group of people (men) have power and privilege over another group of people (women)' so that the 'social reproduction of gender difference is connected to gender inequality' (2008: 3/9). Connell partially explains this by noting a 'fit' between hegemonic masculinity, and emphasised femininity which implies 'the maintenance of practices that institutionalise men's dominance over women' (2002: 61). Delphy notes that 'the use of the singular ('gender' as opposed to 'genders') allowed the accent to be moved from the two divided parts to the principle of partition itself' (2002: 51) whilst Jeffreys further separates the notions of 'gender' and 'genders' when she describes

her perception of the transgender view which, she argues, 'depends for its very existence on the idea that there is an 'essence' of gender, a psychology and pattern of behaviour which is suited to persons with particular bodies and identities.' She contrasts this with 'the feminist view, which is that the idea of gender is the foundation of the political system of male domination' (2014: 1). Bradley cites the influence of Derrida in the reductionist argument that 'all forms of binary categorization ... are themselves oppressive, since they put limits on what we are expected, and thus able to do' (2007: 19), underpinning Jeffreys' perception of women as being placed within a subordinate class or 'sex caste' (2014: 5, after Millett, 1972: 275).

That women may have 'colluded in their own oppression' is commented on by Westwood who explains how both white and Asian women working in a stocking factory insisted 'upon their right to manage the home and their duty in working for their family' because 'to them, this was women's work, their *proper* work, which offered them a place at the centre of family life, and through that, status and power' (2002: 161). Within the home though, Delphy and Leonard explain that women may also 'contribute to their husband's work' and that this is 'most obvious when the husband is self-employed or runs his own business', whilst also 'doing most or all of the household work, which frees men not only for paid work, but also for ... voluntary work, sport, hobbies and socialising' (2002: 172).

Bernard indicates that the benefits for men of such a supported relationship are shown in 'the research evidence (which) is overwhelmingly convincing ... although the physical health of married men is no better than that of never-married men until middle age, their mental health is far better, fewer show serious symptoms of psychological distress, and fewer of them suffer mental health impairments'. Bernard goes on to explain that the picture for married women is very different: 'more wives than husbands report marital frustration and dissatisfaction; more report negative feelings ... marital problems ... consider their marriages unhappy, have considered separation or divorce, (and) have regretted their marriages' (2002: 209). She concludes that 'some of the shocks that marriage may produce have to do with the lowering of status that it brings to women. For, despite all of the clichés about the high status of marriage, it is for women a downward status step' (2002: 212).

On the other hand, as Cockburn observes, 'many men feel a sadness and an anxiety over their alienation from women and domestic concerns ... they suffer from the increased

independence of women and the growing volatility of marriage, which often removes their children from them'. She goes on to suggest that 'if they are to come closer, really share our lives, contribute their own labour of love (as opposed to their money) to child rearing, to the care of the ill and the elderly, to the sustenance of life, men will have to renounce their male sex right and with it their masculine identity as it is currently constituted' (2002: 190).

These notions of gender power, status and inequality are deeply relevant to an understanding of transgender, for, linked with gender inequality, the transition of transsexual people is likely to have an almost inevitably significant effect on their status with others. A note of caution is however necessary, for it may be difficult to clearly distinguish whether such a change in status is consequential on visibility as transgender, or on the alternate binary role which may be adopted. For example, a MtF transitioned person may find their status reduced or questioned as a transsexual person (within both bi-gendered and within 'women's' spaces) and/or by their perception by themselves and others as female (whilst also perhaps coming to terms with a rather isolated life in middle age, when many MtF transgender people transition, without the company and support of a wife and family to which they have become accustomed, and perhaps dependent).

Conversely a FtM person may find that, as their transsexual visibility decreases, their status as a male increases. Amongst a series of examples of this, Fine notes that 'Ben Barres is a professor of neurobiology at Stanford University, and a female-to-male transsexual. In an article in *Nature* (Barres, 2006: 134) he recalls that "shortly after I changed sex, a faculty member was heard to say "Ben Barres gave a great seminar today, but then his work is much better than his sister's"" (2010, 54). That many FtM people tend to transition from relationships other than traditional marriages, with more likelihood of a background of a lesbian partner will be further explored within this thesis.

Transgender status should, by its very existence, disturb the gender binary (though some feminists, including Jeffreys (2014) disagree). Such a questioning of the binary is apparent within gender theory too, for as Connell concludes, a 'shift to a focus on variation' in gender theory was necessary, because 'both femininity and masculinity vary, and understanding their variety is central' (1987: 170/171). That more nuanced notions of gender and gender roles have developed significantly within a progressive social dynamic, since the inception and rejection of biologically based 'sex roles', is reinforced by Connell herself, who explains

that the notion of 'being a man or a woman ... is not a pre-determined state ... it is a becoming, a condition actively under construction' and goes on to say that 'this process is often discussed as the development of 'gender identity' (2009: 5). Similarly Byne distinguishes between 'gender identity' as 'one's sense of belonging to the male or female gender category', and 'gender role' which he suggests refers to 'behaviours (e.g. mannerisms, style of dress, activities) that convey to others one's membership in one of these categories' (2007: 66). Bradley notes that almost sixty years ago Parsons and Bales described how 'within the family in a capitalist industrialist society ... *instrumental* roles (were) carried out by men ... (who needed to be) 'aggressive, ruthless and intellectual' ... 'whilst the family also needed women to carry out *expressive* roles of caring and nurturing, looking after children and providing for people's physical and emotional needs' (2007: 16).

Such sex/gender roles, whilst clearly questionable as to their origins, purpose, value etc., are nonetheless relevant to the subject matter of this thesis because many transgender narratives make just such a distinction, often noting an early awareness of a conflict between inner gender identity and outer gender role. The concept of gender role is an important one within the transgender life story, underpinning the fundamental journey of transition that many transsexuals undertake, to establish a binary gender role which 'matches' their sense of gender identity. However this matching may not be viewed by others as valid (perhaps because of the absence of life experience within the new binary gender role, or because of a perception of over-conformity to the masculine or feminine stereotypes which, rather than undermining the binary, serve to reinforce it). Jeffreys claims that 'transsexualism opposes feminism by maintaining and reinforcing false and constructed notions of correct femininity and masculinity' (1997: 57). Although this stereotypical view of transsgender behaviour may be increasingly questionable, Ladin's comment that 'transition has taught me that conventions of femininity that many women find tedious, draining and oppressive can be empowering, self-affirming, even liberating, as well' (2012: 129) appears to illustrate Jeffreys' concern. Benvenuto suggests that 'while some transpeople see themselves as challenging gender norms, what I've witnessed ... obsession with a certain body type, pride in "feminine" emotionalism and shrinking muscles, a taste for bodice-hugging clothes – would seem to reinforce them' (2012: 29). Nonetheless it seems harsh to blame the very small number of transitioned transgender people in society for not renouncing 'false and constructed notions of femininity and masculinity' when they are so greatly outnumbered by the many non-transgender men and

women who reinforce them daily too, in the clothing they wear, in their personal behaviour and in their attitudes to and expectations of others. And of course such a perspective fails to take into account those transgender people who seek to 'break the rules, codes and shackles of gender' (Bornstein, 1994: 135), as will be discussed in more detail below.

That interactions with others are also an essential element of gender is stressed by Connell when she argues that 'gender is, above all, a matter of the social relations within which individuals and groups act'. Having defined social structures as 'enduring or widespread patterns among social relations', Connell concludes that 'gender is the structure of social relations that bring reproductive distinctions between bodies into social processes' (2009: 10/11), concluding that 'the distinctive feature of gender (compared with other patterns of social embodiment) is that it refers to the bodily structures and processes of human reproduction' (2009: 68). Bradley adds to this link to the organisation of reproduction, 'the sexual divisions of labour and cultural definitions of femininity and masculinity' (1996: 205). This embodiment of gender links with the writings of West and Zimmerman who distinguish between 'sex' and 'sex category', the latter being based on 'the *presumption* that essential criteria exist and would or should be there if looked for' (1987: 132, *italic original*), a concept which may also have particular relevance to pre-transition, transitioning and transitioned transgender people in relation to the surgical or hormonal construction of such structures, and to the degree to which they are accepted within a transitioned gender role.

West and Zimmerman develop the sociological notion of gender within their concept of 'doing gender' which creates 'differences between girls and boys and women and men, differences that are not natural, essential or biological'. They suggest that once differences have been constructed, they are used to reinforce the 'essentialness' of gender suggesting that Garfinkel's (1967: 118/140) 'case study of (a transsexual named) Agnes ... demonstrates how gender is created through interaction and at the same time structures interaction' (1987: 131/137). Similarly, Connell narrates how Robyn, an older transsexual looking back on her gender transition, 'gives detail about learning to dress and present herself as a woman. She first did this in concealment, then wore some women's garments in public, then oscillated between women's clothes and men's clothes, then went full-time. This was a learning process, she wryly acknowledges' (2010: 8).

Bradley explains that 'we refer to this process of doing gender as *gendering*' (2007: 23, *italics original*). Further, the 'acts, gestures, enactments (of gendered behaviour) are

performative in the sense that the essence or identity that they otherwise purport to express are *fabrications* manufactured and sustained through corporeal signs and other discursive means' (Butler, 1990: 185, italics original). Both Connell (2009: 5) and Butler (1990: 11) quote de Beauvoir's famous comment that 'one is not born but rather becomes a woman' (1949, reprint 1997: 295), evidencing de Beauvoir's apparent affirmation of the notion that gender is constructed. Bradley paraphrases and expands this statement 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 construction of gender on an individual level might also be extended to gender in groups, and to gender geographies, where social practices and spaces are denoted as male and female. From a transgender perspective, Browne et al have questioned 'geography's presumption of man/woman and male/female' (2010: 573). Formby's exploration of 'LGBT communities in the twenty-first century' suggests that 'three key elements ... to community have been highlighted ... *'space'* formed an important part of understandings and experiences of community ... *shared experience* related to identity for example ... facing prejudice or discrimination ...and (to a lesser extent) *politics'* (2012: 65, italics added).

Connell notes that 'Butler wrote at length about transsexuality and transgender, critiquing the medical diagnosis and treatment of "gender identity disorder" as a site of gender normativity" (2012: 861). Butler argues that the idea of 'sex' as constituting the biological male or female body, and 'gender' as referring to the social meanings attached to such bodies, has restricted our understanding of gender as distinct from sex, and develops the concept of performativity to address the ways in which the rules of gender are repetitively acted out to reinforce naturality: 'there is no gender behind the expressions of gender ... identity is performatively constructed by the very expressions that are said to be its results' (Butler, 1990, 25)'. Hence, to Butler, gender is not a performance representing an inner sense of being but performance is the essence of gender itself. Bradley notes that 'from the age of 11 and 12 until she dies a woman will spend a large part of her time, money and energy on binding, plucking, painting and deoderising, (from Dworkin, 1981, quoted in Bordo 1993:21) whilst 'boys and men labour ... to develop an adult masculinity by repetitive action to enhance muscularity and macho appeal' (2007: 22).

It seems then that the terms 'male' and 'man', 'female' and 'woman' may be almost interchangeable within a social/cultural context: Butler goes on to argue that 'if there is something right in Beauvoir's claim ... it follows that *woman* itself is a term in process, a becoming, a constructing that cannot rightfully be said to originate or to end' (1990: 45, italics original). So, 'woman' and 'man' become more than just the sex of reproductively defined beings, but active constructs, with the apparent responsiveness and plasticity of 'gender' to social and cultural processes.

Whittle and Turner further explore Butler's (1990) argument that, 'rather than existing independently, 'bodily 'sex' (is) a regulatory practice that *produces* the bodies it governs', indicating that the clarity of the binary distinction between male and female biological sex has been increasingly questioned. They cite the biologist Fausto-Sterling (1992) who, they note, has 'argued mischievously that with manifest variations of chromosomal configurations, there were five sexes rather than two'. They go on to question the sex/gender distinction too, recognising that it has been much debated and still 'remains contested'. They suggest that 'legal sex has never been consistently determined by biology' and that 'normatively in the sex gender distinction, sex precedes gender' but that within the UK Gender Recognition Act 2004 'one's gender precedes one's sex. 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*' (2007: 3, 5, 16/18, italics original). A transsexual 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.

Intersex

At about the same time as Whittle and Turner's (2007) observations, Harper, referring to critiques of the treatment of people born intersex by Kessler (1990) and Dreger (1998), proposed the view that 'the simple dichotomies of sex and gender, and the essentialisms of biological determinism, are destabilised within a biology increasingly understood as medically invented' (2007: 7). A decade earlier Diamond and Sigmundsen had laid the basis for practitioners with guidelines reflecting a changing perspective of persons with ambiguous genitalia (1997b), following a 'long-term follow up to a classic case' who had been initially raised as a girl but who 'was later found to reject the sex of rearing' (1997a: 298). Meadow suggests that practices that rely on the determination of clear cut sex

differences 'maintain the illusion of dichotomous gender while at the same time (they) demonstrate the larger social purpose that these categories serve' (2010: 831). There are clearly similarities between the destabilisation of our understanding of sex and gender through the treatment and management of people born intersex (which in many cases has involved gender assignment shortly after birth, usually based on the appearance of the genitals) and the upturning of legal criteria of sex and gender resulting from the treatment of transgender people.

Gender Identity and Gender Role

Richardson further explores the processes of gender when she affirms that 'the main focus of work on gender ... during the 1970's and 1980's was on exploring the production of masculinity and femininity' and that 'many feminist writers ... argued that gender is culturally determined ... through socialization into gender roles, or as it was often termed then 'sex roles''. She clarifies that it is through a range of learning processes, 'for example observation, imitation, modelling, differential reinforcement (and) agencies of socialization (for example parents, teachers, peers, the media)' that children learn 'the social meanings, values, norms and expectations associated with 'being a girl' or 'being a boy'' (2008: 9). Bradley suggests that Oakley 'appropriated (a) key term from functionalist theory – 'socialization' (2007: 17) whilst Oakley herself, commenting on a 'longitudinal study in which 35 categories of behaviour were rated yearly for 57 females and 58 males', notes that "'socialization' processes are quite sufficient to account for most of the observed and 'documented' sex differences' (2005: 19).

Thirty years earlier, the psychologists Maccoby and Jacklin (1974) had suggested that cognitive theories of 'self-socialisation', by which a child copies certain behaviours because they are old enough to understand that this is normalised behaviour for a child of their own gender, appear to play an increasingly important part once a child's gender identity has been firmly established. Butler's conceptualisation of the internal assimilation of performative routines which enhance and self-socialise, not just within childhood, but throughout one's lifetime – a never ending journey – extends the role of these external influences (1990). However, Maccoby and Jacklin's suggestion that the establishment of gender identity pre-empts the effectiveness of performative routines contrasts with Butler's concept of gender and gender identity as essentially reiterated social performance.

A variety of psychological research suggests that one's sense of self as a boy or girl usually develops early in childhood, although Smith and Cowie in a review of the literature, note that 'the results of research in the infancy period (up to 2 years) do not reveal many consistent behavioural differences between boys and girls. The similarities certainly outweigh the dissimilarities' (1991: 145), but in the intervening years to school age, stronger preferences for same-sex playmates and gender stereotypical activities become apparent. What is stereotypical across cultures, or even across generations within a culture, may of course change and develop. But whether it is the *a priori* development of gender identity that leads to apparent gender differences of behaviour, or whether 'being assigned to a specific gender provides a set of ground rules that govern our behaviour, establishing a cornerstone of identity' (Woodward, 2008: 83), still appears to be a basic issue of contention which underpins many of the ongoing discussions about the nature of gender and gender identity.

It is important to note too that, as Maccoby and Jacklin first reported in 1974, many apparently observable gender differences of behaviour do not translate into measurable differences in children or adults. As Connell notes in a discussion of these findings, the notion of sex-related differences in roles is severely questioned when 'study after study, on trait after trait, comparing women's results with men's or girls' with boys', finds no significant difference'... 'it is *not* true that girls are more social than boys, that girls are more suggestible than boys, that girls have lower self-esteem, that girls are better at rote learning and boys at higher-level cognitive processing, that boys are more analytic, that girls are more affected by heredity and boys by environment, that girls lack achievement motivation, or that girls are auditory while boys are visual. All these beliefs turn out to be myths' (2009: 61).

Similarly Hyde's meta-survey, proposing a gender similarities hypothesis rather than one based on gender difference, found that 'extensive evidence from meta-analyses of research on gender differences supports the gender similarities hypothesis. A few notable exceptions are some motor behaviors (e.g., throwing distance) and some aspects of sexuality, which show large gender differences. Aggression shows a gender difference that is moderate in magnitude' (2005: 590).

The apparent passivity of the learner to 'agencies of socialization' of gender roles is questioned by Connell who stresses the active nature of gender learning, 'the *pleasure*

which is obvious (and the) enthusiasm with which young people take up gender symbolism ... and construct gendered relations', indicating a far from passive response to much of societal gendering. Connell also notes the importance of 'the *resistance* which many young people put up to hegemonic definitions of gender ... the *difficulty* which is involved in constructing identities ... (and the) ... changes of direction that often appear in a young person's life, coming apparently from nowhere', suggesting that the process of gender assimilation may at times be re-active for many individuals. Because of this, and what she describes as its 'far too monolithic' nature, and a reliance on sex role theory, Connell suggests that 'the socialization model should be abandoned', and that 'the contradictory character of human development is much better understood by psychoanalysis' (2009: 95/97, italics original). This view is further explored by Jackson and Scott through 'the conflation of gender and sexuality' (2002: 21). It is perhaps still partially explained by behavioural approaches to child development, particularly if a reflexive, re-active model of social learning is acknowledged rather than the deterministic 'psychologistic' model of 'totally passive and totally malleable' infants and children which is understandably rejected by Stanley and Wise (2002: 272).

For example, Davies illustrates the active 'location' that children undertake on either side of the gender binary as they construct their own understanding of ways of being boys or girls when she describes how 'I once gave a toy car to a three-year old girl as a symbolic refusal of the gender order. She unwrapped the present, looked at my (sic) quizzically and said, 'It's really a boy's toy, but don't worry, I can handle it', at one and the same time reconstituting the gender order that I was attempting to break down, and taking care, as girls should, not to hurt my feelings too much at having my error pointed out to me' (2002: 281).

Bradley suggests that 'while some of the old insights from socialization are useful in showing where ideas of normality come from and in revealing the pressures we are under as individuals to be 'normal', the more active idea of gendering allows us to explore how individuals develop as agents in interaction with their environment' (2007: 23/24). Such an interactive approach to how individuals develop a gendered niche in society is reflected in the notion of blending forms of gender-related self-expression, conveying to oneself and to others both a sense of individuality and membership of a binary gender or transgender category, (and reflecting the absence of unity in the term 'gender role'). This short-hand

term is, however, used throughout the thesis, to reflect how the lives of transgender people highlight an apparent difference between gender identity and gender role. As noted in the glossary of terms, a multiplicity of gendered forms of expression may fit within a wide range of binary masculine or feminine behaviours within society, but, within a transgender role, may be combined in unusual, or non-standard ways.

Meanwhile, some researchers have linked notions of gender stability and gender constancy to notions of gender identity: Smith and Cowie, for example, indicate that gender identity, once initially established, leads boys and girls to the realisation that they will grow up to be men and women (the concept of gender stability) and that this principle applies to other boys and girls too, by about the age of four or five (1991: 146). It had been thought that the realisation that it is not possible for a boy to change and become a girl, for example by growing their hair long, or for a girl to become a boy by wearing boys clothes (gender constancy) developed at about the age of seven years of age (or earlier if the child understood the differences between male and female genitals (Bern, 1975)). However, Intons-Peterson's more recent study suggests that children may actually be aware of gender constancy as young as three years and nine months (1988, discussed in Kennedy and Hallen, 2010).

Kennedy and Hellen note Kessler and McKenna's findings (1978: 102) '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:

'I was three or perhaps four years old when I realized that I had been born into the wrong body, and should really be a girl. I remember the moment well, and it is the earliest memory of my life' (Morris, 1974: 11).

Kennedy and Hellen carried out an online study of transgender forums in the UK, to which 121 people responded, 103 of whom were assigned a male gender at birth, and eleven assigned female (with seven 'others'), with the majority of participants in the 36 to 45 age

group. They suggest that their finding of a modal average of five years and a mean average of 7.9 years for the age at which transgender people remembered feeling that their gender *identity* was at variance with that assigned at birth, and the gender *role* to which they were assigned 'may, to a considerable extent have been predicted' from Kessler and McKenna's (1978) findings (2010: 28). Steele suggests that such a moment of realisation of difference may not be unique to those with a transgender identity, when he observes that 'I have a memory of the first time I realised I was black. It was when, at seven or eight, I was walking home from school with neighbourhood kids on the last day of the school year – the whole summer in front of us – and I learned that we "black" kids couldn't swim at the pool in our area park, except on Wednesday afternoons' (2010: 1).

Such a distinction between the term gender role in relation to the outcome of repeated stylization of gender based behaviour, and gender identity in relation to an inner sense of one's gender, although differing somewhat from much of the gender theory discussed above, is nonetheless particularly helpful in considering transgender identities and life courses, although, as noted above, discussions about the fundamental nature of gender, gender role and gender identity still continue. Such discussions also raise the question of whether a person's sense of self as 'boy' or 'girl', 'man' or 'woman' fluctuates according to the degree of their conformity, as a literal reading of Butler's notion of performativity might imply, or whether what fluctuates (in a person's sense of self and/or in others' sense of them) may rather be the degree to which they feel and/or appear identified with masculine or feminine behavioural traits. As Davies suggests, 'positioning oneself as male or female is not just a conceptual process. It is also a *physical process*' (2002: 284, italic original).

Kennedy and Hellen note the '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 widely. They go on to suggest that consequential secretive cross dressing and non-conformist gender expression becomes a hidden behaviour, and that 'this appears to be one of the main common experiences of MtF transgender children' (2010: 38). They query Butler's (1993: 232) argument that 'femininity is not a choice but the forcible citation of a norm, one whose complex historicity is indissociable from relations of discipline, regulation, punishment', for, within the seeming contradiction of transgender '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).

What is also apparent and important here is the sustained sense of difference and isolation which transgender children carry throughout their childhood and adolescence and into adulthood, as the 'tension between societal expectations of gendered behaviour' and internal identity take their toll. Transgender people have mainly come into the public eye in the last sixty years through adult narratives of transition, but the perspectives and dilemmas of transgender children are only gradually achieving similar recognition.

Transgender

What emerges from the above discussion of theories of gender and sex, in relation to the notion of transgender, is that the perceived conflict described by many transgender people, between their sense of their gender identity, and the gender role to which they feel obliged to conform, sheds a different light on the notion of gender than normative binary perspectives. Such a sense of gender identity and gender role may appear at times to be in conflict, for example, with feminist views of the oppressive nature of gender. However, it may be argued that transgender people who consider or seek to move beyond the binary are perhaps not so far away from such a feminist sense of gender oppression, albeit having experienced their own form of oppression from very different perspectives. Similarly, performativity, particularly within gender stereotypical behaviours following transition, may reinforce a transgender person's sense of 'belonging' to the transitioned gender, although, as noted above, it fails to explain how transgender children develop transgender identities, as does the active process of gendering which has replaced more passive models of socialisation. 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 often within the binary gender role linked to their biological sex, until it seems, the pressure of such a dual inner life requires release and/or resolution.

King, in a comprehensive review of the emergence of transgender in the medical and academic literature, explains that 'in terms of conceptualisation and classification, the category of the transvestite was available around 1910 and the transsexual some forty years later' (1996a; 80). The way in which these concepts have been understood, and the

response of the medical profession in particular, has developed significantly, though, as King notes, the fundamental nature of a distinction between the two main categories was apparent as early as 1928 when Havelock Ellis distinguished between the two.

Jeffreys notes the possibility suggested by Erhardt (2007) that cross dressing and transsexuality 'rather than forming discrete categories, fall on a continuum' (2014: 81), a possibility which, although not widely acknowledged, is suggested by the research of Bolin (1996: 452). In particular Bolin found that 'there was a great deal more diversity among people who were male transvestites than was acknowledged by the ... dichotomy of TV (transvestites) and TS (transsexuals). They regarded gender-variant identities as much more fluid and plural than did the transsexuals. They did not, for the most part, see transvestites and transsexuals as two distinct and static identities. In fact, they frequently stated that the context of a person's life was essential in determining how cross-dressing or one's "feminine" side was expressed. For example, how a man was situated in terms of career, family and age could make all the difference in whether he identified as TV or would actually take the step and begin taking hormones' (1996: 458). Such a dichotomy is not simply of academic interest: it could be taken into account when a diagnosis and prognosis is made for a transgender person prior to consideration of gender reassignment. Similarly, the notion of a continuum within transsexuality is discussed by Cohen-Kettenis and Pfäfflin, who, in a review of diagnostic criteria for gender identity disorder, note several scales for measuring 'core aspects of GID ... in a dimensional way' but note that 'these instruments are only now beginning to be used in clinical practice' (2010; 500/501).

From a transsexual perspective, however, the development of 'sex-change' surgery in the 1950's, and Fisk's origination of the term gender dysphoria to describe those who 'were intensely and abidingly uncomfortable in their anatomic and genetic sex, and their assigned gender (Fisk, 1973, quoted in King, 1996a: 95) led to a growth in this 'possible treatment for 'gender dysphoria' instead of as the inevitable outcome of a transsexual career' (King, 1996a: 80, 82, 96, 97).

McKenna and Kessler (2006) suggest three possible meanings of the term transgender when they distinguish between three meanings of the prefix 'trans'. The first of these is 'change, as in the word "transform". In this first sense transgendered people change their bodies to fit the gender they feel they always were'. The second meaning is 'across, as in the word "transcontinental". In this second sense a transgendered person is one who

moves across genders, (or maybe aspects of the person cross genders)'. The third meaning is 'beyond or through as in the word "transcutaneous". In this third sense a transgendered person is one who has gotten through gender, beyond gender. No clear gender attribution can be made ... gender ceases to exist, both for the person and those with whom they interact'. They add that 'this third meaning is the most radical and one of greatest importance to gender theorists like us who are interested in the possibility, both theoretical and real, of eliminating gender' (2006: 346/349). This latter position, though hypothetical, appears closest to that described by Bornstein in her writings on 'gender outlaws' (1994, 2010) and whose position is discussed below in relation to Ekins and King's notion of transcendence (2006: 181).

Ekins and King (2006) distinguish between four main categories of transgender, based upon a person's observable gender related behaviour. They use four descriptive terms to define these categories - oscillation, migration, negation 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 transvestism, in which cross dressing 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).

Brierley (1979), and Ekins and King (2006), speak almost exclusively about the male to female cross-dresser. The female to male cross-dresser receives much less of their attention, although examples can be found elsewhere, for instance Oram, who identifies women's gender crossing linked with employment ('I could earn more money as a man than as a woman') the military ('cross-dressing women who attempted to join the forces (were shown) admiration'), or to live with a 'wife' (2007: 26, 30, 33). Grémaux found evidence of 120 cases of permanent and institutionalised female cross-dressing in the Balkans, with a resultant crossing of gender identities, 'since the individuals assumed the male social identity with the tacit approval of the family and the larger community' often to fulfil a family need for a son as heir to the head of the family (1996: 242). It is difficult, even from the detailed case studies described, to reach clarity concerning the likelihood of whether the person had a prior inclination to change their gender role, before family

circumstances appeared to require it, although it seems that most individuals were content to have done so.

In most cases however, as Brierley explains, 'transvestism may present an unusually difficult problem because of the large proportion of transvestites who choose never to reveal their transvestism' (1979: 18, 26), which has direct pertinence to this research, and perhaps in particular to the nature of the research samples.

'Migrators', unlike oscillators, are much more 'visible' to services, but there is still considerable variance in estimates of incidence. The 'Mapping Project' noted that 'in 2000, after informal consultations with the Passport Section of the Home Office, Press for Change estimated there were around 5,000 transsexual people in the UK (approximately one in 12,000), based upon numbers of those who had changed their passports' and that 'as of September 2008, 2201 people had ... been awarded a Gender Recognition Certificate' but they concluded that 'nevertheless, there is no substantive knowledge of how many people in the UK identify as transgender or transvestite, or use any other gender identity descriptor' (Combs et al, 2008: 5).

A 1998 survey in Scotland (Wilson et al, 1999) found an incidence of one transsexual person per 12,225 of the population, although prevalence was estimated (within the UK as a whole) to have risen to perhaps one per 5,000 by 2009 according to the Gender Identity Research and Education Society (Gires) (Reed et al, 2009: 4/5). So Scotland, for example, with a population of 5,254,800 in June 2011 (General Register Office for Scotland, 2012a), may have a transsexual population of between 430 and 1,050 individuals, using the parameters of the 1998 survey data and the 2009 Gires estimate. Appendix Two contains estimates of the Scottish transsexual population by council area, based on Wilson et al and Reed et al's estimates of incidence.

Transsexuality affects both men and women (according to birth sex). In the 1998 survey there were believed to be approximately four times as many male to female (MtF) as female to male (FtM) migrators in the UK (Reed et al, 2009: 17). Such a significant difference in apparent rates of gender dysphoria between males and females might suggest a tentative link with the 'well established' finding that 'males are more physically vulnerable than females (and that) this differential vulnerability is particularly pronounced at the beginning ... of the life span' (Jacklin, 1989: 128/129). However Jacklin is clear that

'we do not yet know whether vulnerability does or does not have behavioural or psychological implications' (1989: 131). Indeed Gires found that the ratio of referrals to the Glasgow G.I.C. (gender identity clinic) had reduced to 63% to 37%, linking the ongoing discrepancy perhaps to an absence of FtM role models rather than to any causative factor, going on to explain that the ratio of male to female migrators in the rest of Europe is almost equal and to suggest that such a balance is likely in time within the United Kingdom too, as FtM transsexuals become more visible (Reed et al, 2009: 17).

Billings and Urban note that 'although some physicians asserted that biological predispositions for transsexualism might yet be discovered, most stressed early socialisation in their etiological accounts' (1996: 104). However, there is far from unanimity about mis-applied gender socialisation in the accounts of transsexuals and their families and in the work of other researchers and workers in the field. Benjamin (1966) first speculated on a potential link between oestrogen levels in the womb and transsexuality in the male, and on a link between an abnormal conversion of oestrogen into testosterone in the womb and transsexuality in the female. However, as Jacklin noted, although 'hormonal differences, particularly sex-steroid hormones, are among the most common biological causes given for behavioural sex-related differences' she points out that 'in research on how hormones affect behaviour and how behaviour affects hormones, the empirical data collection necessary to answer basic questions about sex differences has only just begun' (Jacklin, 1989: 129, 131). Recent research involving post-mortems of transsexuals' brains (Zhou et al, 1995), and recent genetic evidence indicating that MtF transgender people may have genetic abnormalities linked to 'repeat length polymorphisms in the androgen receptor' (Hare et al 2009: 93), add support to the argument that there is perhaps a biological basis for gender dysphoria. However, John Money (1994), who for many years advocated an environmental aetiology, came to believe that biological and environmental aetiological influences are likely to work multi-factorially.

Ekins and King's (2006) descriptions of migration and oscillation appear to correspond quite closely with the first two of McKenna and Kessler's (2006) notions of transgender discussed above, but this is not the case with Ekins and King's notion of 'negation' which they use to describe transgender people who seek to erase their former gender characteristics (physical and behavioural) in order 'to 'ungender' themselves in the sense of halting, eliminating or reversing their previous genderings. (This notion seems in some ways like a

self-imposed adult version of 'pinafore punishment', where children are made to wear items of clothing or to behave in ways associated with those of the opposite gender - see Ekins and King, 2006: 9/38). They show that it is not the binary itself which is negated (which becomes exaggerated to the extreme) but the attribution to one's former gender role. Ekins and King note that there are female-bodied negators who provide a converse image to the more widespread notion of male negation, but the examples which they describe in most detail revolve around the notion of 'sissy' males who observe imposed 'rules' in their treatment of themselves and their behaviour, to become 'sissy maids' (2006: 143/180). The absence of reference to 'sissy' males or maids, or to female-bodied negators in other wide ranging overviews and key sources within the transgender literature (e.g. Barrett, 2007; Stryker and Whittle, 2006) suggests that even within the small numbers of transgender people in society, they form a relatively limited minority group.

Lastly, Ekins and King put forward the notion of 'transcendence'. Garfinkel's (1967) first two rules for 'our natural attitude towards gender' (discussed by Kessler and McKenna, 1978: 113), 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' places gender ambiguities within a 'banner of the Third' within which 'transgressively gendered ... people break the rules, codes and shackles of gender' (1994: 98,135). However 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, which of course leads to the question of whether it is indeed possible to actually transcend the binary, or whether perhaps such a notion rather mixes stereotypical or identifiable behaviours from either side of the binary in a novel or unusual, rule-breaking mix.

Transcending though may perhaps be as much an internal process as an external presentation, for as Prosser suggests, some transgender people are actively exploring possibilities outwith the binary, as exemplified in the novel by Leslie Feinberg (Stone Butch Blues) which is 'the story of a transsexual who turned back; or rather of a subject who, like Feinberg herself (sic), halts her transition through surgery and hormones to found an embodied transgendered subjectivity' (1998: 177/8). Jeffreys refers to Kristen Schilt's 2006 study of FtM workers noting that that 'some of her interviewees did not consider

themselves to be men or male (2014: 61), despite the fact that all 'respondents were assigned female at birth and were currently living and working as men or open transmen'. Prosser also refers to Ann Bolin's (1996) contrast between 'transsexuality's conventional binary gendered past with the promise of a brave new transgendered binary-free future' (1998: 202).

Bolin herself describes the notion of a 'transgenderist' – which she uses 'in a very specific sense to include persons such as nonsurgical or even pre-surgical male-to-female transsexuals who want to live permanently as female in gender'. Bolin quotes the International Foundation for Gender Education which explains that transgenderists are 'persons who steer a middle course, living with the physical traits of both genders'. Although 'they may alter their anatomy with hormones or surgery ... they may purposefully retain many of the characteristics of the gender to which they were originally assigned. Many lead part-time lives in both genders; most cultivate an androgynous appearance' (1996: 466).

Burdge comments further on gender transgression in the context of a 'traditional dichotomous gender paradigm' which she describes as 'oppressive': suggesting that conforming to such a paradigm may result in 'psychosocial difficulties (for) many transgendered individuals'. With a particular pertinence and relevance to this research, Burdge argues that it is the responsibility of 'social workers to target society's traditional gender dichotomy for change' rather than seeing the main focus for change as being from transgender individuals themselves (2007: 243). It is not perhaps unreasonable to draw a parallel between the social need for change to accommodate transgender people, with the passion with gender issues underpinning feminism to which Bradley refers when she notes her personal epiphany of recognition of 'the right (of a woman) to be an active human being and not merely a reflector of male glory' for 'gender change like gender identity, is a social phenomenon' (2007: 13). With this in mind it is notable that of the thirty people interviewed by Hines in an overview of transgender caring practices, the majority described themselves within binary gender categories - man, woman, transsexual man, transsexual woman, transsexual female, FtM (female to male), trans-man, trans-woman, or trans-female. Just three participants describing themselves as 'bi-gendered' while another described their gender as 'fuzzy', evidencing perhaps an emerging notion of transcendence among only a relatively small minority, although the use of such terms as transsexual man,

trans-man, transsexual woman, trans-woman, etc. suggests a further degree of flexibility of self-description than the simple binary (2007: 195/198).

From the above outline of transvestism it is clear that the gender identity of 'oscillators' usually remains stable and consistent with their biological sex (notwithstanding of course the debate over what actually constitutes or signifies gender identity or biological sex). Barrett however also notes that some transsexuals may undertake a period of dual role transvestism prior to (self) recognition of their transsexuality, evidencing a discordance between biological sex, gender role and gender identity which is only temporarily assuaged by a transvestitic oscillation of role. For the future migrator, that is, for the transsexual who is still living in the gender of their biological sex prior to transitioning, to live within the daily routines and lifestyle of the 'wrong' gender for their self-perceived gender identity may be a source of great discomfort and unhappiness linked with 'a lifelong sense of insecurity in (their apparent gender) role' (Barrett, 2007: 20, 23). The dual-role transvestitic phase of some transsexuals may perhaps represent an example of a personalised, discrete expression of an otherwise invisible identity, and the relief and release of accumulated tension associated with an accompanying gender dysphoria.

Perhaps some transsexuals imitate the lifestyle which conforms to their biological sex, without internalising its meaning or relating it directly to their inner sense of their gender (despite the conflicts of identity which may result). Others, as is apparent from some transsexual biographies, appear to immerse themselves in the gender role of their biological sex – Jan Morris for example initially joined the army and, later as a journalist, covered the expedition which conquered Everest in 1953 – in attempts, it seems, to expunge an inner sense of gender identity conflict (1974).

Connell suggests that 'a large part of gender theory ... has become abstract, contemplative or analytical in style', drawing attention, in a recent volume entitled *Theorizing Gender* (Alsop, Fitzsimons and Lennon, 2002) to the absence of 'girl's education, domestic violence, women's health ... or any other *policy* question that feminists had been grappling with.' (2009: 41). If such publications appear to ignore mainstream women's issues, it is questionable how likely it is that issues such as transgender will be carefully considered and evaluated within the context of gender theory.

Of equal concern, Mohanty's criticism of feminist literature that homogenizes "third world women' into a single category of victimhood, representing the extremity of gender oppression' (1991), suggests that similar western values may affect our understanding of transgender issues, based on the notion of reassigning bodies to match identities, because, as Connell suggests, 'the crucial step of *theorizing* occurs overwhelmingly in the metropole' (ignoring) 'the richness of ideas from the global South' (2009: 44, 46, 49).

Nonetheless this section has evidenced significant progress in seeking to understand the concept of transgender, and the likely subgroups of which it seems to be constituted. As Hines suggests, nowadays 'the concept of transgender is extensive – incorporating practices and identities such as transvestism, transsexuality, intersex, gender queer, female and male drag, cross-dressing and some butch/femme practices (2008: 28)

Transgender and Sexuality

Just as Taylor notes that sexuality is inextricably linked to the continual reinforcement of heterosexuality (2008: 106) so discussions of sexuality and transgender may however be sublimated within discussions of LGBT sexuality. Kitzinger for example, while also recognising that 'the contemporary field of LGBT psychology developed in response to social and political discrimination against anyone who is not (or who is assumed not to be) heterosexual' (2001: 273) goes on to discuss LGBT sexualities within primarily gay and lesbian considerations, rarely mentioning bisexuality and devoting just thirteen lines of a thirteen page article to transgender sexualities.

Eliason and Schope draw attention to Coleman et al's (1993) suggestion that 'transgender individuals go through two development stage processes: first for gender identity and then for sexual identity' (2007: 12/13), and for post-transition migrator sexuality, at least initially, the picture does indeed seem equally complex, for as Richardson suggests 'transsexuality and transgender are theorised in ways that demonstrate the potential to trouble as well as reinforce the links between gender and sexuality' (2007: 468).

Connell explains that 'bodies are affected by social processes' including, amongst a range of issues such as food distribution, warfare, work, sport, education and medicine, 'sexual customs' and that 'all of these influences are structured by gender. So we cannot think of social gender arrangements as just flowing from the properties of bodies' (2009: 54). In the particular case of sexual customs, this is the case from transgender perspectives too, for

the preference to live within the role of the opposite biological sex is likely to lead to the adoption of the adornments of this sex, most obviously through cross dressing which in the case of MtF transsexuals in particular may involve overtly sexualised clothing, both prior to and following transition and surgical procedures. As will be discussed within the sections on transphobia and attitudes to transgender below, the potential for the 'fusion of gender and sexuality also has distinct implications for the problematic of violence' (Namaste: 2006: 588).

In addition, 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 – see Appendix Six). 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).

Hines suggests that 'transgender sexualities are often fluidly and contingently situated; experiences of gender transition may enable an increased freedom of sexual expression, and offer a greater diversity of sexual identification' (2007: 125). Such a point of view appears consistent with queer theory, which 'emphasizes the fluidity, instability and fragmentation of identities and a multiplicity of sexuality and gender categories' (Richardson, 2008: 15), within 'a full-frontal theoretical and practical attack on the dimorphism of gender- and sex- roles' (Whittle, 1996: 202). Perhaps too the apparently fluid nature of transgender sexualities described by Hines might sometimes be explained if pre-transition sexuality forms part of the maintenance of a 'fabricated' gender which, once dissolved, confuses the bases of and for post-transition sexuality. Interestingly, Jeffreys suggests that 'while feminists had ... aimed to demolish gender differences, the queer approach was much less radical, and paved the way for transgenderism to be seen as an emblematic practice of queer politics (2014: 42).

Byne refers to sexual orientation as 'one's pattern of erotic responsiveness' which may be androphilic ('attracted to men'), gynephilic ('attracted to women'), or bisexual ('attracted to both') (2007: 66), to which Barrett, a psychiatrist, adds autogynaephilia : 'a disorder of sexual object ... being aroused by the thought of oneself as female' which has been linked

with transgender people, and which has subsequently been a source of some controversy (2007: 35, 37). The NHS/Glasgow University Scottish Transgender Survey found that '21/36 (58%) MtF and 1/9 (11%) FtM respondents (had) been sexually aroused by the thought of being a man/woman' and that 'MtF respondents attracted to females were actually less likely to report autogynephilic attraction than those who were sexually attracted to men' (Wilson et al, 2005: 11, 29). It is unclear to what extent such sexual arousal may be associated with an early phase of dual role transvestism, or whether it is mainly found in pre-transition transsexuals and disappears from their repertoire once a lifestyle in their preferred gender role has been established. Perhaps societies' emphasis on some items of women's clothing, particularly underclothing, as being sexually attractive and arousing within heterosexual relationships, produces initially contradictory feelings in the MTF transgender person, which lose their relevance as such associations decline.

Indeed Whittle suggests that wearing the clothes of the opposite sex, more commonly known as transvestism, has no 'direct relationship to sexuality' but is 'to do with ... role play', and that, despite initially at least, for many being 'associated with reaching sexual orgasm ... for many transvestite men, as they mature, cross-dressing becomes less associated with sexual relief than with a sense of personal well-being and relaxation' (2000: 16, 18). Buhrich supports this view when, in a review of a 'heterosexual transvestite club', he concurs with Whittle that 'although fetishistic aspects of transvestism are emphasised in the literature ... the primary reason for cross-dressing reported by club members is not that it produces fetishistic arousal, but that it makes them feel natural and relaxed' (1996: 65). Incidentally Whittle also describes how the Beaumont Society was persuaded to allow the admission of FtM transsexuals and to remove the bar on homosexual transvestites, greatly affecting 'how the transvestite community viewed itself ... to allow a huge level of diversity, (and) gender acknowledgement' (1996: 206).

Barrett records that dual role transvestism 'may represent a stable way of life' and is 'much commoner than transsexualism'. He indicates that dual role transvestism is 'not sexually driven, but might have evolved from a previous fetishistic transvestism' (2007: 32). Barrett, like Brierley, comments that 'no matter how much time is (spent in a female role) the men concerned do not feel as if they are truly female. They view their male personas, and particularly their genitals, as valuable'.

Ekins and King's negators clearly fall into a separate category from the oscillating group, for 'those with male bodies seek to nullify their maleness/masculinity and eliminate in themselves the existence of a binary divide'. From the perspective of sexuality, although cross-gender, submissive masturbatory fantasies are an important aspect of negation, Ekins and King note that 'it might seem that we are dealing with a sado-masochistic facet of oscillating transvestism [but] it is (the) erasing of masculinity that is privileged' (2006: 144/145).

Lastly, the nature of transcendence might suggest a similar fluidity within sexuality as in gender identity and gender role, for as Ekins and King confirm, 'transcending stories ... in their different ways, all render problematic the binary structure of gender and the socially prescribed interrelations of the body, gender and sexuality' (2006: 184). Bolin concurs when she argues that 'it is in the arena of sexual orientation where the unrealised potential for a third gender may be found. Out of deconstructed gender polarity arises the possibility of a social woman with a penis. This woman embraces the ineffable by eroding the coherence of heterosexuality and biological gender' (1996: 483). What Bolin fails to acknowledge of course is how society would respond to such a 'social woman' outwith sexual circumstances, for as will be discussed below, even surgically reconstructed transgender people may not be readily accepted within women's spaces. Idealism and pragmatism still seem very far apart.

Transgender and Society

Transphobia

In this section, wide ranging evidence will be considered of the consequences of ignorance, misunderstanding, and transphobia which may be expressed through discrimination or acts of rejection including sexual or physical violence, as experienced by transgender people (and in the main, by transsexual people), within close relationships, local communities and wider society. That a deficit in information on transgender issues may reinforce both misunderstanding and ignorance and may be the precursors of prejudice, discrimination and transphobia in a wider public is explored further within the second of the research findings chapters. Respondents' comments on limits in information availability are discussed, in relation to coming to terms with their gender identity, and the 'knock on' effect for families, friends, colleagues, neighbours, and by implication, the wider public.

The 2006 Scottish Social Attitudes Survey Main Findings from 1,594 interviewees across Scotland, indicated that 'half ... would be unhappy about a relative forming a long-term relationship with a transsexual person ... in general, discriminatory attitudes are most likely to be expressed by those with few educational qualifications and by older people. Those who know someone who belongs to a particular group are less likely to express discriminatory attitudes' (Bromley et al, 2007: 15).

Almost a decade later, a YouGov survey for PinkNews indicated that 10% of voters from Scotland would not support a transgender child (2% said that they would not support a gay child), although this compared favourably with London, where the figure was 20%. Overall, only a little more than a quarter of those polled (27%) said that they 'would be happy to have a child who wanted to change their sex', while 39% would be unhappy about this. Within the LGBT community, 57% of gay or lesbian respondents said that they would be happy to have a transgender child. Overall, two thirds (67%) of voters across the UK said that they would support a transgender child (PinkNews: 2015).

As Goffman suggests, in a broader discussion of the relationship between stigma and the 'discrediting' of social groupings, there is likely to be 'no open recognition to what is discrediting' (1968: 57) so that it is possible that lack of eye contact or avoidance of personal contact or conversely an unfriendly glance or stare, an inappropriate comment or joke, or poor service in a shop (or within one's home) might be viewed as discriminatory.

The findings of the Scottish Transgender Alliance (S.T.A.) survey of seventy one transgender people in Scotland in 2007, looked at more overtly apparent forms of discrimination, indicating 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).

The Equalities Review 'Engendered Penalties' (based on a 2006 survey of 873 individuals, and supplementary data from Press for Change and the FtM Network from 1998 to 2005) reports that '73% of (transgender and transsexual) respondents experienced comments, threatening behavior, physical abuse, verbal abuse or sexual abuse while in public spaces' (Whittle et al, 2007: 53).

The NHS/Glasgow University 'Scottish Transgender Survey' of 2005 found that 'most (of the fifty two transsexual) respondents had experienced verbal aggression ... most respondents had also experienced threats ... there were also many reports of physical aggression'. These 'were both physical and sexual, and had been committed by acquaintances, neighbours and strangers' (Wilson et al, 2005: 27/29).

The Press for Change report on transphobic hate crime in the European Union was the result of an online survey launched in 2007, receiving 2669 responses. It reported that '79% of respondents had experienced some form of harassment in public ranging from transphobic comments to physical or sexual abuse', leading the authors to suggest 'that trans people are three times more likely to experience a transphobic hate incident or crime than lesbians and gay men homophobic hate incidents or crimes'. In addition '67% of trans women reported harassment compared to 57% of trans men' (Turner et al, 2009: 1). Transphobia can also be institutionalized and legally enforced. Most recently, in Russia, transgender people have been banned from driving because 'transsexualism and transgenderism are now listed ... (alongside Psychiatric disorders (including schizophrenia and drug addiction)) ... as examples of 'mental disorders' that can make someone 'unfit' to drive' (Rogers: 2015).

National figures are of interest, not least because they indicate a valuable British perspective: 'Greek, German and British/UK respondents reported the highest levels of verbal abuse (25%) (and) English respondents reported the highest levels of physical abuse (7%)' (Turner et al, 2009: 1).

That transphobia appears to be growing either more widespread, or is being more widely reported, is suggested by the Independent *i* which reported that 'some of the UK's biggest police forces have recorded a rise in transphobic hate crime (in 2014), with victims subjected to assaults, verbal abuse and harassment in the street ... the Metropolitan Police saw offences against transgender people rise by 44% in 2014, with 95 crimes recorded, up from 66 last year. Meanwhile Merseyside Police recorded 32 hate crimes, double the previous year' (Mercer: 2014).

Namaste distinguishes between violence and discrimination though noting that they 'support each other'. She uses the term violence 'to refer to a variety of acts, mannerisms, and attitudes ... (including) ... verbal insults ... invasion of personal space ... intimidation and the threat of verbal assault ... (as well as) the act of attacking someone's body ... through sexual assault, beating, or with weapons' (2006: 587). McNeil et al's findings regarding rejection, silent harassment and sexual objectification or fetishism, explore the boundaries between violence and discrimination further:

McNeil et al's 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). Comstock notes that 'when family members are cited as perpetrators by victims of anti-gay/lesbian violence, they are mostly brothers who attack their gay brothers ... and that the pattern of domestic anti-gay/lesbian violence 'reflects traditional roles and assignments of power' (1992: 112). It may be that future research on the family dynamics of transgender people may indicate similar patterns of behaviour.

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).

The S.T.A. survey found that one in seven of respondents rated the quality of the service they received from their NHS General Practice as 'very' or 'extremely' poor. Many respondents also commented on negative experiences of mental health services, leading to the conclusion that a 'lack of understanding and knowledge about transgender issues by general psychiatrists often results in transgender people being given inappropriate treatment which fails to assist them with their gender dysphoria' (Morton, 2008: 11/18).

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).

Jeffreys presents a contrasting perspective however, when she suggests that 'female partners of men who transgender ... often find it impossible to accept that their husbands have become women' and cannot use pronouns for them that they understand to be specific to their own experience as women (2014: 9). Benvenuto, for example, refers only to 'he' and 'him' throughout her two hundred and ninety four page account of her (and her children's) experience of her husband's and their father's transition, and beyond, because 'even now I can't think, speak, or write about this' (2012: 193). Although Jeffreys does not present evidence for the frequency of such responses, potential inter-personal difficulties are highlighted, which may arise when a partner undertakes gender reassignment. Whether the use of the term 'transphobic' is appropriate to describe such a response as not using the preferred pronoun is perhaps only understandable within each partnership dynamic. Indeed Ladin suggests that "non-supportive partners are portrayed as problems

to be coped with, rather than as suffering individuals in their own right' (2012: 24), opening up the potential for a rather more balanced perspective on the effects of transition on other family members other than the transgender person.

However, Jeffreys goes further than simply defending accusations of transphobia against partners, citing what she describes as 'psychological violence' by transgender husbands who 'go beyond a lack of empathy with their partners suffering and become more abusive' (2014: 86) and 'abusive relationships' by lesbian partners, evidence for which is cited within a study by Brown (2007), where partners reported manipulation, emotional and verbal abuse, name calling and demeaning put-downs (2014: 115). Jeffreys goes on to note that 'no research has specifically examined this problem' so it is difficult to speculate on the degree to which partners of MtF or FtM transgender people do themselves feel isolated, unsupported, distressed, helpless, and/or abused. Benvenuto, highlighting the changes that accompanied her partner's transition describes herself as a 'transwidow', (2012: 199). She writes about a trans-based website for 'SO's' (significant others) where all but one of the participants were women, who 'told themselves and one another that ... yes, their husbands were putting them through hell. Yes, they seemed to care only for themselves. Yes, they could be emotionally abusive. But didn't the husbands really have it much worse? ... I wanted to tell them, *Stop taking this on yourself!* But I never entered the fray' (2012: 127/8, italic original).

Such considerations need to be taken into account in the provision of social care to partners and families of transgender people, whilst also recognizing that at least some transgender people retain their long-term relationships with partners prior to and following gender reassignment, within apparently mutually caring and supportive roles. So, for example, while the pair of books by Ladin and Benvenuto, published in 2012, describe two quite different perspectives on the fragmentation of the same marriage during and following transition, Jan Morris, whose transition in the 1970's is referred to several times in this thesis, re-married her former wife within a civil union, in 2008, almost sixty years after their original marriage, and some thirty years post transition, having lived together throughout the intervening period (BBC News, 04.06.08).

The early internalisation of transphobia 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). Kennedy and Hellen explain that 'gender variance for these children could be characterised as performance of a gender identity which is not their own but which is imposed on them by their local gendered community of practice (leading to) internalised transphobia' (2010: 40).

Attitudes to Transgender

Hill and Willoughby in carrying out pioneering work developing and validating a genderism and transphobia scale (G.T.S.), found that 'the G.T.S. was not simply measuring self-esteem, gender role orientation, or positive self-presentation strategies (but) was moderately associated with homophobia and gender role ideology' and that 'anti-trans views were neither rare nor difficult to elicit. (Although) there was a wide range of responses to the G.T.S. scale ... some scores indicated extremely intolerant attitudes towards gender variance. The extent of negative attitudes toward gender non-conformists was somewhat surprising, considering the samples studied ... were, by and large, well-educated members of a cosmopolitan city (Montreal) well-renowned for its liberal attitudes towards sexuality and gender issues' (2005: 541/542). Of relevance to this postulated link with homophobia is Whittle et al's suggestion that 'much homophobic crime is actually transphobic, as it is a person's gender presentation which attracts attention ... rather than ... their sexual orientation' (2007: 55). Namaste also notes that 'the perceived violation of gender norms (is) at the root of many instances of assault, harassment and discrimination', going on to consider 'gaybashing', 'queerbashing' and 'genderbashing' within a discussion of perceived intrusion on heterosexual public space (2006: 584 to 590). Connell explains how Butler not only regarded 'the medical diagnosis of "gender identity disorder" as a site of gender normativity' but that she also viewed 'anti-transgender violence as a sign of the ferocity with which heteronormativity is enforced' (2012: 861). As Ekins and King note, 'conceptualising gender in terms of 'performance' (Butler, 1990) – as opposed to category or identity – places cross-dressing and sex-changing (now theorized as transgenderism) at the forefront of contemporary challenges to gender oppression' (1996: 3).

As noted previously, Namaste suggests that the confusion and 'fusion of gender and sexuality has distinct implications for the problematic of violence' (2006: 588). She quotes Comstock's 1992 findings that 66% of gay men had been attacked when alone, whilst 44% of lesbian women had been attacked in pairs, but that 'these numbers are drastically reduced when men and women walk together: only 8% of women respondents were

physically assaulted when they were with a man' and that this figure dropped to just 1% of male respondents when they were accompanied by women (2006: 589).

That transgender people may also be less at risk of antagonistic or transphobic behavior in the company of a man or a woman might be anticipated from these findings. Although no figures regarding the effect of male or female companions on transphobic responses to MtF or FtM transgender people are currently available, personal experience suggests that being accompanied by either a male or female significantly reduces the likelihood of discriminatory behavior from others. This idea may have significance in relation to the notion of the value of an 'ally' to a transitioning or transitioned person as explored within the discussion section of this thesis. Incidentally, it is suggested that perhaps the company of another transgender person is *more* likely to lead to antagonistic or transphobic responses, which may partially explain transgender people avoiding transgender groups etc following transition, though once again there is an absence of research to support such speculation.

Mitchell and Howarth further explore the notion of underlying homophobic attitudes within their review of the transgender research literature, noting the 'discomfort that some people feel in terms of their sexual orientation when they cannot ascribe a fixed gender identity to a person'. They go on to suggest that 'prejudice can be linked to sexism, the associated definition of rigid gender roles and behavior linked to sex' (2009: 35). The notion that transphobia may be affected by sexism within very close family relationships might also be evident in research by Whittle et al, where higher levels of familial support were noted for trans-men than for trans-women' (2007: 69).

Schilt and Westbrook (2009) explore the links between gender, sexuality and transphobia in their discussion of two case studies that suggest that 'doing gender in a way that does not reflect biological sex can be perceived as a threat to heterosexuality', implying perhaps that West and Zimmerman's notion of 'sex category', based on 'the *presumption* that essential criteria exist and would or should be there if looked for' (1987: 132, *italic original*), is discordant with the observed gender behaviour. Westbrook collected newspaper data on a total of 232 murders in the United States of (predominantly MtF) transgender people 'doing gender so as to possibly be seen as a gender other than the one they were assigned at birth'. Implicit within her findings was that over half (56%) of reports spoke of perpetrators being deceived by the victim, within a sexual context. However, Ross, within

an interview with Namaste, describes the Transgender Day of Remembrance' (held annually on 20th November), as 'the most shameful example of political appropriation' suggesting that 'trans-activists use (these) deaths as fuel in their crusade for 'transgender rights''. She goes on to explain that 'we do not necessarily know why these individuals were murdered. It could have been because of hatred and prejudice against sex workers, because of racist or misogynist attitudes ... but it was definitely not, in most cases, due to 'transphobia' (Namaste, 2011: 123). However, reference to the list of people commemorated (GLAAD, 2014), very often doesn't give enough information to be clear as to the reason for each murder, so it is perhaps important not to discount transphobia (or, as the GLAAD website notes 'anti-transgender violence') as a motive in an unknown proportion of these deaths. Incidentally, even a cursory perusal of the website indicates that such deaths are predominantly reported from within North and South America (particularly Brazil, Mexico and the U.S.A.). Murders of transgender people within European countries are recorded in limited numbers, the most numerous apparently being perpetrated in Turkey.

The nature of transphobia is not just a contemporary issue, for as Pfäfflin and Junge note 'during Nazi times in Germany ... transvestites and transsexuals were interned in concentration camps' (1998: 19).

One particularly high profile relatively recent example of violence to a transgender person living as a man – the murder of Brandon Teena in 1993 – displays a degree of erasure of his transgender status by, as Prosser records 'the representation of Teena in the press as a cross-dressing lesbian' (through the use of female pronouns, although he had lived as a man and articulated his desire for sex reassignment surgery, which 'was experienced by many as a second erasure of the subject' (1998: 175).

Schilt and Westbrook's second study, concerning the 'repatriation' of FtM individuals within the workplace, suggested that 'heterosexual women ... police the boundaries of who can be counted as a man – in sexualized situations, transmen's masculinity is simultaneously reinforced – as men frame them as heterosexual men – and challenged – as women position them as homosexual women' (2009: 442, 445, 447), once again indicating a conflation of sex, gender and sexuality.

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.

Stryker and Whittle's summary of Raymond's views, that trans-women 'remain deviant men ... (using) ... the appropriated appearance of the female body to invade women's spaces ... in order to exercise male dominance and aggression ... an undesired penetration ... tantamount to rape (so) that all MtF transsexuals are by definition rapists' is extraordinary in its apparent outright, vehement rejection of this minority group's right to exist. Such views might simply be dismissed as unreasonable if they weren't still 'uncritically accepted by some on the cultural left ... as a paragon of feminist criticism of medical-scientific practices' (2006: 131). Thirty years after 'The Transsexual Empire' the uncompromising criticism of transgender people within Jeffreys' book suggests that such views may still pervade modern thinking on transgender, leaving 'visible' transgender people feeling ill at ease and unwelcome in either men's or women's spaces. As Ladin recounts: 'since transition, I had avoided women-only events as scrupulously as I had when I was a man. Janice Raymond wasn't the only woman who didn't accept the validity of male-to-female transition; at a Sukkot gathering of queer congregants at my local

synagogue, one lesbian told me frankly that, after her history of abuse by men, she felt violated when she found trans-women in women-only spaces' (2012: 234).

Attitudes to Gender Reassignment Surgery

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).

However Cromwell emphasises the essentially intrusive nature of medical intervention when he argues that 'transsexual discourses are those created by medico-psychological practitioners (whose role is to) 'diagnose, classify, regulate, and produce trans-sexed bodies' (2003: 259). Billings and Urban argue 'that transsexualism is a socially constructed reality which only exists in and through medical practice ... for a diverse group of sexual deviants and victims of severe gender-role distress' (1996: 100). This idea is extended beyond the heterosexual male or female by Jeffreys who proposes that 'the transgenering of lesbians can be characterised as another example of the ways in which the medical profession has sought to straighten out lesbians' (2014: 107).

Jeffreys further extends this idea when she argues that 'the construction of transgenderism in the late twentieth century resembles in important respects, the construction of the homosexual'. Although she acknowledges that 'there were some who argued that the construction of homosexuality owed something to biology as well as culture' she goes on to explain that 'for most lesbian and gay academics it was well understood that history, culture and politics constructed the homosexual' (2014: 16). Jeffreys acknowledges Butler's recognition of the 'right to transsexual surgery as a matter of justice', suggesting that such a point of view ties 'the transgender project into a vision of progressive social change' whilst herself arguing that from a feminist perspective, 'women's freedom requires the abolition of gender' which, she implies, gender reassignment does little to promote (2014: 44). Indeed Jeffreys goes on to suggest that 'transgender 'feminism' argues that gender difference and femininity must be protected from the feminists who seek to demolish them' (2014: 48/54).

Perhaps it is the fundamental nature of gender reassignment surgery (Appendix Three) which has attracted comments about 'mutilation' (Bindel, 2007) in a more extreme way than cosmetic surgery, which, as Dull & West indicate, is also 'the expropriation of the aesthetic realm as (an) arena of medicalization' (1991: 67). These same medical-scientific practices are also the cause of increasing concern to some transsexuals themselves. Connell explains that 'most (transsexuals) hesitate, often for years, and only go forward after agonising debate ... if they go forward with reassignment it is with the hope of producing enough change to support a new practice and a viable existence'. She observes that 'most are aware of the limits of bodily change in transition and know the results will not be normative ... with many more transsexual women making open transitions and with a wide range of bodily effects being visible, sexist stereotypes are now perhaps more disrupted than enforced' (2012: 873).

The emergent transgender movement against the apparent pressure put on transitioning transsexuals to re-form their bodies as fully as possible to reflect the 'natural' male or female body, to some degree mirrors a similar movement within the intersex population. Harper's opinion has been noted that 'the simple dichotomies of sex and gender ... are destabilised within a biology increasingly understood as medically invented' reflecting increasing signs of a movement away from the reinforcement of socially constructed binary gender through medical intervention, in some of the work being undertaken with intersex patients (2007: 11/13). 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 re-formed transgender body does not have to (and indeed cannot) conform fully to the 'norm'.

Life Histories

Recently Germaine Greer (2009) has commented on MtF transgender people with an approach that suggests little progress within at least some feminist, intellectual and/or academic communities. Like Raymond, Greer fails to address the position of the FtM transsexual man (an issue that is however touched on by Jeffreys, who argues that 'the transgending of women is an antidote to feminism because it is a way in which individual women can raise their status by joining the caste of men' (2014: 101)). Both Greer and

Raymond recognise a dilemma faced by many transsexual people within society: 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 lifetime of wishing for such a transition, or feeling 'trapped' within the wrong body.

The notion of 'history' also plays a major role in 'passing' at a level beyond that of appearance and behaviour. It seems that some transsexuals create a history at transition which fits with their new role, seeking to start their lives again in a new location with a 'clean sheet' and with stories from a fictional 'boyhood' or 'girlhood' to recount, which fit with their post transition selves, and which may provide another level of protection against transphobia and hate crime. Meyerowitz notes that, from the earliest days of more widespread gender reassignment, 'Benjamin and others urged post-operative patients to hide, and even to lie about, their past lives as the other sex' (2006: 382). For other transsexuals the notion of making up a childhood, adolescent and adult history to suit their new gender role is perhaps too close to being an extension of the 'living a lie' that was part of the chronic difficulty of living in their original gender role. Goffman, in a broader discussion of stigma, acknowledges the intrinsic pervasive nature of the dilemma of 'the management of undisclosed discrediting information, about self ... in brief, 'passing'' through which an individual with a stigmatising condition must decide 'to display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case, to whom, how, when and where' (1968: 57/58).

One potential problem with constructing such an artificial history is that, if such a transsexual is found out, the notion that they might be now perceived as, at heart, someone who deceives others, might undermine at least in part the credibility that they have gained as an individual within their community. It may even be possible that this

aspect of some transsexuals' behaviour might be considered as a possible contributory factor to rejection within their community, and perhaps to the emergence of transphobia.

Kessler and McKenna report how Rachel, the transsexual subject of their study, made suggestions for what may be 'necessary' deceptions in certain situations which give insight into an apparently carefully constructed façade: 'a lot of things could be explained such as my pills, no children and the absence of the menses if I said that I had had a hysterectomy because of a cervical malignancy ... the menses, obviously I've never had them but I've been included by women enough that I can pretty well make anyone think that I have them or have had them' (1978: 178/179).

One further troubling example adds to the notion of deceptive creativity that some transgender people appear to display in seeking to meet others' expectations of them, and concerns the 'script' that some pre-transition transsexual people are said to follow in order to obtain treatment and surgery, as evidenced in a quote from Hines: 'if you see a doctor for an hour once every three months ... you quickly learn the script ... for what you should say (such as) 'I'm a woman trapped in a man's body' or 'a man trapped in a woman's body ... I've known always', you know ... the things that people say' (2007: 63). The S.T.A. survey of 2012 found that '27% of respondents reported that they had either withheld information or lied about something to a gender identity clinician. This was mainly because participants feared that treatment would be stalled or stopped, and because they did not feel that the questions were relevant to their diagnosis' (McNeil et al, 2012: 87).

Such examples need at least in part to be balanced by an understanding that some degree of caution is needed by transgender people in sharing information about their background in a world which at times can result in responses from antipathy to overt verbal, physical, emotional or sexual abuse. While deceptions practiced by some transsexuals might be regarded as contributing to the suspicion with which they are sometimes viewed, it is also important to balance such concerns with the need which many transsexuals demonstrate to please their families and those closest to them, as well as to please the 'gate keepers' for medical treatment. Hines quotes from Williams (2004: 42), who describes the transsexuals in these narratives as 'energetic moral agents ... weighing up the pros and cons of the consequences of their actions, considering others' perspectives and needs and reflecting on the decisions they make' (Hines, 2007: 129), which counter-balances Jeffreys' view of 'the self-centredness of transgenders' (2014: 83). Indeed Ladin further questions such a notion

when she explains that 'transsexuals' lives may seem strange, even bizarre, but the questions we face in becoming ourselves are the questions life poses to us all: how can we become ourselves? How can we put the selves we are becoming into meaningful, moral relationships to others?' (2012: 18).

It is also worth bearing in mind that the Beyond Barriers report on LGBT people in Scotland notes that only 80% of LGB people are open about their sexuality with their family, whilst 95% are open about this with their friends, but this figure drops to approximately 66% with their GP or employer, 75% with work colleagues, just over 50% with teachers and lecturers and just under 50% with a faith group (Morgan and Bell, 2003). Caution regarding the sharing of intimately personal information is not just the prerogative of transgender people in a less than open minded society.

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 power which was available to him previously as a woman.

The key issue of 'core values', acquired and assimilated during the period of time which was spent in one's original gender role is discussed in greater detail later in this thesis. It needs to be acknowledged, for it might be argued (and indeed, is strongly advocated by some feminist academics) that the nature of such values underpins all relationships with others because of the nature of one's self-concept. It may be that some transgender people feel that they have never identified with the values of their original gender role, although some transsexual life stories indicate an attempt to submerge transgender feelings by immersion within their original gender role. It may be that if such issues are to be resolved at an individual level and understood at a wider level, the role and importance of personal pre-transition history, as Greer and others have argued, may need to be acknowledged to a greater extent than is currently apparent within the transgender literature.

However the absence of research into this issue precludes judgement: indeed not only are we lacking detailed data into the core values of transgender people both pre- and post-transition, we lack information about the degree to which transition is reflected in alterations to their interests, activities, hobbies and leisure activities, as well as within their social circles and the nature and extent of their personal relationships and friendships.

Passing and Being Read

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 perceived or '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).

Both FtM and MtF transsexuals may seek to, consciously or unconsciously, adopt the different 'codes of conduct' of the gender to which they have migrated. Research such as that of Deborah Tannen (1992, 1995, 1996) suggests that the speech patterns and content of men and women may differ considerably, and that the presence of other men and women will also have a significant effect on these patterns and content too.

Connell brings a sense of optimistic realism when she observes that 'in the positive case, recognition as a woman need not involve passing. Recognition can equally be a matter of pragmatic acceptance by those with whom one lives and works. In most circumstances, other people do sustain interactions with transsexual women, whatever they take their identity to be'. She suggests, memorably that 'to borrow a phrase from Tennessee Williams, transsexual women depend on the kindness of strangers' (2012: 871).

Greer questions a related aspect of transsexual 'integration': their own insight into 'the extent of their acceptance as females' (2009: 74). Her query is highlighted by a quote from one trans-woman that 'to my knowledge I've never been doubted as a true woman with one exception' and that 'convincing other people hasn't been difficult ... there are lots of everyday women who are much further away from the traditional female stereotype than I

and we never question their femininity or womanhood at least' (Kessler and McKenna, 1978: 176/7). Similarly, Ladin describes her own (literal) first steps dressed as a woman: 'the sun shone full on my face as I climbed the picture-postcard hills, and, as men and women returned my smiles – I couldn't stop smiling – for the first time in my life I knew that no flaw in makeup or bone structure would keep me from being seen and accepted as a woman' (2012: 46), later relating how 'I will change from male to female on streets, in café bathrooms, in parking lots, and in the restroom of a moving bus, and one day I will set a personal record by shifting between male and female five – count them, five – times at a literary studies conference, without raising a single eyebrow on either side of the gender binary' (2012: 51).

Connell quotes Robyn, a MtF transsexual interviewee, who describes how 'I have had men call me 'love' and 'darling' and you know, so obviously I am passing as a woman now, and this suits me fine'. However, Connell goes on to indicate that 'I know from another source that she continued to have difficulties about recognition and social integration, later in life' (2010: 13, 15). That 'passing' on the street or with acquaintances and colleagues may equate to unquestioning acceptance of one's womanhood, is suggested by Ladin's description of her third meeting with Alana, who is 'gay, the best friend of one of the members of my little life-support network' during which Ladin sidesteps those questions which would allow her to indicate her background openly. She appears to be unaware of the likelihood that Alana may have been provided with more than a little background information by their mutual acquaintance, preferring to believe that 'Alana was the first friend I had made as a woman ... and, as such she had the power to confirm that my lifelong wish to become myself had finally come true (2012: 77/78). The degree to which transitioning people may need to believe this themselves, is probably incredibly high at this time, but, as others have suggested, such a belief may be misplaced. Indeed, taking a much wider perspective, Whittle states that 'in reality, despite all that medical technology can achieve, the majority of trans women cannot and will never 'pass' (and) similarly for trans men, although 'passing' might appear at first glance easily achieved, the limitations of gender reassignment mean that they will never be able to form a sexual relationship without having to disclose their past' (2000: 49/50). For some at least, Morris' 'dream of ways in which I might throw off the hide of my body and reveal myself pristine within – forever emancipated in that state of simplicity' (1974: 88), may remain just that: a dream.

As Ladin later acknowledges, after her description of her meeting with Alana, ‘to become who I am, I must admit – no, affirm, what I have been’ (2012: 80).

Kessler and McKenna discuss the ‘everyday process of gender attribution, a process that even members of the medical team engage in when evaluating transsexuals according to medical criteria’. They note that ‘genetic males at the initial stages of estrogen (sic) treatment may look like “feminine” *men*, and at some later stage may look like “masculine” *women*’ but that ‘no matter what stage of “transformation” transsexuals we have met were in, in each and every case it has been possible, necessary, and relatively easy to make a gender attribution’ (1978: 13, italics and inverted commas original).

Follow up on the notion of gender attribution suggests however that ambiguity may be more widespread than might be imagined: in interviews and group discussions of ‘visual prompts of men and women engaged in a range of non-traditionally gendered activities ... ‘trouble free’ cases were relatively rare, accounting for just 8 of the 46 instances’ of gender attribution in the study which, interestingly, does not appear to have used mainly transgender subjects. (Speer, 2005: 73).

Although Yardley undertook training in feminine skills with a male transsexual, with the result that ‘fewer people, either in the treatment situation or in outside social situations, passed comment on her behaviour or suggested that she was cross-dressed’ (1976: 336), there appear to be few studies into the success in passing of MtF and FtM transsexuals. The comparative importance of behaviour, mannerisms, height, body shape and size, facial characteristics, speech patterns, language and voice would be fascinating to explore and investigate further within the cultural context of gender attribution of males and females and transgender people, and to the acceptance or side-lining of MtF and FtM transsexuals within women’s, men’s and mixed society.

Religion

A further aspect of society’s acceptance or rejection of transgender people is also noted within this section: the role of religion. In an overview of the Jewish, Church of England, Jehovah’s Witness, Catholic, Evangelical Alliance, Buddhist, Islamic and Hindu attitudes to transsexual issues, Barrett explores the importance of religion on the attitudes of friends, relatives, close family and on the transsexual person themselves. He notes both profound opposition to gender reassignment (e.g. the Catholic church ‘does not believe that surgery

or the use of hormones is the answer'), and apparent acceptance (the Ayatollah Khomeini recognising the need for 'a clear sexual identity' (and that) 'gender reassignment surgery would be acceptable' in Iran) (2007: 278/282). The Scottish Social Attitudes survey found that there is a twelve point difference between the attitudes of those 'who attend a religious service once a week (58%) (who) are far more likely than those who do not attend at all (46%) (to be unhappy or very unhappy) about a relative forming a relationship with a transsexual person' (2007: 35/36). Ladin (2012) and Benvenuto (2012) address in some detail the notion of religion and transgender when they recount their individual stories of transition (Ladin) and coming to terms with transition (Benvenuto) within Jewish culture. Their accounts, from the separate perspectives of partners within the same marriage, highlight the dilemmas and difficulties that they faced in seeking and finding support within their religious community for their very different experiences of gender reassignment.

Links with LGBT

It is not difficult to find examples of transgender people who have found that others within the lesbian, gay and bisexual movements have been less than willing to engage with them, (Prosser, for example refers to Rubin's (1992: 474) description of 'the "xenophobia" of lesbian culture towards transsexuals' (1998: 171) which suggests it is a little questionable that LGBT should have become such an established unitary acronym. Browne and Lim in a review of 'trans lives in the gay capital of the UK', point to the 'tentative and fragile relationship trans people can have to 'LGBT' communities' so that 'trans people can then be neglected by ... mainstream policy makers ... effectively reducing 'LGBT' to the interests of the particular groups of 'L' and 'G' (2010: 621/622). Nonetheless Whittle suggests that 'many transgendered individuals have made their home in the space inhabited by the homosexual community ... lesbians and gay men have often provided a safe and welcoming space for transgendered people, no matter what level of commitment they have had to either cross-dressing or cross-living (1996: 201/2). This must be balanced however, by the recent YouGov survey for PinkNews which indicated that within the LGBT community, just 57% of gay or lesbian respondents said that they would be happy to have a transgender child (PinkNews: 2015).

The Commission for Social Care Inspection note that 'the similarities of discrimination experienced by trans people, especially when they are in same-gender relationships, explains why the LGB and transgender communities may come together in sharing areas of

joint concern, resulting in joint LGBT approaches although not all trans people, however, are comfortable with being aligned with LGB communities' (CSCI, 2008: 36). Of course this may also be true in reverse – not all LGB people may see something positive from being associated with transgender people, particularly when transsexuals appear to be perceived so negatively by so many (Bromley et al, 2007) .

Broadening this perspective, Doan, within the context that 'feminist geographers and urban theorists have argued that space is gendered and that gendering has profound consequences for women', notes that 'rigid categorisations of gender fail to include the intersexed and transgendered populations, a small and highly marginalised segment of the wider population' (2010: 635).

That such marginalisation takes place in a variety of forms within the LGBT 'community' is exemplified by the views of the feminist Julie Bindel who explained her view that 'sex change surgery is modern-day aversion therapy treatment for homosexuals' (which) 'renders gays and lesbians "heterosexual"' (Bindel, 2007). Such a confusion of the needs of transgender, gay and lesbian people, does little to aid the understanding of the general public of the different issues which affect each of these separate groups, and perhaps serves as fuel for further prejudice and transphobia.

Why does transsexuality attract such powerful dissent from within the LGBT 'leftist' sphere? Is it because, as Bindel suggests, the stereotypical gender roles which some transsexuals take, perhaps at least initially, offend feminists rather than other LGBT people in particular? As Bornstein neatly summarises: 'the concept of passing is built into the culture's definition of transsexuality, and the result is that transsexuals don't question the gender system which their very existence could topple' (1994: 127). On the other hand Rees suggests that some transitioned people are well aware of the dangers of stereotypes; 'it seems absurd to undergo all that a role-change involves in order to become a male (or female) stereotype. That would be as much of a prison as being trapped in the wrong body' (1996: 35). Perhaps though, such insight comes only with experience, for as Riddell notes: 'transsexual women were, because of our biology, usually brought up as male children ... and therefore developed ideas of what the actuality of women's existence is through the blinkers of male identity' (1996: 180).

Bindel also notes that at least some of those who "transition" seem to become stereotypical in their appearance – 'fuck-me shoes and birds'-nest hair for the boys; beards, muscles and tattoos for the girls. Think about a world inhabited just by transsexuals. It would look like the set of *Grease*' (2004). This is counter-balanced by the observation from one of Hines' interviewees that 'trans-people often over-compensate at certain times ... but I think a lot of trans people become a lot more balanced as they go through transition' (2007: 97). Connell's interviewee, Robyn, explains how 'when I first started to go through it, before I had surgery, I was over-dressing, I was blustering' (2010: 8).

That MtF transitioned people appear to attract rather more criticism than those who are FtM, and who, in time will pass more easily, suggests that appearance is a key factor in transgender acceptance or rejection, for as Skeggs suggests, in a discussion of femininity in the context of an ethnographic study, 'appearances ... are more than just surfaces. They are intimately linked to valuations of oneself, to knowing oneself and to being an accepted part of a group ... femininity is a carefully constructed appearance and/or form of conduct' (2002: 317). While it may be acceptable, and indeed for some, desirable, that some biological women do wear 'fuck-me shoes and birds' nest hair' as part of their personalised style, for those transgender people who dress in a sexualised manner, it seems that being subsequently read by others as transgender may result in a very punitive response. Perhaps the degree of this punitive rejection may be at least partially explained by Skeggs' observation that, in relation to a feminine presentation, 'all the women were concerned to be seen as desirable. To be fancied was a validation of themselves' (2002: 320), and as has been noted above, notions of homophobia and transphobia may be linked to a 'fusion of gender and sexuality' (Namaste, 2006: 588).

It is not difficult to find examples of transgender people feeling rejected within their local lesbian and gay communities. Hines for example, quoted one interviewee's experience:

'There used to be a club in Liverpool that was very gay friendly that I used to go to. And a lot of gay women went to it and I was, how can I put it? They didn't want to engage. I know that has been the experience of a lot of people' (2007: 96).

There are some heartening tales of acceptance too: quite a dissimilar experience is recorded by a second interviewee:

‘Obviously you’ve got a lot of trans men who came through a lesbian community and were affiliated to very much a sense of community’ (who) ‘may be rejected by some, but they keep quite a lot of those friends. And quite a lot of those women work through their issues with the trans thing and quite a lot resolve it ... so there are quite a lot of lesbian women who are supportive’ (2007: 99/100).

Transgender Attitudes to Transgender

What of transgender people’s own attitudes to other transgender people? Hines suggests that ‘support groups are ... vital for providing advice and information that is lacking within medical care (which is) particularly significant at the start of transition’. These support groups may ‘become less significant after the early years of transition’ so that while some transgender people may ‘still socialize in transgender environments, others ... have little social contact with other transgender people’, and ‘some transgender people do seek to move away from a transgender identity’. Hines also notes that ‘involvement in support groups was uneven, and there existed competing discourses around politics of transgender visibility and recognition’ (Hines, 2007: 171, 173/175, 189).

Whittle, in an earlier review of developments in the trans community, welcomed the notion of a ‘move away from the ‘politics of passing’ (which brings with it the) constant fear of discovery’ because, as alluded to earlier in this discussion ‘it means that all relationships begin as lies, and they rarely have a space in which the truth of one’s journey across the gender divide could be told’. Whittle goes on to explain that ‘in the community in the past, those trans people who were the most ‘non-transsexual’ looking were awarded status and privilege, whilst those who were most obviously transsexual or transgender were often the butt of private jokes and exclusionary behaviour ... but in the 1990’s the trans community took a serious look at itself and worked out that it was only by being inclusive of all trans people that the legal issues that caused ... universal oppression could be addressed’ (2000: 48/50). ‘Visibility’ has not just, however, been penalised in transsexual and transgender communities: as Newton points out, the incongruity of masculine/feminine transformation expressed by a drag queen ‘connotes low status for most homosexuals because it bears the visible stigma of homosexuality’ (2002: 442).

Fourteen years on from Whittle’s comments, it seems that most transgender people, like most non transgender people, still accept the bi-gender cultural norm in relation to gender identity and gender roles (within of course the wide ranging, individualized ways in which

such roles might be expressed) although, as has been suggested above, in an overview of Hines' research participants, there may be a range of views on binary gender and transgender identities. Namaste argues that 'society appears to want to make transgendered people invisible, possibly because no established rules or conventions exist for social interaction with people who do not consider themselves as either 100% male or 100% female' (2000: 51, from Hellen, 2009: 82). But, as the section on transcendence above has noted, there is evidence that some transgender people are seeking acceptance within society in their own right. Indeed Iantiaffi and Bockting suggest that those transgender people who have 'less rigid gender beliefs (have) lower levels of internalised transphobia, which in turn are associated with higher levels of self-esteem (2011: 1).

If some transgender people are indeed seeking acceptance in their own right, it remains to be explained why a widespread positive ethos hasn't evolved for a notion of transgender identity similar to the sense of gay pride evidenced in LGB communities. Perhaps Bornstein is right in suggesting that transsexuals keep away from each other because of a sense of implicit threat, because, 'two or more transsexuals together ... can be read more easily *as* transsexual – so they don't pass' (1994: 63). And is transphobia still present if contemporary transgender people who don't easily pass, and who fail to consistently meet 'performance' standards, also evoke the very feelings and prejudices in other transgender people which are so readily displayed by the rest of society, of rejection of someone who blatantly breaks the gender code, as Whittle (2000) has so eloquently described?

Historically, 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). In the last decade there has been an increasingly common 'reality or docu-drama' approach to the lives of transgender people on television, including the recent series 'My Transsexual Summer' looking at the experiences of seven trans-men and trans-women, aged from twenty two to fifty two, meeting for 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). With public interest and knowledge of transgender apparently

greater than ever before, perhaps there is an opportunity for a greater unity and pride amongst the transgender community to ensure inclusivity of all transgender people, including those who do not or cannot fit within binary gender norms.

In the meantime, within the last decade, observers such as Bockting et al are still suggesting that 'transgender people who feel socially disconnected may look to other transgender people for companionship, support and a feeling of community, (but) individuals with an idealized image of safety and support may be surprised and disappointed to find that they are not uncritically accepted and welcomed, that shared transgender identity is not sufficient common ground for intimate relationships, or that internalized transphobia affects bonding between transgender peers'. They explain these comments further when they add that 'some transgender individuals shun connection with the transgender community in an effort to normalize and mainstream their lives in conformity with social norms' (2006: 68). Bockting later argued that 'the desire to "change sex" in a binary way and the actual reality of living life as a gender variant person can be quite different; through facilitating a "coming out" process, psychotherapy can aid in grieving the loss of the ideal to make room for a deeper level of acceptance of one's transgender (as opposed to male or female) identity' (2008: 211).

Ladin, in a disarmingly honest account of her first attendance at an LGBT public demonstration, describes 'the real reason I had to go to the march – to learn to see myself as us, or rather, to see my internalised transphobia, my own self-loathing for being trans, projected outside me, to stare it in the face, in all of our faces, and see whether I could see through it to the human beings behind our handmade masks of gender ... I wasn't there because I was proud; I was there because I was ashamed. I was there not because it was my responsibility to stand up for others but because only among those I didn't want to resemble – only among us – could I learn to stand upright' (2012: 201).

Transgender and Mental Health

By exploring mental health issues this section pre-empts a little the following, wider ranging, discussion of the medicalization of transgender. This section looks at how transgender conditions have been viewed within psychiatric services, through clinical diagnoses which suggest that predominantly medical models of treatment may therefore be appropriate, before considering the wider social implications of being transgender on mental health.

In the case of transvestism, for example, the recognition that diagnoses and treatments are no longer widely available is put into perspective by Brierley's detailed exploration of such treatments, going back to the 1950's and 1960's when ECT, behaviour (usually aversion) therapy, and classical conditioning (to reward normalised behaviour) were each in evidence (1979: 159/194). Even when such treatments have proved ineffective, it may be hypothesised that at least some contemporary referrals to transgender related health services for oscillating transvestites might be linked with 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).

Few of these treatments have been viewed as successful and/or appropriate in the long-term, except perhaps for reducing fetishistic cross-dressing, although Barrett comments that both fetishistic and dual role types of transvestism would still 'probably be reasonably familiar to any general practitioner or psychiatrist' (2007: 31). 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, although Barrett's health services oriented 'practical guide to management' does not discuss this issue, despite the recency of publication (2007) and ongoing discussions about the use of puberty blockers for young people. Work in Holland in particular indicates notable success in clarifying and addressing the needs of transsexual adolescents prior to puberty, including the use of puberty blocking hormones where appropriate. The potential value of puberty blocking hormones is further explored in depth by Cohen-Kettenis and Pfäfflin (2010). The results of this work, with young transsexuals being given time to make an informed decision about the option of gender reassignment without the imminent threat of puberty, does however highlight the dilemma of working with young people with apparent gender identity disorders, who may in some cases at least, come to believe that they are not transsexual. Follow up studies are discussed in more detail in the second section of Appendix Six to this thesis. Jeffreys however, severely criticises the practice, and, while making a link between eugenics and the transgendering of children, expresses concern that 'children as young as ten years in Australia with the connivance of the Family Court, are being put on puberty delaying drugs' (2014: 122). She concludes that 'a form of social engineering to force children to conform to rigid gender categories is taking place' (2014: 140). Ladin however provides a perspective on one transgender adolescent's dilemma when she describes, presumably with a touch of humour, her own experience of puberty, long before her transition: 'my gender identity was female, but my hormones weren't, and, as tsunamis of testosterone washed over me, I felt like a groin with legs, a sperm delivery system looking for somewhere, anywhere, to erupt' (2012: 124).

Kennedy and Hellen, referring to Whittle et al's (2007) 'Engendered Penalties' document, 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 of these (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' (2010: 40). Kennedy and Hellen's conclusion, that 'as a minimum, schools (should) introduce children to the concept of transgender people, so that transgender children are able to feel that ... their gender identity is as valid as any other' appears to be a proposal which is far from the experiences of many. Almost twenty years earlier, Martin had suggested that 'cross-sex behaviour in boys generally is viewed more negatively than cross-sex behaviour in girls ... sissies were more negatively evaluated than

tomboys ... (because) sissies ... were expected to continue to show cross-gender behaviour into adulthood (and) were rated as likely to be less well adjusted, and more likely to be homosexual when they grow up than other children' (1990: 151), in apparent confirmation of the notion that imitating a subordinate group is likely to be interpreted negatively. However Whittle et al note that their research counters the notion that there is less tolerance of 'sissy boys' than tomboys, finding 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).

These additional difficulties for trans boys gradually dissipate for, 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).

Meyer explores the internalization of negative stereotyping in considering the effects of homophobia on LGB people along a continuum from 'external objective stressful events and conditions ... expectations of such events and the vigilance this expectation requires ... concealment of one's sexual orientation and ... the internalization of negative societal attitudes' (2007: 244). While no direct link is made to the likely effect of transphobia on transgender people, it seems probable that the equivalent experiences for transgender people (with a substitution of gender identity for sexual orientation) have similar stressful consequences, perhaps linked with the internalization of transphobia noted earlier.

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, as Hines notes 'the partnering and parenting relationships of transgender people are ignored not just within sociologies of the family, but also within gender research' (although 'many participants stressed the significance of their friendships with other transgender people') (2007: 127, 156). 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' and 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). Benvenuto, in her search for support for herself and her three children regarding her partner's transition, describes the difficulties of finding suitable support, eventually working with a transgender specialist who, 'for the first time in her practice ... was being asked to consider the ramifications of switched gender not for the person who chooses it, but exclusively for the partner and family members' (2012: 90).

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). Goffman's broader consideration of stigmatizing conditions suggests that 'the possession of a disreputable secret failing takes on a deeper meaning when the persons to whom the individual has not revealed himself are not strangers but friends' (1968: 84). Perhaps coming out for the first time as transgender prior to transitioning might cause rifts in friendships where the nature, reality, and honesty of a relationship are subsequently re-examined and questioned.

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). Kennedy and Hellen also explored these issues when they suggest that the effect of living 'many years of their lives unnecessarily having to deal with feelings of guilt and shame' may lead to 'substantial underachievement in all areas of their lives'. They particularly draw attention to 'one of the most marginalized and excluded groups: transgender children', who, they argue, becoming aware of their gender dysphoria at a very early age, subsequently live a life that 'is about concealment, suppression, stigmatization, fear, isolation, doubt and repression' (2010: 25).

The recent YouGov survey for PinkNews, indicating that 10% of voters from Scotland would not support a transgender child and that only a little more than a quarter of those polled across the UK (27%) said that they 'would be happy to have a child who wanted to change their sex', is perhaps indicative of the degree to which transgender continues to remain unacceptable (and by implication, unaccepted) within society (PinkNews: 2015).

However, 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 transpeople' (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).

These findings must however be counter-balanced by the 81% of participants who felt that they had gained 'confidence, new friends, improved/better quality relationships, community and a sense of belonging, self-expression and acceptance, knowledge and insight, happiness and contentment, resilience, and a future' as a result of being trans, transitioning, or expressing their gender identity. However, while 'only 53% had no regrets (and) 34% had minimal regrets' almost one in eleven '(9%) had significant regrets ... in terms of social changes that they had made in relation to being trans. The most common regrets ... were: not having the body that they wanted from birth, not transitioning sooner/earlier (problems with surgery and) losing friends and family'. 'Most worried that other people would find their bodies unattractive (81%) or that few people would want to have sex with them (79%) (while) 58% were also worried about their physical safety in relation to having sex ... following transition, many participants experienced changes in

their sex lives, although while 38% indicated that this had improved, 20% felt that their sex life had worsened following transition' (McNeil et al, 2012: 89/90).

A wide perspective on current services was sought by Mitchell and Howarth in their UK based 'Trans Research Review'. They noted that despite 'health and social care issues (which) included isolation, risk of alcohol abuse, suicide, self-harm, substance abuse and possible higher rates of HIV infection, there was a lack of health services targeted specifically at trans people outside of gender reassignment provision'. They concluded by noting that 'future research might ... examine the issues around mental health, sexual health and physical health more systematically and examine how subsections of the trans population may experience health inequalities in different ways' (2009: 62).

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 a 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. However, '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 overall mortality, death from cardio-vascular disease and suicide, suicide attempts, and psychiatric hospitalisations in sex-reassigned transsexual individuals compared to a healthy control population' (2011: 7). (Additional Follow Up studies are discussed in Appendix Six). The NHS/Glasgow University survey found that levels of self-harm 'far-exceeded expected population norms' (Wilson et al, 2005: 28) and McNeil et al found that 52% of participants had self-harmed in the past, with more than one in ten (11%) currently self-harming (2012: 88).

McNeil et al's survey also found that within mental health services, 29% of the respondents felt that their gender identity was not validated as genuine, instead being perceived as a symptom of mental ill health ... 17% were also told that their mental health issues were because they were trans' (when they themselves saw them as a separate issue) ... '45% of participants had 'used mental health services more before transition, 18% more during, and 0% more ... post transition'. 88% of participants felt that they were either currently suffering from depression or had previously experienced it, 80% felt that they were either currently suffering from stress or had previously experienced it, and 75% felt that they were either currently suffering from anxiety or had previously experienced it (McNeil et al 2012: 87).

Greenwood and Gruskin note 'high levels of daily stress due to stigma ... discrimination ... and transphobia for ... transgenders' (sic) which they link with 'high rates of smoking ... and drinking', while acknowledging that 'precise estimates of disparities in smoking and drinking for LGBT's have been difficult to gauge (and that) the direction of causality is not clear' (2007: 566/572). McNeil et al suggest that as many as 62% of respondents may have either alcohol dependency or abuse issues (2012: 88). In addition Lawrence found that 'some transgender persons have a high prevalence of ... HIV/AIDS and other sexually transmitted infections (and they) appear to have an elevated prevalence of co-existing mental health problems' (2007: 473).

Kuiper and Cohen-Kettenis are particularly explicit in their support of 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).

Health and Social Care Services

In this section, the notion of support to transgender people, particularly at the time of transition to those who are transsexual, is explored within the context of the literature on both health and social care services.

The Medicalization of Transgender

The growth of interest in transgender matters since the middle of the 20th century was fuelled by the publicity surrounding Christine Jorgenson in 1952 ('the most famous transgender person in the world', Stryker, 2008: 48), in the U.S.A. Roberta Cowell had received similar publicity in the UK two years earlier, and, following her gender reassignment may be cited as one of the earliest transgender people to recognise the construction of gender roles : 'I always had to remember that I was building a new personality' (Hausmann, in Stryker and Whittle, 2006: 343) Although Meyerowitz notes that 'by the mid-1950's the mass media were reporting constantly on sex change ... it was not until the late 1960's that more American surgeons began to perform sex reassignment surgery' (2002: 97). Similar gradual developments in the provision of reassignment surgery (see Appendix Three) in Britain may have reflected the uncertainties of 'legal implications (because) in most countries the law was hazy about the definition of sex and even obscurer about the legality of trying to change it (but by 1972) the climate of medical opinion had shifted, ... in England ... several hospitals now operated upon transsexuals (and) perhaps ... a hundred and fifty had been operated on in Britain, many of them free under the National Health system' (Morris, 1974: 121).

Information on reassignment of transsexual people in Scotland came from Wilson et al who sought information from GP practices in Scotland, 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'. Eighty five patients (31%) had presented within the last 12 months. However 'several responders added comments to the effect that they lacked knowledge both of the condition itself and of pathways of referral' (1999: 991).

Whittle has argued that 'the medical discourse surrounding transgendered behaviour which labels them (sic) mentally ill (is one of) several big obstacles to be overcome' (2000: 45). Despite many transgender people believing that the condition of being transgender should not be regarded as a disease, it is still included within 'the ICD-10 (the International Classification of Diseases) (where it is defined) as a desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with one's anatomical sex' (Barrett, 2007: 17). Whittle notes that the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-3) 'removed homosexuality from the list of psychosexual disorders, whilst at the same time it added transsexuality' (1996: 197). However the 2013 version (DSM-5) notes that having a transgender or gender non-conforming identity will no longer be classified as a mental disorder. Instead the notion of gender identity disorder is replaced by gender dysphoria whose critical diagnostic feature is 'clinically significant distress associated with the condition' (2013). Increasing rejection of medical diagnoses of transgender conditions as disorders of personality and behaviour within ICD 10, has also resulted in pressure to amend the next ICD edition accordingly.

Whittle and Turner cite Kessler (1990) and Dreger (1998) who in critiques of the treatment and management of people born intersex, suggested that a distinction between two separate sexes can only be maintained by 'medical intervention into chromosomal gonadal and genital variation'(2007: 3). Harper suggests that 'there are arguments that transsexuals are 'psychological intersexuals' blending the *psyche* of one sex with the *body* of the other (Harper, 2007: 11, italics original). It does not seem such a large step then, from the potential 'optional' identity of 'intersexuality' as a later choice for some assigned intersexual children, that some transsexuals may also choose to retain their ambivalence to a single male or female gender, and instead opt for a truly 'transgender' option. Often, as Bradley suggests, 'to be transsexual ... means rejecting an identity in one half of the binary, as a man, and repositioning oneself firmly as a woman' (2007: 74/75). The possibility of intersex being recognised as distinct from the male and female sex has offered a tantalising hint of the possible recognition of transgender as being distinct from the male and female genders, within Scotland.

However, as Hines points out, the notion of 'transgender identity' is a complex one, which may not be easily assimilated into society because '(trans) gender identities are cut

through with difference, while the concept of difference itself is contingent upon social, cultural, political, temporal and embodied considerations. This is significant when considering the divergent identity positions and varied subjectivities which fall within the broad umbrella of ‘transgender’ (2006: 63). Moran and Sharpe take this approach too, concluding that ‘it is necessary ... to recognise the many differences between transgender people ... along the axes of race, ethnicity, class, age and sexuality as well as differences between transgender women and transgender men and the different meanings the term *transgender* has, including its relationship to surgery, for different people’ (2001: 281, italic original).

Health and Social Care Service Provision to Transgender People

Mitchell and Howarth found ‘no large scale surveys or research that focused specifically on the health and social care needs of the trans population’ (2009: 62), and this finding is reflected by Boehmer who expresses concern that ‘LGBT issues have been neglected by public health research’ (2002: 1125). Significantly, Feldman and Bockting (2003: 25) note in relation to actual service provision that ‘transgender persons represent an under-served community in need of sensitive, comprehensive health care’.

Transgender people may present with specific (gender-related) health needs which may be directly related to their transgender condition (e.g. transitioning issues such as breast removal or vaginoplasty) or linked with these (e.g. associated surgical, hormonal or psychological health issues). In addition they may seek treatment appropriate to their transitioned gender (e.g. breast screening for MtF transsexuals, screening for coronary heart disease for FtM smokers), or to their biological sex (e.g. prostate screening for MtF transsexuals, cervical screening for FtM transsexuals).

Health Care

There is a variety of guidelines, policy documents and information booklets to residents within the UK and beyond. Whittle et al’s ‘Transgender Eurostudy’ provides a wider view on the attitudes of and services that are provided by European governments to transgender people, and this gives a useful perspective on current British and Scottish provision. For example, almost half (thirteen) of the twenty seven member countries provide funded psychotherapy, although the UK is not included in the list of providers. Thirteen member countries provide vaginoplasty, and a similar number provide phalloplasty to transsexual

people. The UK is one of only four member countries to provide specific privacy protection for transgender people in their new gender role (2008: 25, 27).

Good practice guidelines for working with transgender patients in the UK include the first edition of the 'Parliamentary Forum on Transsexualism: Guidelines for Healthcare Providers who Commission Treatment Services for Individuals Experiencing Gender Dysphoria or Transsexualism' (2006). This thoughtful, referenced report includes a discussion on the treatment of children and young people, including reference to the 'Gillick' court case regarding a dispute between a person under 16 and a 'Responsible Person' about treatment for transsexuality. It is later indicated that a 'Gillick competent' young person may, for example, make decisions about puberty blocking hormones (assuming that these can be made available via the NHS) without reference to a person with parental responsibility.

The second, retitled, edition of these guidelines (Parliamentary Forum on Gender Identity: Guidelines for Healthcare Providers who Commission Treatment Services for Trans People, 2009: 8) has been significantly rewritten, and while still both very informative and balanced in its reporting of research and knowledge of gender dysphoria, including definitions, terminology, legal responsibilities and obligations, and health commissioners obligations, (and a useful annex on diagnosis and aetiology) does not mention Gillick, and is much more cautious in discussing the potential use of puberty blockers, which however, it suggests 'may be given to carefully screened individuals'.

The booklet 'Medical Care for Gender Variant Children and Young People : Answering Families Questions' (Department of Health, 2008), sensitively attempts to directly address the concerns of parents as well as other family members, as well as gender variant children themselves. The booklet also covers assessment, suspension of puberty, changing gender role (including hormonal medication) and treatment elsewhere than in the UK.

There is also a companion to the 'Medical Care for Gender Variant Children' booklet : the Department of Health guidelines 'A Guide for Young Trans People in the UK' which is a document written by and for young trans people, covering issues from 'what is trans?', to talking to parents, passing tips, and 'taking it further'. The final section of the booklet, on support and positivity, builds on aspects of self-esteem, including issues such as 'trans

respect', and 'identifying positively as trans' which includes an exhortation to 'celebrate our trans status' (Department of Health, 2007a).

The second edition of the Parliamentary Forum guidelines (2009) is intended to be complementary to Department of Health guidance within a leaflet providing an 'Introduction to Working with Transgender People for Health and Social Care Staff' (2007b). This provides ten basic information statements, including explanations of the incidence of transsexuality, the nature of transvestism, and short statements on the terms transgender and trans, employment discrimination, transition, reassignment surgery, and sexuality in trans people.

Examples of Health Service local agreements on working with transgender people are becoming available too: for example, NHS Greater Glasgow and Clyde have developed a transgender policy which addresses both the provision of generic health services (including access to services, in patient accommodation, sex-specific services and transgender identity disclosure) and the duty of the NHS Greater Glasgow and Clyde to its transgender employees (including respect for their gender identity, the issue of genuine occupational qualification (see below), single sex facilities, dress codes and harassment (2010: 7/11).

(This notion of 'genuine occupational qualification' appears occasionally in the media, and refers to the 'very limited circumstances (in which) an employer can claim that a certain religion or belief is necessary for a role. In other words, the religion or belief is considered to be a genuine occupational requirement. Similar exceptions apply to other grounds for discrimination, such as race and gender' (E.H.R.C. 2010a). Once a transgender person has legally changed their gender, they have a legal right to take on gender specific tasks which may include those linked with a genuine occupational requirement for gender).

In addition Whittle et al have written guidelines which include recommendations for 'all healthcare providers (covering) training about trans people's issues (including) an understanding that ... there is no basis ... to refuse medical help ... to someone ... presenting with a trans issue, (as well as) education on ... trans patient's rights, simple education and leaflet guidance for doctors, nurses and other health care staff ... on issues of dignity ... the right to be treated as a member of their new gender, and privacy obligations' (2007: 51).

These recommendations might usefully be considered in the light of existing research into doctor/patient relationships. Stewart et al noted that 'there are aspects of the

doctor/patient relationship which make important contributions to compliance, satisfaction and recovery'. For example 'the doctor's knowledge of the patient's complaints was positively associated with their alleviation' (1979: 81). As one concern of transgender people already noted is that their GP may not understand their condition, a doctor's knowledge of transgender issues may be of significant importance to the trust established between the GP and the transgender person. Of course it is likely to be the GP who will make the initial referral for assessment to a gender identity clinic or for mental health assessment, for someone presenting with gender identity problems for the first time. Robinson 'describes challenges faced by transgender patients in seeking medical treatment' and details best practice that medical services should implement in order to optimize positive outcomes including an initial lexicon of terminology and policies and practices to provide effective and appropriate healthcare services to transgender patients (2010: 364).

Additional guidelines which have been drawn up in other countries include Feldman and Goldberg's (2006) sensitive, detailed and wide ranging 'guidelines for clinicians' regarding transgender primary medical care in British Columbia. These include valuable appendices that detail recommendations for MTF and FTM patients, summarised by area of health, which may be of assistance to medical practitioners elsewhere who are unsure of the consequences for both general health and specific transition health issues in transgender patients. This wide ranging but accessible paper includes discussion of general medical histories, physical examinations, cancer, cardiovascular disease, diabetes, HIV and Hepatitis B/C, mental health, musculoskeletal health, sexual health, substance use and thrombosis.

Similarly, de Vries et al's thoughtful guidelines for 'caring for transgender adolescents in British Columbia' (2006) explores 'ethical, legal and psychosocial issues'. It notes that 'the sex ratio of (transgender) adolescents approaches a 1: 1 relationship' and that these adolescents 'may suffer deeply from fears relating to the physical changes of puberty ... or to the changes already experienced in puberty', while noting that 'prevalence data are lacking for pre-pubertal children' (2006: A-1/A-2). Diagnostic procedures are discussed in detail as are potential psychological interventions. A consideration of physical treatments includes 'fully reversible interventions: pubertal delay ... partially reversible interventions: cross sex hormone therapy (and) irreversible interventions: surgery' (2006: A-9/A-10). Some psychosocial issues are also addressed including safety, poverty and homelessness, sex work, sexual health and body image (2006: B-3/B-5). The latter part of the paper

sensitively explores ways of 'supporting transgender emergence in adolescence (2006: B-13) with a touching final section on the 'integration of transgender identity into core identity which 'some clients describe ... as being 'able to imagine a future'' (2006: B-16).

Fikar and Keith's valuable paper on library resources and the information needs of LGBT individuals and LGBT members of health care teams suggests that 'major areas of need include the topics of health care proxy, cancer, adolescent depression and suicide, adoption, sexual health and practices, HIV infection, surrogate parenting, mental health issues, transgender health issues, intimate partner violence and intimate partner loss'. They note that advice and information relating to each of these topics need to be made available within LGBT-friendly health information services in 'an effort to show acceptance of cultural diversity' (2004: 1/2).

In a review of ways of 'enhancing transgender health care' Lombardi suggests a number of strategies including acknowledging 'the authenticity of transgender individuals' identities and lives', promoting 'the view that discrimination and denial of services to transgender men and women will not be tolerated'. Lombardi suggests that there is a need to allow 'young people some flexibility in questioning their gender identity', for advocating 'for cultural relevancy within research, policy, education and prevention programs, and direct care contexts', and also for advocating 'for more and better promotion of transgender-related research and for more innovation within transgender health care practices' (2001: 871).

The notion of a coordinated health care service has been explored in the south of England in a detailed proposal for 'a client-centred Care Pathway for Transpeople in Brighton and Hove'. This would include GPs, Consultant Endocrinologist, Consultant Psychiatrist, Gender Reassignment Surgeon, Voice Therapist (all of whom were already identifiable within the local PCT) and counselling (which was 'not represented within the NHS system') (West, 2004: 24/27). West stresses that although Brighton and Hove 'already has everything we need to make a fine Integrated Local Service (what) is needed is to integrate what already exists'.

Lastly, the Scottish Needs Assessment Programme (2001: 16) which reviewed services to transsexuals and those with gender dysphoria in Scotland, concluded that 'transsexual people in Scotland should be offered the full range of (local, community based, patient-

centred) services ... taking into consideration a social model of health'. Their report also recommended that 'urgent consideration should be given to establishing a surgical facility in Scotland. It was concluded that 'most of these recommendations would be met by the establishment of a national service such as a Managed Clinical Network for Transsexual People in Scotland' within which the issue of post-transition health issues might also be usefully included.

The recent publication of the Scottish Protocol for Gender Reassignment for Transsexual Patients (a summary of the protocol is included at Appendix Three) is a valuable step towards such a national managed service. This 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 available in Scotland, and who are referred to the Tavistock Centre in London.

The Real Life Test/Experience

Barrett distinguishes between a time limited real life test, and the real life experience, which 'is very likely to last the remainder of the patient's days'. The real life test affects migrators who are seeking to live permanently in their preferred gender role. It is a requirement of health services in Britain that a minimum of one year is spent successfully living in this role prior to gender reassignment surgery which is largely irreversible (see Appendix Three). Private surgery is unlikely to require any test period. Some gatekeepers to NHS funded surgery require a longer test period - the Charing Cross Hospital requires migrators to live in their chosen role for two years, for, as Barrett records, 'several patients who have seemed to be good candidates at twelve months have seemed very much less so at eighteen'. He notes however that delaying surgery for too long may result in 'increased psychopathology' (2007: 71/73).

Although Doan notes Namaste's (2000) description of 'the powerful silencing of transgendered individuals, rendering them invisible for the most part to North American society' she argues that 'gender transitions are never private affairs; by design they occur in public spaces and provide a different lens with which to view the gendering of public spaces' (2010: 640). Thus Barrett defines success in living in a chosen gender role as 'occupational, sexual, relationship and psychological stability', and goes on to explain the

first of these criteria in more detail: holding 'down a fulltime (or equivalent part time) occupation' (not including 'work in a purely transvestite or transsexual environment'), where the transgender person 'is treated by most others as if they are of the assumed sex'. Barrett explains that clarification of the degree to which a patient is 'passing' (both within their preferred gender, and the test itself) may be ascertained by whether a stranger would 'address the patient as male or female' (2007: 72).

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. Although figures are not available to indicate the number of transgender people who enter the real life test with the intention of permanent migration, it is anticipated that the proportion is likely to be significantly higher than those who view the real life test as a trial to see whether life in an opposite gender role is both feasible and satisfying.

Whittle's 2008 paper provides useful guidelines for changing a range of documents within banks, health services, government agencies, etc. In some cases these are relatively straightforward, particularly if a letter of support from a doctor can confirm that the change is intended to be permanent. The issuing of a Gender Recognition Certificate (GRC) of course may make any future name changes more straightforward, but Whittle is clear that a GRC 'is never required for a lawful change of names and gender pronouns for trans people' (2008: 3). As a transgender person needs to live in role for a full two years before an application for a Gender Recognition Certificate can be made, the provision of a GRC is perhaps of little relevance to documentation changes during the real life test.

Social Care

The O.E.D. online (2014) gives a broad definition of 'care' as 'the provision of what is necessary for the health, welfare, maintenance, and protection of someone or something'. It defines 'social' as 'relating to society or its organization', whilst also acknowledging that social involves 'companionship' because we are 'best suited to living in communities', suggesting a potential definition of 'social care' as the promotion and provision of social welfare etc., *by* and *within* a community.

In an introductory paragraph the UK Government website suggests that social care involves 'extra care or support - practical or emotional - to lead an active life and do the everyday things that many of us take for granted'. This includes enabling 'people to retain their independence and dignity', and treating 'service users with respect, dignity and compassion' (UK Government, 2013). It is the word 'extra' here that stands out, implying as it does that, without additional support and care, some people might be unable to retain (or indeed attain) independence and dignity.

The British Association of Social Workers (B.A.S.W.) adds a further dimension to this discussion when, within its code of ethics, it explains that 'the social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being' and that 'principles of human rights and social justice are fundamental' (2012: 6).

These statements and principles usually become translated into social care practice through underpinning legislation. Following the introduction to the UK Government website referred to above, there is a list of six policies relating to different aspects of social care. This is perhaps unsurprising, for as Hill suggests 'social policy making must ... be seen as a political process' (1988: 9). How such national policies are subsequently translated into local policy strategies and policy statements is alluded to by Coulshed when she explains that local planning and development takes place within 'the boundaries of (the organization's) authority in policy-making'. She notes that, following the development of a local mission statement, and consequent strategic and operational plans, 'developing a new service ... customarily starts with information gathering (leading to) a community profile by which ... needs and present resources are assessed' (1990: 53, 65). One of the central themes of this research is, of course, to assist with information gathering on the needs and present resources for the social care of transgender people in Scotland.

Need and Needs Assessments

Coulshed goes on to link policy making with the notion of needs assessment (1990: 64/65), distinguishing between Forder's (1974) understanding of social need within five categories: 'felt', 'expressed', 'prescribed', 'comparative' and 'national' needs. However, before discussing these terms with specific reference to transgender issues, Maslow's (1943) more generalised categories of need ('physiological' 'safety', 'love/belonging', 'esteem' and 'self-actualisation') are firstly considered in this context.

Maslow's hierarchy of needs, nowadays often represented in the form of a pyramid, begins with basic 'physiological' needs including food, water, sex and sleep. It might be difficult to argue that transgender people are regularly unable to meet any of these needs, any more than most other people in society, although perhaps access to both pre- and post-transition sex may be affected by transgender status. However, McNeil et al found 'high rates of homelessness' in their survey, with 19% reporting 'having been homeless at some point, and 11% having been homeless more than once' (2012: 90).

At the next level, 'safety', examples have already been noted highlighting the potential vulnerability of transgender people and in particular those who are undertaking transition. At the level of 'love/belonging', it is also clear from parts of this literature review that friendships, family and intimate relationships which bring companionship and affection, may be disrupted or fractured for transgender people, particularly during and after transition.

'Esteem' (which includes self-esteem, achievement and respect by others) is potentially less clear cut, for transgender people may see the achievement of a state of resolution of their gender dysphoria as something to be justifiably proud of, as a boost to their self-esteem, even if this is not always reflected in others' perceptions of them, or the respect they receive from others. The final level, including morality, lack of prejudice and acceptance of facts, is one to which transgender people may have aspired through their transition in giving, as Williams alludes, consideration to their families as well as themselves whilst seeking to accept and resolve the complex reality of their own situation within an often prejudicial society (2004: 42).

Forder's (1974) needs may be interpreted as even more relevant to the provision of social care for transgender people because they suggest ways in which assessment and self-assessment may assist the progress of an individual from a state of need to one of progression or even resolution of that need. 'Felt' need for example may be attributed to the state that many transgender people describe when they first realize that their gender identity is radically different from others' perception of their gender. 'Expressed' need within a transgender context might be first seen in the simple sharing of this conception of gender identity with a trusted other such as a sibling, parent, friend, counsellor or teacher, or a request by a transgender person to voluntary sector workers, their GP or staff at a gender identity clinic for assistance. 'Prescribed' need may be the result of formal or

informal assessment by others, including voluntary sector workers and gender identity clinic staff, to determine the nature of someone's apparent gender dysphoria and to determine support plans. 'Comparative' need may result, for example, from an assessment of the differences in assistance needed to help MtF and FtM transgender people to transition. And 'national' (or societal) need may be unwritten, (for example the 'need' to retain a bi-gender dichotomy within society) or may be highly specified (for example through the bureaucracy that ensures that documentation reflects a person's current gender status within clearly prescribed binary categories).

The notion of needs assessment within a community profile, as noted above, is also applied at an individual level within 'a developmental framework – one that deals with the normative stages, tasks and crises of the entire life span' as explored by Egan (1986: 128). This stage completes this necessarily brief, generalized exploration of the processes of government policy and the meeting of individual needs within both formalized social care services and also within less formal support networks, for 'the 'concept of 'care' (is also) practiced at both an individual and collective level (which) goes beyond a political comprehension of care as it relates to welfare policy, to explore care as a practice of everyday support' (Hines, 2007: 35), involving the input of friends, family, neighbours, and colleagues too, to which might be validly added, appropriate support to each of these groups.

Good Practice in Social Care

As noted earlier, Mitchell and Howarth found 'no large scale surveys or research that focused specifically on the health and social care needs of the trans population' (2009: 62), and this absence of research is necessarily reflected in the brevity of this section. However, despite some documented evidence for discrimination against transgender people in social care situations, there are also valuable suggestions for good practice and guidance for organizations, staff and transgender people to be found too.

Mitchell and Howarth (2009) discussed best practice in social care with specific reference to the Commission for Social Care Inspection's guidance (2008), Johnson's comprehensive study of care within transgender communities in the UK (2001), and Burns evaluations of care services for transgender people (2005), each of which may provide useful methodologies of social care evaluation. They note that the CSCI guidance is mainly concerned with LGB issues, with just 'a short chapter on trans people', but that Johnson

provides 'a discussion around the general issues for trans people in care, both informal and residential (and) provides many recommendations for residential carers to meet the needs of trans people' (2009: 60).

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). Such fears are evidenced and discussed within the film *Gen Silent* where gay, lesbian and transgender people discuss their experiences of aging openly and honestly. Where these experiences are within a relationship or community they can be heart-warming. Where the individual is alone they become distressingly evident of isolation and fear of discrimination (Maddox, 2010). 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 a 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).

At the time of writing, there were several readily available UK based factsheets or booklets aimed at transgender people or their carers:

The Age UK factsheet on 'transgender issues in later life' in England (2010) addresses issues from types of trans people to transitioning in later life, from pensions to wills, from sexual orientation to the Gender Recognition Act (UK Government, 2004) and as such provides valuable though fairly basic information which care staff might find useful, although much

of the way that the factsheet is presented suggests it is aimed more directly at trans people themselves.

The Age Concern booklet on 'opening doors to the needs of older lesbians, gay men and bisexuals', recognizes a number of issues affecting transsexuals, including the distinction between gender identity and sexuality, pensions, benefits and housing, and the need for dignity and respect which 'were highlighted as a basic entitlement even if the person does not conform to society's perception of 'normal'', concluding that there is a need to educate people such as health care workers to respond to the person and not to the shape s/he inhabits, and not to treat people as curiosities (2002: 22).

There is also guidance provided by the Scottish Executive for local authorities in Scotland on 'how to improve policy and practice in relation to ... LGBT people' although this is undermined by its inclusion of all four groups together, with very little differentiation of the needs of lesbian, gay, bisexual and transgender people. It does however contain useful checklists for a number of service areas including policy and planning, and employment and training (2006: 1, 18/23).

These guides to social care have so far implicitly suggested that social care is the product of a service provider, either statutory or privately funded. Hines however notes the 'concept of 'care' as practiced at both an individual and collective level' (2007: 35). It might be assumed that transgender people might look for social care support from within the network of their immediate family or friends, reflecting the practices of a wider society, not least because as Ryan et al have noted, family acceptance predicts greater self-esteem, social support and general status (2010: 205). However, as previously noted, Hines has acknowledged that 'the partnering and parenting relationships of transgender people are ignored ... within gender research (although) many participants stressed the significance of their friendships with other transgender people' (2007: 127, 156) and Whittle et al noted that while 'support within the birth family can be excellent ... this is primarily the case for trans-men and not often for trans-women' (2007: 69).

Indeed Johnson notes that 'unlike most family units, transgender people can have little or no support to call on, and often use statutory, voluntary and private caring services, who in turn may themselves have prejudiced views about the transgender client' (2001: 6). Johnson's paper, while not directly reporting on the experience of transgender people in

care, does attempt to write guidelines for how carers might better meet the needs of transgender clients, some of which correspond with current, more general Care Standards issued by the Commission for Social Care Inspection (CSCI) in England (now the Care Quality Commission (CQC)), and the Scottish Commission for the Regulation of Care (SCRC).

CSCI also issued a bulletin within their 'Equality and Diversity Matters' series, on 'Providing appropriate services for lesbian, gay and bisexual and transgender people', within which three pages (of thirty eight) are devoted to the needs of transgender people (2008: 36/38). Just six out of four hundred home care agencies and care homes in the sample of those who had submitted Annual Quality Assurance Assessment forms 'had carried out some work on gender identity, in every case in response to having a transgender person using the service'. In recognizing that 'transgender people may face prejudice from staff, other people using the service or even members of their own family, the CSCI bulletin lays out twelve 'good practice pointers' ranging from the inclusion of transgender people within equality aspects of policies and procedures, to ensuring that transgender people are supported in maintaining contact 'with other transgender people or the broader LGBT community, as this is important for identity and self-esteem'.

Other aspects of social care may involve counseling as well as practical support, and Kirk and Belovics (2008) in a discussion of employment support to transgender people, offer advice to counselors to become more transgender literate, because of widespread employment discrimination. Similarly, Poole et al note from their research that 'probation officers need access to information and/or guidance in order to feel confident in working effectively with transgender offenders' and offer a 'list of useful contact points', whilst also expressing concern that as 'rehabilitation requires a successful re-integration into society ... this may only be possible if' (transgender offenders) 'are able to live within their chosen gender role' (which) 'may present additional problems' (2002: 231).

Finally, at a more personal and individual level, within an American handbook aimed at supporting families of transgender children, Brill and Pepper seek to assist family members, and in particular parents, in clarifying whether their child is transgender, and stages in acceptance of this, 'from crisis to empowerment. The developmental stages of a transgender child are also considered, from the development of gender identity 'by age 2 to 3 ... when a transgender identity is often very clear', through pre-school childhood, when 'many ... transgender children ... are struggling to express their difference' through the

development of gender stability and gender consistency, to puberty and beyond (2008: 39, 61/67). Additional useful chapters on transitioning, disclosure and coping with the educational system, and with medical and legal issues complete a valuable reference book for both 'families and professionals'.

There are also handbooks aimed specifically at practitioners, for example addressing the role of 'social work practice with transgender and gender variant youth' (Mallon, ed. 2009), with individual chapters looking in detail at ethical and legal issues, and at the range of physical and psychological changes, external pressures and possible treatments which might affect transgender and gender variant youth, within individual, family orientated and group work. Some of the ideas within this book on good social work practice will be explored further within the discussion chapter of this thesis, when considering possible ways forward in the light of the results of this research. More detailed consideration will also be given at that time to several chapters of Brown and Rounsley's book on understanding transsexualism, for 'families, friends, co-workers and helping professionals' (2003) and to Morrow and Messinger's resource book on 'sexual orientation and gender expression in social work practice' (2006). In this latter book the social care needs of transgender people and their families are considered alongside those of gay, lesbian and bisexual people, within four main contexts: social work practice, identity development and coming out, relationships and families, and society and culture.

Chapter Summary

This chapter began by exploring a range of contemporary theories on the nature of gender, gender roles and gender identities, highlighting the way in which transgender identities appear early in life, perhaps before performativity is likely to have an influence on their formation. Despite the potential artificiality of such a separation, it is noted that transgender people's lives highlight an apparent difference between gender identity and gender role. Because transgender theory is felt to be of primary importance in underpinning this thesis, a theoretical acceptance of a separation of gender role and gender identity has therefore been adopted within the research surveys, and throughout the data analysis and discussion sections of this thesis.

The apparent lack of clarity in a distinction between the biological sexes was noted, particularly in relation to intersex individuals, together with the consequences of the Gender Recognition Act (UK Government, 2004) which alters both the gender status and the sex of transgender individuals who receive a Gender Recognition Certificate.

The chapter has explored differing interpretations of the nature of transgender, and the differing lifestyles of Ekins and Kings' (2006) oscillators, migrators, and transcendents in particular. Each of these groups need to be considered in relation to the social care needs of transgender people (which may easily be mistakenly conflated into the needs of transsexual people).

Issues for transgender children have also been noted, particularly in relation to complicating factors in diagnosis, and the urgency that puberty brings. Follow up studies suggest that outcomes for younger transsexuals are likely to be better than those of adults who have undergone puberty in their original biological sex prior to transition. FtM transgender adults are likely to adapt more successfully to their new role, as are homosexual MtF's (see also Appendix Six). The needs of older people and the prejudice that they may face, has also been noted, raising concerns to ensure that the social care needs of transgender people of all age groups and at differing transition stages are identified and addressed by social care services.

In addition 'the tension between societal expectations of gendered behaviour and ... people (who) are unable to conform to gender norms' (Kennedy and Hallen, 2010: 38) has been

noted within both transgender children and adults, which raises the possibility that social care organisations may need to both support transgender people with the consequences of their unusually gendered lifestyles, and also as Burdge argues (2007: 243), to work to change societies' perception and acceptance of these sometimes maligned and side-lined individuals who may at all stages of their lives be subject to widespread transphobia.

The following section reviewed literature which sheds light on values and attitudes which may underpin transphobia. What seemed to emerge repeatedly was the strength of the notion of binary gender and, at times, a sense of outrage when transgender people appear to consciously or unconsciously undermine the binary. That some transsexuals are unable to conform to this norm effectively and consistently means that they may be almost permanently visible and subject to transphobia. Whittle's attempt to conjure a sense of inclusivity within a diverse transgender community appears to be undermined sometimes by transphobia within society in general, within other potentially empathetic LGB minority groups, and perhaps too within transgender people themselves (2000: 48/50).

Concerns that transgender people may be more likely to suffer from poor mental and physical health were evidenced within the section of this chapter beginning with Kennedy and Hellen's finding that transgender children 'achieve well below their abilities at school ... and are more likely to self-harm or attempt suicide and are more likely to suffer from mental health issues in early adulthood' which may lead to 'substantial underachievement in all areas of their lives' (2010: 25, 40). That social care support to transgender people may need to take into account this sense of underachievement is highlighted by the NHS/Glasgow University finding that 'the single most important health issue is the lack of appropriate mental health services for trans-people' (Wilson et al, 2005: 28/29).

Whittle et al's finding that higher numbers of biological females who become trans men later in life initially face more harassment and bullying at school than natal males was counterbalanced by their finding that trans men 'will experience some social problems in the first year or so of transition ... (while) ... trans women will face difficulties for many years' (2007: 8, 63). This may mean that social care support to trans-men and trans-women will vary or need to be varied according to their different social experiences both prior to and post transition at different times of their lives.

The chapter concluded with a review of health and social care services. The medicalization of transgender was noted within the context of the increasing rejection of medical diagnoses of transgender conditions as disorders of personality, although the transition process of gender reassignment is heavily concentrated within a medical model including hormone treatment and surgery, following a medically supervised 'real-life test'. Following a contextual discussion of social care policy development and the needs of transgender people, factors affecting good practice, and examples of social care guidance were noted.

Chapter Two: The Methodology of the Research

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Introduction

The three research questions which underpin this research are discussed within this chapter on the methodology of the research. The chapter begins by reflecting on the ontological and epistemological bases of the research questions in order to understand the choices which underpinned the research methods. The discussion continues with a section exploring these methods, and in particular the role of a mixed methods approach and of grounded theory. A description of the subsequent implementation of these methods, their amendment following the pilot study, and their role within the research process itself is followed by consideration of the importance of reflexivity and of ethical issues within the research. A review of the design and methodology of the research, following its implementation and the collation and analysis of the data is included at the beginning of the discussion chapter of the thesis.

The Background to the Research

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 evolutionary nature of research questions is hinted at by Blaikie who suggests that there are three types of research questions, preceded by the use of 'what, why and how'. He adds that 'in some fields, and on some topics, little research may have been undertaken ... before 'why' questions can be tackled, a good description of what is going on is needed' (2009: 60). By their final version, each of the three questions fell most clearly into 'what' and 'how' categories, reflecting in part my growing understanding of the limited available knowledge of the nature of social care to transgender people.

In formulating the research questions, Dale's comment that 'both qualitative and quantitative commentators identify transparency as fundamental to good research practice' (2006: 79), was taken into account, to draw up questions which were consistent with and linked to each other, adding up to a coherent, transparent whole, detailed and open enough to allow for a degree of exploratory enquiry (Mason, 2002: 19). The detail, transparency and coherence of the research questions were subsequently important factors in the identification of sub-themes and themes from the original questionnaire to transgender people, and from the interviews with transgender people, leading to the development of the second transgender questionnaire, as described in more detail within the section on grounded theory later in this chapter.

Ontology and Epistemology and the Development of the Research Questions

Brannen notes that 'it is rare for a researcher working on a project to pose only one research question' and goes on to suggest that different research questions may be based on realist or on interpretivist assumptions (2005: 8). Similarly Clough and Nutbrown note that 'in our own work we have ... worked within both positivist and interpretivist paradigms ... the important point here is that we adopt research stances as they are appropriate to our world' (2002: 19, from Grix, 2010: 58).

It is the purpose of this section to explore the degree to which my own realist and/or interpretivist assumptions have influenced the writing of each research question and subsequently the research methods chosen, and how they can meaningfully co-exist within this mixed methods research to best answer the research questions.

Durkheim (1972) explored how what is known 'from without' is different from what is known 'from within', and, in relation to social facts, suggested that the sociologist should explore the social world with the same realist perspective as a physicist or a chemist. A realist perspective is 'an ontological notion asserting that realities exist outside the mind' (from Crotty, 1998: 10). On the other hand Weber's (1962) proposal that the intent of social behaviour is related by the individuals involved, using interpretation to strive for clarity, laid the basis for an interpretivist theoretical perspective which 'looks for culturally derived and historically situated interpretations of the social life-world' (from Crotty, 1998: 67).

The three research questions gradually evolved from draft lists of six and seven questions, initially including additional questions concerning, for example, transgender people's age, level of disability and ethnicity. There are indications of how the fine-tuning of the questions appears to indicate movement from an interpretivist outlook to a realist outlook and vice-versa, evidencing a fluidity of underpinning ontology regarding the nature of knowledge (within either an objectivist approach or within a constructionist model), together with a linked epistemology of how this knowledge can be understood (through either a positivist (realist) or an interpretivist perspective), according to a gradually evolving perception of the main underlying issues within each question.

So, for example, the interpretivist nature of the original version of the first question appears immediately evident from its references to 'assumptions' and 'needs':

'What assumptions are made by services and service users about the needs of transgender people which result in social care services which are made available to, requested, accessed and/or received by transgender people in Scotland, and through which the providing organisations seek to meet the particular needs of transgender people?'

While the second part of the question, concerning services which are 'made available to, requested, accessed and/or received', may stem from a realist model, the question of whether such services are indeed being 'made available' for example, is one that suggests a more interpretivist model, as it is by no means easy to establish in a simple factual manner. If a service provider makes available a service to transgender people, but does not seek to accommodate the needs of transgender people within the service, can this service really be said to have been 'made available'?

In the more realist next version 'assumptions' have been carefully excised, and the emphasis has moved to an apparently more objective identification of services, even if an interpretivist approach still appears necessary to clarify which services have been 'made available or requested' and the 'particular needs of transgender people':

'What social care services are requested, made available to, or received by transgender people in Scotland, through which commissioning and provider organizations seek to meet the particular needs of transgender people?'

In the third version of this question, the realist approach has been further extended to include clarity on the notion of ‘particular needs’, which have now become the ‘assessed and/or perceived needs of transgender individuals’:

‘What social care services are requested, made available to, or received by transgender people in Scotland, through which commissioning and provider organizations seek to meet the assessed and/or perceived needs of transgender individuals?’

In the final version of the question (see ‘research question one’ above) distinctions have been made between ‘dedicated/specialist and generic social care services’ and between ‘statutory and voluntary commissioning and provider organisations’, together with the inclusion of ‘transgender networks and/or individuals’, clarifying still further these emergent realist categories, whilst opening up a much broader notion of social care than had hitherto been recognized. Finally the phrase ‘types of ... services’ was inserted, to suggest the wide range of services which might need to be considered.

In relation to the second research question, a more realist approach to social care support (despite the inclusion of the vague notion of ‘appropriate’) to complex or ambiguous gender identities was apparent in the earliest version of the question:

‘Can appropriate social care support be readily accessed by transgender people, particularly those seeking support for gender reassignment, or for those with more complex or ambiguous gender identities?’

This was subsequently replaced by a rather more interpretivist version, reflecting both a greater recognition of the range, complexity and/or ambiguity of gender identities, and the importance of self-perception, and perception by others:

‘Do transgender people’s self-perceptions, (and their perception by others), as having binary, transgender, complex or ambiguous gender identities (including ‘cross dressing’, ‘male to female’, ‘female to male’, ‘a-gender’, ‘bi-gender’, ‘sissy’, ‘gender outlaw’, ‘fuzzy’ gender, ‘poly’ gender, ‘androgynous’, etc.) affect the extent and/or quality of social care services which are available to them?’

The final version (see ‘research question two’ above) consisted of a variation of the realist initial version, which emphasised the newly added notion of assisting ‘understanding and

resolving issues of gender identity or gender status as individuals with binary, transgender, complex or ambiguous gender identities’, rather than simply exploring how self-perceptions of what may have been viewed as prescriptive examples of gender identities, affect social care. To this was added the notion of ‘to what extent do/might social care services ... assist’, which as well as seeking an understanding of current support services, also opened up the possibility of exploring ideas for future service development from both the research evidence from the surveys and the interviews, and from the research literature, which was thereby recognized as an integral part of the research, and not simply an underpinning background of references.

In writing and formulating the research questions, it was also important to recognize the importance of subjectivity and interpretivism in the use of terms employed frequently within the research. For example it seems that the multi-faceted nature of ‘transgender’ is itself based heavily on self-perception, and that the recent evolution of terminology within both the transgender community and wider society indicates a growing consensus about what constitutes ‘transgender’. In the second half of the 20th century, the use of the term ‘transsexual’ was widespread in referring to one of the main groups of people who are now perceived as transgender, while this latter term, now apparently superceding the former, clearly has a much wider frame of reference.

The implications of the imprecise nature of terminology became evident for example, within a survey question concerning the self-categorisation of one’s transgender status, which depended on my own subjectively influenced choice of terms included as category choices, and on the understanding which I and the participants in the survey might have had of the meaning of such terms. It may be unlikely that there is a commonly agreed understanding of several terms offered for self-categorisation, including for example, ‘gender outlaw’, ‘a-gender’ and perhaps even the term ‘transgender’ itself.

I believe that knowledge is an evolving process from a realist perspective too, as evidenced, for example, by the developing understanding of the likely incidence of transgender people within society in recent decades, as noted within the literature review which preceded this chapter. Despite the ‘boundary changes’ of who might be reasonably included within the term ‘transgender’ knowledge of the incidence of people self-identifying within each of the constituent categories, and in particular within what was once known as transsexualism,

appears to have grown steadily, although accurate, consensual understanding of the likely incidence of transgender people has not yet been reached at the time of writing.

An understanding of knowledge may begin as a hint of meaning, a suspicion of a link, a personal insight, a possibility of a reality, each of which may develop, take shape, be deeply pondered and considered, discussed, argued about, demolished, re-constructed and co-constructed, over months, years or decades, through personal analysis and contemplation, and through exposure to others' ideas. That the outcomes of such processes become gradually accepted as 'as good an approximation to truth' as can be reached at present (by an individual or within a wider consensus) with currently available information, is a view which I have come to accept gradually, and reflects my beliefs about the nature of knowledge itself, and of 'how we know what we know' (Crotty, 1998: 8). It is this which forms the ontological and epistemological bases of my research. Not that I believe in an ultimate absolute truth – Popper's appraisal of falsification as a criterion for scientific theory through his example of the black swan seems enough to counter any notion of fixed certainties in knowledge (Magee, 1973).

I believe that a lack of absolute truth is as valid for a 'scientific' or realist understanding of knowledge as for a less rigorously scientific, interpretivist perspective. As Grix suggests, 'knowledge, and the ways of discovering it are not static, but forever changing' (2010: 65). The consideration of the origins of this research through the evolution of the first two research questions suggests that a subjectively inclined, interpretivist ontology and epistemology intertwines inextricably with seemingly diametrically opposed realist perspectives so that research may quite reasonably and rationally contain examples of this interrelationship within the most quantitative or qualitative aspects of its methodology.

In summary, this discussion of the development of two of the three research questions highlights their underpinning ontology and epistemology in relation to an understanding of social reality which varies from the 'subjectivity' of interpretivism to the 'objectivity' of realism, within an evolutionary view of knowledge (including of course my own, particularly during the development of ideas and concepts which related to this research) which spans both ontological and epistemological poles. It is next necessary to explore how these views of ontology and epistemology led to the derivation of suitable methods to progress the research. The use of mixed method research was believed to be necessary to answer mainly 'what' and 'how' research questions, about both individuals and agencies and about

experiences and procedures, in order to understand some of the 'why' issues which underpin ideas and policies, to help move forward an understanding of the current state of social care provision to transgender people in Scotland, and its potential for the future.

It was also necessary to consider how the research questions might be best answered, by posing the question: 'what forms of research might provide the most useful research data?' Having considered questions one and two in detail, within the context of realism and interpretivism, it is the turn of the third question to be scrutinised, to explore an example of how evidence which might assist in answering the question might best be collated. The research question reads:

'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?'

It was initially believed that carefully constructed detailed surveys of service providers' and transgender people's experiences of social care provision might provide a valuable perspective on the nature and extent of support (or its absence) to transgender people, regarding 'relationships with family and friends, at work and within their wider communities'. That such surveys might not always fully encompass all aspects of the research question, was evident from the need to draw up and circulate a second questionnaire for transgender people, following the analysis of themes from the data from the first survey responses and interviews, as explained in more detail within the section on grounded theory below.

It was also considered important to include individual transgender people's perspectives too. At first the intention had been to use focus groups and interviews as the formats for such sharing of individual experience, but, as explained within the discussion of the pilot study later in this chapter, the use of focus groups was dropped after the pilot study in preference to the more personal and individual format of an interview. In the context of this research question a focus group might have been a 'safe' forum, allowing for transgender people's experiences within family, work and community settings to be shared in more detail, in a way that might shed light on the experiences of others too. This might have been particularly valuable in allowing a group to explore, for example, such complex issues as the types of difficulties encountered with family members, friends, colleagues and

within wider society when undertaking gender reassignment. However, following the experience of the pilot study focus group, I felt that it was difficult to be clear to what extent individual members of the group agreed with what might appear to be a group consensus, and this lack of detailed individual feedback was one of the main reasons that led me to drop the idea of focus groups in preference to individual interviews.

Lastly, it should be noted that the deliberate use of the term 'might' in each of the three research questions was used to open up each question further, allowing consideration of other perspectives too, particularly from the wider research literature. In the particular example of this third research question, this does not anticipate a definitive answer, but allows for the shared perspectives of a survey/interview/literature based approach. It was felt that this was unlikely to be matched by the use of any one of these approaches individually, particularly for such a complex topic for which there also appeared to be very real limitations in currently available knowledge and understanding.

Mixed Research Methods

In this section the rationale behind the research methods which were chosen is further explored to reflect the diverse underpinning epistemologies which have been identified through the earlier discussion of the research questions.

Two main methods have been used in the research: online surveys and online interviews. Surveys were chosen because it was believed that they would offer the opportunity to collate both descriptive and analytical data. Buckingham and Saunders suggest that social surveys seek to firstly '*discover facts about a population (i.e.) descriptive research*', and secondly to uncover '*evidence about some of the likely causes of people's behaviour or attitudes (i.e.) analytical or explanatory research*' (2004: 55, italics original). Online interviews were chosen to supplement the survey data because I wanted both myself and the participants to be able to take the time to consider ideas within questions and responses, and, by having constant access to a developing record of the interview, to be able to reconsider what had been said earlier in the process, in the light of subsequent comments. In this way I believed that there was more likelihood of getting closer to interviewees 'authentic ... realities' (Roulston et al 2003: 645) than might be achieved within a straightforward survey.

Each of these approaches was implemented in this research with both transgender people and with service providers, as explained in detail within their respective sections below. It soon becomes apparent in reviewing these two, quite different, research methods that they are, in part at least, as might be anticipated from the previous discussion, based on quite different assumptions:

When Mason notes that researchers may 'choose qualitative interviewing ... because (their) ontological position suggests that people's knowledge, views, understandings, interpretations, experiences and interactions are meaningful properties of the social reality which (the) research questions are designed to explore' (2002: 63), the link with an interpretivist theoretical perspective seems apparent.

It seems from such a perspective that social reality is not, as has indeed already been intimated, a universal truth, but varies, to greater or smaller degrees from culture to culture, group to group, and person to person, and, by extension, from period of time to period of time. Exploring the notions of scientific realism and interpretivist subjectivism has earlier aided a fluid understanding of the notions of 'knowledge' and 'truth'. It is also necessary, in the context of this discussion of interpretivist and realist methods, to explore the notion of social reality too:

It might be argued that for a relatively brief period, for a significant proportion of the population, the 'social reality' of Britain from late July through to early September 2012 appeared rather different from that of the first half of 2012, and it is worth exploring why this may have been the case.

At the end of the recent Olympics games in London many in the media spoke of a sense of loss at the end of an exceptional sporting event, and also, it seems of a temporary phase of greater national unity than normal. For a brief period in the summer of 2012, social reality may have, for many people in the UK, involved feeling a little more unified as a nation, a little more confident of the standing of the UK in the world, with a sense of a legacy for young sports people too (the nature of legacy from sporting events is explored, albeit hypothetically, by Grix (2010: 41/47)).

Later in the summer, at the conclusion of the Paralympic games, a similar sense of loss and of temporary unity was again apparent within media reporting, though, it seems, affecting a smaller proportion of the population. But for many who watched the Paralympics there

was another significant dimension – by the end of the Paralympic games it was not uncommon to hear television and newspaper commentators suggesting that the games marked a change in perspective of the status of disability in Britain. Once again there was a sense that social reality may have changed, but in a more profound sense than that of the earlier Olympic legacy.

Two years on and that increased respect for disabled people seems to have been lost, at least partially, as even disabled Olympians have found themselves on the receiving end of cuts in financial support from a welfare benefits system which it has been regularly implied is being taken advantage of by those who are unwilling rather than unable to work. The notion of a sporting legacy seems to have dropped down the political agenda too, leaving only the fading glow of national success reflected from these quite exceptional sporting and cultural events.

That the nature of social reality might be perceived as having fluctuated so rapidly, (albeit within an undefined proportion of the UK population, and, to date, without research to support the notion) might be interpreted as evidence that social reality is indeed constituted of ‘people’s knowledge, views, understandings, interpretations, experiences and interactions’ (Mason, 2002: 63). Such cultural shifts in social reality as appear to have happened during the second half of 2012 and the winter of 2012/13, are perhaps not too far from Kuhn’s notion of paradigm shift within scientific theory (1970).

In relation to the piece of research which is the subject of this thesis, there are two serious implications of such a point of view:

Firstly, hypothesising a sense of a shared, subjective ‘social reality’ across a significant proportion of the population, affirms the use of qualitative methods for researching the nature of such social realities, and, in relation to this research, to the social reality which transgender people ‘live’ on a daily basis, which, it is suggested, is also based on individual and societal subjective perspectives of the nature of transgender. And secondly, such a suggestion of even a temporary change in the social reality of disability within a period of just a fortnight, if evidenced, might confirm how the social reality for many minority groups, including that of transgender people, might also have changed, rather more slowly in the last fifty years, and how it may change in the future.

Roulston et al describe the qualitative interview 'as a site in which interviewers and interviewees co-construct data for research projects rather than as a setting that provides authentic and direct contact with interviewees' realities' (2003: 645). This constructionist epistemology seems to sit appropriately with Mason's ontological position (2002). As we grow older the constructive nature of memory becomes more and more readily apparent, for example when comparing one's recollections of an event with a contemporary detailed diary or journal entry. Denscombe in a discussion of the methodology of phenomenology, affirms the notion that 'people ... through their actions and interpretations, literally make sense of their worlds' (2003: 99).

It might be anticipated that the surveys used in this research would provide a more realist perspective than qualitative interviews, but as De Vaus explains: 'surveys are characterised by a structured or systematic set of data (which may consist of) numeric or quantitative data (e.g. age, income) (or) may be filled with much more qualitative information ... about equality, conflict ... feelings of intimacy' (2002: 3, 5/6). Both types of question are apparent within each of the surveys used in this research: the attribute questions which begin each survey are mainly numeric or quantitative data, whilst the main bulk of questions vary between further essentially quantitative questions (e.g. how many hours of support people receive) and questions which produce more qualitative data (e.g. rating a range of sources of support in order of their importance regarding a particular aspect of social care provision).

Data of a qualitative nature might be expected to be obtained through responses to more qualitative 'open' questions, while the initial examples of age and income suggested by De Vaus (2002) seem more likely to be data of a quantitative nature which appears to fall outwith the sense of subjective social reality of Mason's ontology (2002), and the interpretivist/constructionist epistemology of Roulston et al (2003). But asking participants to indicate whether they fall into categories of male, female, transgender or 'other' categories of gender identity may require them to make quite subjective judgements.

As Bryman confirms, while 'to elect to use a self-completion questionnaire is more or less simultaneously to select a natural science model and an objectivist world view ... research methods are often more 'free-floating' in terms of epistemology and ontology than is often supposed' (2008: 593). Bryman consolidates this view when he notes that 'the idea that

research methods carry with them fixed epistemological and ontological implications is very difficult to sustain’.

It seems that the step to using mixed methods is shorter than might be anticipated. Blaikie lists a number of rationales for mixed methods research including the provision of ‘more comprehensive evidence’ and the ability to ‘answer research questions that cannot be answered by one method alone’ (2009: 219). Bryman summarises the outcomes of a content analysis of the underpinning rationales given for mixed methods research published in articles for the period 1994 to 2003 (2008, 2006). He is able to supplement Blaikie’s observations by adding a range of further rationales, including: triangulation or greater validity of findings; the offsetting of inherent weaknesses in quantitative and qualitative approaches; a more complete and comprehensive account of the area of enquiry; an account of both structures and of processes; and one research method being used to explain the findings of the other (2008: 608/9). Some of these rationales are likely to be more evident retrospectively, and this applies within the research under consideration too, for example, within the development of the second questionnaire for transgender people, which was strongly influenced by the analysis of the findings from the first questionnaire and the interviews with transgender people.

Brannen affirms Sammons’ et al’s (2005) seemingly holistic justification of mixed methods by noting that ‘complex and pluralistic social contexts demand analysis that is informed by multiple and diverse perspectives’ (2005: 9): that the nature of transgender experiences is complex within both individual perspective and social context, has already been noted.

The Influence of Grounded Theory

While it appears reasonably straightforward to describe what a mixed methods approach to research might consist of, and how this has been applied to this research, the notion of grounded theory is neither so straightforward in its applications and versions, nor perhaps because of this, to appraise in relation to this piece of research.

One of the difficulties is that, while grounded theory ‘has become by far the most widely used framework for analysing qualitative data’ (Bryman, 2008: 541) there are ‘probably as many versions of grounded theory as there are grounded theorists’ (Dey, 2007: 2). Bryman suggests that ‘to some writers (grounded theory) is a distinct method or approach to qualitative research in its own right; to others it is an approach to the generation of theory’.

He makes it clear that he adheres to the latter point of view, and clarifies his position still further when he notes that 'grounded theory can be used in connection with different kinds of data' (i.e. not just qualitative data) (2008: 541). Charmaz further explains the link with quantitative data when she notes that 'by 1990 grounded theory not only became known for its rigour and usefulness, but also for its *positivistic* assumptions. It has gained acceptance from quantitative researchers who sometimes adopt it in projects that use mixed methods' (2006: 9, italics original).

Glaser and Strauss published their first book on grounded theory in 1967, and Dey notes that 'the new methodology was aimed at *producing* grounded theory, which was defined as 'the discovery of theory from data'' (Dey, 2007: 3, italics added). Twenty years later, Strauss noted that grounded theory 'is a style of doing qualitative analysis, that includes a number of distinct features such as theoretical sampling, and certain methodological guidelines such as the making of constant comparisons and the use of a coding paradigm to ensure conceptual development' (1987: 5).

The debt of Glaser and Strauss to Dewey and Mead's work of the 1930's is acknowledged by Strauss and explained in more detail by Charmaz when she records the basis of the 'pragmatist philosophical tradition that Strauss embraced while in his doctoral program at the University of Chicago'. Charmaz explains that 'pragmatism informed symbolic interactionism, a theoretical perspective that assumes society, reality and self are constructed through interaction and thus rely on language and communication. This perspective assumes that interaction is inherently dynamic and *interpretive* and addresses how people create, enact and change meanings and actions ... symbolic interactionism assumes that people can and do think about their actions rather than respond mechanically to stimuli' (2006: 7, italics original).

Much of this explanation of the background to grounded theory within symbolic interactionism fits, and feels congruent with, earlier discussion about the relevance of interpretivism to this research, just as congruence with realism has also been noted. With both the positivist and interpretivist epistemological bases of grounded theory appearing to sit equitably with the epistemological bases of this research, how do the research methods fit with the methodology of grounded theory?

The comments and responses to the first questionnaire and the detailed responses within the ten online interviews to transgender people were analysed in a manner consistent with a grounded theory approach, by identifying the key issues which appeared repeatedly in responses and comments, by reading and re-reading the transcripts and highlighting potential sub-themes and themes as they appeared. This enabled the development of an informal, flexible agenda for the subsequent second questionnaire, around seven main social care themes:

Issues related to coming to terms with being transgender

Support with transitional issues

Mental health problems linked with gender identity or gender role

Support to family members in coming to terms with being transgender

Assistance with documentation during/after transition

Support with long-term physical or mental ill health, disability, or problems related to old age

Post-transitional and societal issues

These seven social care themes were derived from forty five sub-themes, as indicated within one example below:

Sub-themes:

The need for reliable information re documentation changes including recommendations for the timing/order of such changes

Coping with the persistent use of wrong gender terminology in correspondence and others' documentation

Applying for and submitting evidence to meet the standards of the G.R.C. (gender recognition certificate)

Coming to terms with the dilemmas of the G.R.C., including the issuing of a new birth certificate

Theme: 'Assistance with documentation during/after transition':

These 'sub-themes' correspond to the outcomes of Charmaz's notion of 'initial coding' whereby 'through comparing data with data, we learn what our research participants view as problematic and begin to treat it analytically'. Similarly the 'themes' correspond to the outcomes of her notion of 'focused coding' which follows 'after you have established some strong analytic directions' (by initial coding) by 'using the most significant and/or frequent earlier codes to sift through large amounts of data'. She notes the importance of concentrated, active involvement in the process, so that it becomes a constructive, emergent process (2006: 47, 57).

The emergence and active identification of sub-themes and themes apparent in the analysis of the comments from the first questionnaire and the ten interviews of transgender people evidences a process of grounded theory coding. Is the emergence of the generation of theory as apparent too? Perhaps an appropriate way to initially structure this discussion is to ask whether hypotheses and theories were consciously or unconsciously built into the research, from the beginning of the research process and the formulation of the questions, before any surveys or interviews were carried out, whether they were an emergent part of the research process, or whether they simply emerged after the analysis of the data? Although I did not set out with consciously explicit research hypotheses, an examination of the research questions suggests that they are not free either of the influence of the relevant research literature, of preconceptions about social care services, or of ideas and possibilities about factors which may affect both the nature and degree of success of such care services. These issues might be better perceived when one of the individual research questions is considered:

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

This question appears to anticipate that transgender people are likely to have difficulties understanding and resolving their gender identity and/or gender status, and that it is or might be the role of social care services to assist them with these issues. This example seems to confirm a degree of pre-theorising, based on both my own experiences as a

transgender person, and on the theoretical issues contained within the transgender literature, before the writing of the research questions. A range of reference sources had also been explored throughout the literature search and drafting of the literature review and my perception of the influence of my own experiences is also included within the section on reflexivity below.

It is not difficult to find similar hypothesising throughout the research process, as results came in: the identification of sub-themes and themes through what might be designated as initial and focussed coding did not simply arise through a 'falling into place' of the data, but through my actively exploring the data, hypothesising about what it might mean, and constructing a framework for how it might fit together in a coherent form which transcended individual responses and had a broader, more generic meaning. As Charmaz notes: 'breaking through the ordinariness of routine actions takes effort. To gain analytic insights from observations of routine actions in ordinary settings, first compare and code similar events. Then you may define subtle patterns and significant processes' (2006: 53).

Dey's summary of Glaser and Strauss's (1967) initial statement that grounded theory involves avoiding 'theoretical preconceptions – ignoring the literature in that area at first' (2007: 4) is not concordant with the research process undertaken, as the brief analysis of the development of the research questions above indicates. Bryman notes that 'Bulmer (1979) has questioned whether, as prescribed by the advocates of grounded theory, researchers can suspend their awareness of relevant theories or concepts until a quite late stage in the process of analysis' (2008: 548/9) and this apparent inability to suspend awareness seems evident to me within my own research, particularly once the literature search and draft literature review were completed.

In summary, the influence of grounded theory has been shown to be evident within the process of data analysis, in the identification of sub-themes and themes through what might reasonably be interpreted as 'initial and focussed' coding, and in the hypothesing and theorising both prior to, concurrent with and following the main research process.

The Research Process

The Pilot Study

The pilot study was undertaken with an existing transgender support group, and consisted of a questionnaire and a focus group. As the main purposes of the pilot study were to pilot the questionnaire and to consider the potential value of focus groups within the forthcoming research methodology, the outcomes of the pilot study will be discussed in this section, rather than in the results sections of the thesis.

The Pilot Questionnaire

The pilot questionnaire was drawn up in the early autumn of 2011 using the Bristol Online Survey system. A number of attribute questions were included in its first section including age range, home circumstances, ethnic group, country of birth, qualifications, and employment status. The second section sought information about the participant's self-perception of their biological sex, gender identity, gender role transition status, transgender category (transsexual, cross-dresser etc.) and status (e.g. MtF, FtM).

The third section of the pilot questionnaire sought information on sources of advice and support, including social care services, which the participant or their family had been able to access to assist with coming to terms with their gender identity, gender transition, changes in documentation, mental health problems linked with transgender issues, and other disabilities, as well as support and assistance which the transgender person themselves provided to others.

The pilot group was an established transgender support group in the North East of England which was found via a Google search. I wanted to use a group in England for the pilot study to avoid using potential participants at this stage who may later have been eligible to participate in the main study in Scotland. Following initial contact with the group's co-ordinator I attended their next meeting to explain that the purpose of my request was to pilot my questionnaire to pick up any potential problems such as badly worded or unnecessary questions, or to identify the need for additional questions etc. before I began my research fieldwork.

I explained the background and purpose of my research to a group of eight to ten transgender people who attended that evening, and who agreed to the proposal to pilot

the questionnaire shortly afterwards. Hard copies of the questionnaire were circulated to the group, and access to the Bristol Online Pilot survey was made available too, so that those who preferred could complete the questionnaire online.

Only four completed pilot questionnaires were submitted by the pilot group, each of which was made using the online system. The responses to the first section were too few from which to draw any serious conclusions, but nonetheless reinforced the potential usefulness of these attribute questions. The second section, on sex, gender identity and gender role, suggested that much useful information should be gained from including this section within the more widely circulated survey in Scotland. The success of the third section was the most difficult to gauge from such a small set of respondents, but nonetheless gave a satisfactory indicator that social work support might indeed be usefully compared with other potential sources of support in this way.

A further section was subsequently included within the revised research questionnaire reflecting some of the comments from the pilot focus group regarding the type and timing of additional social care services to which transgender people would like to have access, either for themselves or their families, to supplement those that they may have already received. Lastly a number of small alterations within questions were made which had been suggested or otherwise identified by the group, which improved the questionnaire further.

The Pilot Study Focus Group

Towards the conclusion of the pilot questionnaire I made contact with the pilot group again to ask if it would be possible to arrange a fairly short focus group about social care issues, in order to invite people's comments about how social care input might have been of help to them in the past, at the present time, or in the future, regarding their transgender identity and status.

I had suggested running this on the evening of the group's next meeting so that the members didn't have to travel to the venue twice in a short period of time. However my suggestion of coming to the venue for 5.30, and meeting with those members who would like to be involved in such a group, until the whole group meeting started at 6.30, was not taken up. Instead I was asked to come for 6pm, giving me barely half an hour for the focus group.

Prior to the focus group I put together a written participation agreement, covering issues of confidentiality and ethics, based on the School of Social and Political Science's (S.S.P.S.) Research Ethics Policy and Procedures, (University of Edinburgh, 2012) and this was given out to the group once they had all arrived. I had pre-signed each copy, and the focus group members were asked to counter-sign this, if they felt comfortable with the agreement. All except two of the members were happy to sign this agreement. The two who did not wish to participate, being new members of the group, were allowed by the rest of the group to stay and listen to the discussion.

I was aware that my own transgender status was inevitably an issue to be taken into account by the group. I therefore ensured that it was mentioned early in the focus group.

Despite the brevity of the focus group, it proved useful in highlighting a number of areas where the group felt that social care input might be helpful – including for example, the suggestion of a support role between the initial referral by a GP to a gender identity clinic, and the actual first appointment at the clinic (I was advised that the gap between the referral and first appointment was often around a year). It seemed from the pilot group that the need for additional counselling support might lessen during transition, as this was perceived as the period of the clinic's main support role by the pilot group. However, post-transition, the sense of isolation appeared to return, as clinic involvement reduced and this was also suggested to be another period during which social care service support might be appreciated. The possible role of a social care worker as an advocate for the transgender person, either in liaison with, or as part of a multi-disciplinary team within the clinic, was another interesting idea which was touched on briefly. These and other possibilities also provided further information on how the first questionnaire might be suitably amended still further.

While these generalised views of social care were helpful, what I felt was missing from the focus group however, was a sharing of personal experiences, and an individuality of response. For example, I noted how a comment that 'social workers know little or nothing about transgender issues', received nods of agreement, but without the detail to indicate whether this was actually a view held by most of the individual members of the group, or whether this was more an apparent consensus based on group dynamics or hearsay rather than actual experience. Although this may have been partly related to the limited time available for the group, it was this apparent deficit in the outcomes of the pilot group which

led to a gradual rethinking of the role of focus groups within the main research, which began in the spring of 2012. Indeed, it soon became apparent, after the first completed research surveys were returned, that a more individualised approach to research was needed than the focus group format appeared to offer: it was this recognition of the need for individual perspectives and experiences which led to the displacement of focus groups by individual interviews as the preferred follow-up methodology to the first of the survey questionnaires for transgender participants, and the survey of service providers.

Gibbs notes that ‘focus groups can help to explore or generate hypothesis ... and develop questions or concepts for questionnaires and interview guides’ (1997: 2) and, notwithstanding the value of trying out the possibility of using this methodology within the research, generating and exploring hypotheses, questions and concepts proved to be the main additional outcomes of the focus group which was the final step in the pilot study.

The Three Online Surveys

Following the pilot study it was a short step to develop the first questionnaire, in line with the feedback received, into a working model which could be used for the research with transgender people, and also to develop the survey for social care services too. The second questionnaire, as has already been noted, followed the analysis of these first questionnaires and the interview transcripts.

Introduction

Buckingham and Saunders define a social survey as ‘a technique for gathering statistical information about the attributes, attitudes or actions of a population by administering standardised questions to some or all of its members’. Their breakdown of the purpose of surveys into descriptive and analytical or explanatory research has been touched on above and they suggest that ‘most surveys set out *both* to discover facts and to test some causal propositions’ (2004: 55, 56, italics original). The questions within each of the three surveys sought both analytical and descriptive data. For example, one of the attribute questions within the two transgender surveys asked for analytical information on age, largely within ten year bandings (table ten), whereas a later descriptive question in the first of these surveys asked whether the quality of social care support received was affected by the

recipient's gender identity or gender/transgender status (see table thirty eight). Many of the questions apparently seeking analytical data involved a degree of descriptive data too, for example when respondents to survey one were asked to indicate limitations to day to day activities because of a mental health problem or disability linked with being transgender (table twenty nine), by choosing a statement which was closest to their present situation.

Before considering the sampling and data analysis used for the research, and then describing each of the surveys in turn, it is necessary to first consider the notion of online surveys, for this was the chosen method of distribution and completion.

De Vaus suggests that 'since the mid 1990's the internet has become a viable and popular means of administering questionnaires'. He supplements this comment with an exploration of the options available to researchers who wish to take advantage of the internet in this way, noting that a questionnaire may be embodied within an email, circulated as an attachment to that email, or (and this was the preferred option for this research), is constructed with specialist software and is accessed through a webpage address specific to the questionnaire (2002: 123/4).

The Bristol Online Survey provided a safe, secure and confidential site within the University of Edinburgh's website for the storage of responses. However, because it relied on circulation of the website address by email, it also offered the opportunity to carefully target transgender individuals or services whose opinions and experiences were of most relevance to the questionnaire, and who could forward the web address very easily to other transgender people or services of their acquaintance.

Bryman confirms that website based surveys offer a greater degree of confidentiality than email based surveys and also suggests that low cost and faster response times are two of the main advantages of using online surveys over postal questionnaire surveys. He also indicates that 'there is evidence that online questionnaires are completed with fewer unanswered questions than postal questionnaires, resulting in less missing data' (2008: 652/653).

I was of course keen to ensure that the questionnaire was both as visually appealing and pleasing to complete as possible, using, for example, the 'guidelines for designing mail and web questionnaires' suggested by Dillman et al (2009: 182/218).

Each of the questionnaires, whether for transgender people or service providers was self-completed, with the introduction to each questionnaire serving to provide both a background to the research and guidance on how to complete the questionnaire. Denscombe suggests that the introduction should also include detail on the purpose of the research, a note on confidentiality and the voluntary nature of responses, and lastly a word of thanks from the researcher, and these were all included either in the introduction or within a postscript to the research questionnaires (2003: 148).

Sampling Circulation and Distribution

This section considers shared sampling issues for the two questionnaires for transgender people in Scotland. Because the sampling issues which arose in regard to the questionnaire for voluntary and local authority services in Scotland were so different, these are discussed within the appropriate separate section below.

The geographical boundary of the research had been set at Scotland, within the terms of the Scottish Government/ESRC funding agreement for this research. I was keen to reach as large a non-probability sample of the transgender population in Scotland, with as wide a variety of self-perceived categories of transgender people as possible. However, this is not an easy group to reach in order to obtain a representative sample: as has been noted within the literature review above, many oscillating transgender people who seek to spend time temporarily in an opposite gender role, are relatively invisible to support services. Similarly migrating transsexual people may take a long time to 'come out' about their transgender status, and then may 'disappear' after transition from support groups and transgender networks as they seek anonymity within their new gender role. It seems that transcending transgender people may be represented by only small numbers of individuals, and that negators are likely to occupy an even more specialised niche with even fewer representatives.

In order to reach as many transgender people as possible, it therefore felt necessary to target them as directly as possible, and to do this I sought the support of the Scottish Transgender Alliance (S.T.A.), a voluntary organisation based in Edinburgh but with nationwide connections to individuals and transgender groups in Scotland, to circulate information about the research on my behalf, and, most importantly, to circulate the web addresses of the two questionnaires for transgender people. The S.T.A. mailing list therefore became the sampling frame for the transgender population, from which

information was shared with individuals and transgender groups, and by which individuals self-selected to participate in the research.

It would also have been possible to seek similar support from the gender identity clinics in Scotland, most notably those based in Edinburgh and Glasgow, but as it was realised that the transgender people who were attending these clinics were likely to be much fewer in number, and to be restricted to those currently undertaking the transition process, this route was not chosen. By using the S.T.A. it was hoped that younger people prior to transition, and older, post transition transgender people too, would also be more adequately represented. It was anticipated that at least some of the people attending the clinics would also have links with the S.T.A. too.

Attribute data for the respondents to surveys one and two indicate a wide range of ages (table ten), home circumstances (table eleven), employment status (table twelve), gender identities (table thirteen) and gender descriptors (table fourteen). These are discussed in detail in the second of the research findings chapters, but, as noted in the section of the discussion chapter reviewing the design and methodology of the research, young, school age, and retired transgender respondents were actually largely missing from the research.

The transgender research participants themselves consisted of a high proportion of transitioning 'migrators', with only a small number of 'oscillators' and 'transcenders' taking part, and with no apparent representatives of Ekins and Kings' (2006) 'negator' category. It is difficult to conceive of how these 'minorities within a minority' might have been better represented, not least because no reliable estimates of their incidence are available for reference. Nonetheless the number of participants who identified with non-binary identities was evidence of the importance of transcending categories.

Each of the questionnaires for transgender people was made available within a website based online format via University of Edinburgh links with the Bristol Online Survey. The web addresses for the surveys were circulated by email correspondence to the twenty six support groups and two hundred and thirty transgender individuals who were on the S.T.A. mailing lists in Scotland, directly by the S.T.A. Each of the organisations and individuals was asked to 'please forward information about this survey to as many other trans people in Scotland as possible'.

The first questionnaire for individual transgender people was made available in identical online and hard copy paper formats. The paper copy of this questionnaire was made available via the Scottish Transgender Alliance, who offered assistance with completion too, at their Edinburgh based headquarters. No participants in this survey chose to complete a paper copy and for this reason questionnaire two was only made available online.

A reminder email was sent out to both the S.T.A. support groups and to the members of S.T.A., three weeks later, one week before the surveys closed, for each of the transgender questionnaires. By that time the flow of completed questionnaires had slowed considerably, but the reminder did elicit a few further responses.

Two of the advantages of using a mainly website based approach to the survey questionnaires were that it included the potential for the contacting of more geographically dispersed individuals than would be possible through interviewer administered questionnaires, and that it avoided the expense and distribution issues of paper copies, while still accessing all STA members.

It was not possible to ensure that only responses from transgender people were included in the surveys, as it was not possible to restrict access to the website. However, it is believed from the detail contained within the individual completed surveys that only people who perceived themselves as transgender (and living in Scotland) actually completed the questionnaires. It was not possible to directly contact transgender people who were not members of the S.T.A.

One of the final questions in the first transgender questionnaire and in the voluntary and statutory sector questionnaire asked participants whether they would be willing to take part in an interview about the issues arising within the questionnaires. Ten transgender participants took part in the subsequent interviews.

Data Analysis

This section summarises an overview of the processes of data analysis for the research as a whole. Specific information relating to data analysis for each of the questionnaires and for the interviews is included in their respective sections below.

The data from each of the online questionnaire responses to the three questionnaires was automatically collated by the Bristol Online Survey. Numbers and percentages of responses

were calculated and collated automatically within frequency tables for each category of each question.

Cross tabulation, between one item and all other questions, was chosen for the first two questionnaires, within five sets of calculations by age, biological sex, gender identity, current gender role and home circumstances (approximately eighty cross tabulations in total, for each questionnaire).

Data from surveys one and two is not directly comparable, because, although the participants were drawn from the same sampling frame of members of the S.T.A., it cannot be verified whether any of those who responded to survey two had already completed survey one and they have therefore been treated as two separate populations. As identifying data is not available for all survey participants, longitudinal data cannot therefore be tracked, for even those participants of survey one who provided contact information when offering to take part in an interview did not give permission to be contacted again directly for follow up surveys in the future.

Each of the nineteen interviews was recorded in full within the online email format chosen, from which a transcript of each complete interview was produced to include details of the date and time of each question and of each response, with email addresses deleted. These transcripts were then analysed, for both the transgender and service interviews, by identifying and listing the sub-themes which were raised (as described in the section on grounded theory above). These sub-themes were then collated alongside information from the first transgender survey, and the survey of statutory and voluntary sectors, to identify seven main themes which, in the particular case of the transgender survey and interviews, subsequently proved invaluable in the writing of the second transgender questionnaire.

Questionnaire One: The First Survey of Transgender People in Scotland

There was a dual purpose to this first questionnaire. The first purpose was to gain information on the services which transgender people have been able to access or to which they would like/have liked to access for support with transgender and social care issues. The second purpose was to gain information which might inform the process and content of the imminent interviews with transgender people, or indeed with the staff of local authorities and/or service providers of social care services.

This survey of transgender people in Scotland was circulated in February 2012 following trials of a draft version of the questionnaire with a small group of members of the Scottish Transgender Alliance (S.T.A.) and a meeting to discuss the questionnaire and its subsequent circulation with the co-ordinator and assistant co-ordinator of the S.T.A. The draft version of the questionnaire which they considered was itself a revision of the pilot questionnaire which had been altered following feedback from the pilot study group in November 2011.

The introduction to the questionnaire contained information on the background to the research, including the explanation that 'it will seek to present a range and balance of views from the perspectives of a wide range of transgender people and service providers', the minimum age for participation, and a brief summary of the structure of the survey. The participation agreement which followed explained that the questionnaire was for residents of Scotland only, the nature of the conditions of research confidentiality and of the use and storage of information, and a statement of agreement which participants were asked to read through prior to continuing to the questionnaire itself.

Structure

The first section of the survey included seven questions seeking 'a little background information' about the participant. Where pre-existing questions could be located from within the attribute questions from the 2011 Scottish Census these were used in preference to writing new questions, as it was believed that these Census questions were likely to have been fully field-tested and revised accordingly.

The second section consisted of ten questions seeking information concerning the participant's self-perception of their sex, their gender identity and their gender role. A wide range of options for contemporary gender categories were listed and, as noted above, these included suggestions put forward by the pilot group and the Scottish Transgender Alliance (S.T.A.). Each of these questions was carefully worded to avoid misunderstanding. For example, the questions on biological sex and gender identity included an explanatory clause to indicate as clearly as possible what was being sought:

How would you describe your biological sex? (usually this corresponds to the sex that you were assigned at birth)

How would you describe your gender identity? (the internal sense of which gender you belong to)

The research findings for these questions are discussed within chapter four. There are several anomalies in these results which suggest that some respondents may have lived a contrary original gender role to their biological sex. It seems likely however that respondents have shown more flexibility than might have been anticipated in their responses to questions about their biological sex and gender roles, or that some misunderstanding of the questions has contributed to the results. The possibility of such misunderstandings (in relation to the wording of these and one or two additional questions), is discussed more fully in the section of the discussion chapter (chapter seven) which critiques the design and methodology of the research.

The third section of the survey was structured around a series of questions which asked about the importance of each of a wide range of potential sources of advice or support, including transgender support groups, family and friends, GP's and gender identity clinics, for a range of issues such as 'coming to terms with your gender identity', 'helping you to make (a gender) transition', 'helping you to change your documentation' etc. These were accompanied by a series of questions about the perceived value of 'assistance from an appropriately trained social worker or care worker' in relation to the range of potential issues (whether this had been previously available to the participant or not) which varied between asking how much the participants themselves valued such support, and (where appropriate) about the value which was likely to be placed on such support by members of their families.

Additional questions within this section sought to clarify the nature of any disability which affected the participants, and sources of any advice and support they received. The survey also sought information about the nature and quality of social care support which was being received or had been received in the past, by each participant.

Each of the questions included within this survey was written with reference to guidelines from Dillman et al (2009 65/150) and De Vaus (2002, 22/37), often going through several revisions before it was felt that the question had reached a clearly written, unambiguous state that should result in valuable data. The success (and some inadequacies) of some of these questions is considered within the review of the design and methodology of the research in the discussion chapter of this thesis.

The last question of the survey was an open question seeking additional comments about social care services to transgender people in Scotland. The questionnaire ended with a request for participants to indicate whether they would be willing to take part in an individual interview, followed by a formal thank you to each participant for completing the questionnaire. In accordance with one of the outcomes of the School of Social and Political Science (S.S.P.S) Ethics Committee meeting of the previous month, the final section of the document was a list of contact details (mainly phone numbers and email addresses) for support groups and organisations, with an explanatory note indicating the assistance which may be available if participating in the research had raised concerns for the participant, or if they had used the survey to explain about their own past experiences, which may yet have a subsequent emotional impact.

Sampling, Circulation and Distribution

The main shared issues concerning sampling for the first two questionnaires are discussed in the overall review of sampling of transgender people in the separate section above.

With particular regard to the first questionnaire, approximately a fifth of the S.T.A. membership completed forty seven questionnaires. 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 1998 survey data (1999) and the 2009 Gires estimates (Reed et al, 2009: 4) quoted within the literature review) and using the population of Scotland of 5,254,800 from June 2011 (General Register Office, 2012a), it is possible to estimate that the number of respondents to questionnaire one (forty seven) was between 4.5% and 10.9% of the estimated transgender population of Scotland.

Data Analysis

Many of the data tables produced from the raw data from the Bristol Online Survey have been included within the text of the research findings chapters but in an order which seeks to further understanding, rather than to simply reproduce the order of the original questionnaires. For example the juxtaposed tables thirteen and fourteen indicate how individuals described their gender identity, and also the gender descriptors with which they identified. Analysis of this data indicated that whilst just nine participants of survey one described themselves as 'transgender' in preference to male, female or 'other' (table

thirteen), much higher numbers of respondents (twenty three) identified with the term transgender when they could choose this term as well as male, female etc. (table fourteen).

In addition to the main questionnaire data from this survey, five sets of cross tabulations were systematically undertaken across all survey responses by age, biological sex, gender identity, current gender role and home circumstances. The results of these cross-tabulations are referred to, where they shed additional light on the research results, throughout each of the research findings chapters concerning the surveys of transgender people. For example, cross tabulations proved valuable in suggesting links between age, biological sex, current gender role, and gender identity in particular, which led to further hypothesis at the discussion stage regarding the age at which transition appears more likely to occur, according to biological sex and gender identity. Following on from the example above of the data reproduced in tables thirteen and fourteen, the following table, table fifteen, cross tabulates preferred gender descriptors with age, showing an increased likelihood for trans-men, trans-males etc. to be in younger age groups than trans-women, trans-females etc. as well as a slightly greater likelihood for participants in the younger age groups to describe themselves as transgender.

Table sixteen also follows this themed approach to data analysis by summarising the importance of each of a wide range of potential sources of advice or support in helping individuals to come to terms with their gender identity, using colour coding to quickly indicate the strength of responses, measuring highest and lowest responses from deep red, orange and yellow, to light, mid and dark blue across each of the categories of sources of advice or support.

Key themes were identified from the data of the first questionnaire, consistent with a grounded theory approach, by identifying the key issues which appeared repeatedly in responses and comments (together with sub-themes and themes from the ten interviews described below) enabling the development of the subsequent second questionnaire, around seven social care themes:

Issues related to coming to terms with being transgender

Support with transitional issues

Mental health problems linked with gender identity or gender role

Support to family members in coming to terms with being transgender

Assistance with documentation during/after transition

Support with long-term physical or mental ill health, disability, or problems related to old age

Post-transitional and societal issues

However, the data from the first survey had not been able to separate past, present and future valuation of services because the series of eight related questions did not allow for such separation. These aspects were (in retrospect, mistakenly) combined in an attempt to reduce the length of the questionnaire, after concerns had been raised by the S.T.A. about the number of questions included in the survey, at a meeting in January 2012. The absence of this information was redressed within questionnaire two.

Questionnaire Two: The Second Survey of Transgender People in Scotland

The second survey of transgender people in Scotland was circulated in August 2012 following an analysis of the original questionnaire (originally circulated in February 2012) and analysis of the transcripts of the ten interviews with transgender people which had been carried out between May and July 2012. An explanation of how the sub-themes and themes which form the basis of the second survey were initially identified from the data of the first questionnaire and the ten interviews of transgender people, was included above within the section on grounded theory, leading to a much broader survey of potential support needs in this second questionnaire. The inclusion of individual questions concerning whether social care had been/was/would be of value across a range of possible support services was another significant development which provided much valuable information, supplementing the information on the perceived potential value of a range of sources of support which has been collated from the first survey.

The introduction to the questionnaire, as with the original first questionnaire, once again contained information on the background to the research, and a participation agreement as detailed within the description of questionnaire one above.

Structure

The first section of the second transgender survey was reduced from the seven questions which had been included in the comparable section of the original questionnaire to just

three questions seeking 'a little background information' about the participant: 'age' and 'home circumstances' were two of the attribute questions which had been found to be most useful in cross tabulations with the majority of the remainder of questions within questionnaire one and the question on country of residence was again included to ensure that all participants were currently resident in Scotland. Once again these three questions were reproduced from attribute questions from the 2011 Scottish Census.

The second section consisted of three of the ten questions which had been included at the same stage of the first questionnaire, restricted this time to seeking information about the participant's self-perception of their sex, their gender identity and their current gender role.

The main purpose of this questionnaire was to explore further the sub-themes and themes from questionnaire one. The remainder of the survey was therefore structured (within a further six sections) around a repeated series of three separate questions which asked whether 'advice, information or support from a suitably experienced social worker or care worker is valued/would be valued/was valued' for a range of potential issues such as coming 'to terms with your gender identity and being transgender', 'to make plans for the future', to help 'your family ...' or 'your partner and/or one or more of your children ... to better understand about your being transgender' etc. These significantly expanded on the series of questions about the perceived value of 'assistance from an appropriately trained social worker or care worker' which had been included within questionnaire one.

Additional separate questions sought to clarify whether 'advice, information or support from a suitably experienced social worker or care worker is valued/would be valued/was valued': 'to help you to address social isolation linked with being transgender', 'to help you address the consequences of social rejection and/or abuse linked with being transgender', 'to help you to better understand and/or address differences/disagreements or conflicts with your friends ... colleagues, neighbours and/or acquaintances concerning your being transgender', and lastly 'to develop a more confident community presence'. These were new sub-themes which had not been explicit within the first questionnaire but which had emerged within the subsequent ten online interviews.

The last question of the survey was an open question seeking additional comments about 'any issues raised in this questionnaire'. The questionnaire ended with a formal thank you

to each participant together with a list of contact details for support groups and organisations, as per questionnaire one, in case participating in the research had caused the participant concerns or distress.

Sampling, Circulation and Distribution

The main shared issues concerning sampling for the first two questionnaires are discussed in the overall review of sampling of transgender people in the separate section above.

A total of twenty seven completed responses were received to this survey, drawn from the two hundred and thirty members of the Scottish Transgender Alliance. Twenty seven responses represents between 2.6% and 6.3% of the estimated transgender population of Scotland, according to figures based on the Wilson et al (1999) and Reed et al (2009) estimates.

Data Analysis

As with survey one, many of the data tables produced from the raw data of survey two from the Bristol Online collation have been included within the text of the research findings chapters, occasionally allowing a comparison of data from both questionnaires where the same question was used in both surveys (for example, table thirteen).

In addition to the main questionnaire data from this survey, five sets of cross tabulations were systematically undertaken across all survey responses by age, biological sex, gender identity, current gender role and home circumstances. Such cross-tabulations had already been undertaken and found useful in relation to the data from questionnaire one, and the cross tabulations from survey two are similarly referred to within the research findings chapters where they shed additional light on the research results.

Data from questionnaire two was carefully considered in relation to the findings of questionnaire one. For example, following on with the themed approach within the section on data analysis for questionnaire one above, linking tables thirteen through to sixteen, the next table (table seventeen) indicates a related finding from questionnaire two, concerning the degree to which advice, information and support regarding gender identity, and being transgender would be valued from a suitably trained and experienced social worker. In addition the subsequent text summarises further linked data concerning people who are receiving such support at present, have received such support in the past, or are receiving/have received such support from another source.

The informal, flexible agenda of questions for the ten online interviews had led to the identification of the forty five sub-themes and seven main themes which were explored within this second questionnaire. These seven main social care themes formed the basis of the structure of the three research findings chapters that presented data from the surveys and interviews of transgender people (chapters four, five and six).

A summary of the value of advice, information and support from a social worker, across all categories covered in this second questionnaire (and one of the categories from questionnaire one) has been collated as table forty six, in Appendix Four. Further statistical analysis was also undertaken, initially by cross-tabulation (tables forty seven and forty eight) together with statistical testing using Yules Q for strength of association between variables (tables forty nine, fifty, fifty one and fifty two), details of which are also included at Appendix Four.

Questionnaire Three: Voluntary and Local Authority Social Care Services

The third questionnaire, for local authority and voluntary sector commissioners and service providers, sought to explore the range of trans-specific service provision, and appropriately adapted generic services to transgender people within usually bi-gendered community or institution based services, across Scotland.

This survey was circulated in March 2012 following discussion of the draft version of the questionnaire with two members of a Scottish Council Social Work Department.

There was a dual purpose to this questionnaire. The first purpose was to gain information on the availability and accessibility of dedicated and generic services for transgender people provided by the statutory and voluntary sectors. The second purpose was to gain information which might inform future interviews with staff of local authorities and/or service providers of social care services, or indeed with transgender people.

The introduction to the questionnaire contained information on the background to the research, and a participation agreement similar to that described for questionnaires one and two above.

Structure

The first section of the survey consisted of two questions seeking information concerning the status of the organisation to which the participant belonged (statutory or voluntary), and the Region of Scotland in which the service was based.

The second section addressed the provision of dedicated/specialist local service provision to transgender adults and children in the Region of Scotland where the service was based, both by the service which the participant represented, and by other services of which they were aware.

The third section of the survey was structured around a series of questions about the accommodation by generic service provision of the needs of transgender adults and children.

The fourth section sought information about full time equivalent staffing of dedicated/specialist support to transgender people, and the training which both they and generic staff had received in transgender issues, or, where applicable, their unmet training needs.

Additional questions within the fifth and final section of the survey sought information on policy statements/guidance documents that were in place for the provision of social care services to transgender people within dedicated/specialist and generic service provision, and which areas these policy statements and guidance documents covered.

The last question of the survey was an open question seeking additional comments about any aspect of social care services to transgender people in Scotland. The questionnaire ended with a request for participants to indicate whether they would be willing to take part in an individual interview, followed by a formal thank you. Where responses from some voluntary and statutory sector participants suggested alternative sources of expertise and information, these additional sources were also contacted, and, with their agreement were included within the interview process. Nine participants from the voluntary and statutory sectors took part in the subsequent interviews.

Sampling, Circulation and Distribution

As noted above, the geographical boundary for the research had been set within Scotland. I was keen to reach as many organisations providing social care to transgender people in

Scotland, and chose to try to reach these organisations through the sampling frame of the twenty six support groups and voluntary transgender organisations on the S.T.A. mailing list. Actual contact with these groups and organisations was undertaken by the S.T.A. themselves, who circulated the web-address for the questionnaire which was made available online, via a University of Edinburgh link with the Bristol Online Survey.

In addition the survey was sent 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 service support in their local Region of Scotland. Following a presentation to the A.D.S.W. Contracts Officers at their monthly meeting, the web address for the survey was circulated via a representative of one of the local authorities, in March 2012 and these members were asked to complete the questionnaire and to forward the web address to any other organisations providing social care support to transgender people in their Region of Scotland of which they were aware.

It was believed that such a distribution process should provide a representative non-probability self-selecting sample of statutory, private and voluntary organisations in Scotland. Reminder emails were sent out to both the S.T.A. support groups and to the members of the A.D.S.W. Contracts Group three weeks later, one week before the survey closed. Results suggested that a representative sample of statutory organisations was reached (twelve in total, from the thirty two regions of Scotland) and voluntary organisations too (eight in total, from the twenty six voluntary organisations on the S.T.A. mailing list), though no private social care providers participated in the survey.

Data Analysis

Raw data from the statutory and voluntary sector respondents was initially collated jointly within the Bristol Online Survey format. Prior to data analysis, responses from these two main groups were separated because of immediately apparent fundamental differences in their involvement in transgender social care services. All subsequent collated data showed the results from the two sets of sector respondents separately.

Four key themes had been built into the third questionnaire and these were subsequently used as a framework to use within the nine interviews with service representatives, by

identifying key issues which appeared in their responses and comments. The four key themes were:

Dedicated/specialist social care services to transgender people

Generic social care services to transgender people

Staffing and training

Policy statements and staff guidelines

The Online Interviews

Two sets of online interviews were undertaken within this research. These interviews were carried out asynchronously, allowing the participants to fully consider each question (and myself to fully consider each response). As discussed in more detail below, interviewees were able to carefully consider their responses over several hours (or even days) and to reconsider their initial responses too, offering additional perspectives if they needed to, after further reflection. This period of reflection allowed me too to seek more detailed information, particularly where an original response had been quite brief. Where interviewees raised issues outwith the immediate perspective of the interviews, I sought to address these appropriately of course, before returning to the focus of social care.

I sought to maintain a strict focus on 'social care' issues throughout these semi-structured interviews, basing the questions on the participants' original answers to the preceding questionnaire. I also usually avoided an exploration of tangential and background issues beyond those perspectives already explored within the questionnaire, unless these appeared particularly relevant.

The semi-structured approach was also maintained within the service interviews, with the inherent flexibility of this approach allowing me, for example, to seek additional information from new contacts or organisations mentioned by the original interviewee. This was particularly important in assisting me to make contact with local service provision.

Online Interviews: Transgender Individuals

The first set of interviews was undertaken with the ten transgender participants who had indicated at their completion of questionnaire one that they would be willing to take part in

an interview. Of the twenty two people who expressed an interest in taking part in an interview (almost half of the forty seven people who completed the questionnaire) ten followed this through by completing an interview online. Case studies on six of the ten individuals have been included at Appendix Five. Because these mainly reflect the 'social care' focus described above, they do not necessarily reflect a fuller life story. Some additional attribute information has therefore been added to the case studies from the interviewees' original survey responses, to reflect a broader perspective.

Online Interviews: Statutory and Voluntary Social Care Services

The second set of interviews was undertaken with those representatives of Statutory or Voluntary Social Care services who had indicated at their completion of questionnaire three that they would be willing to take part in an interview. Of the twenty people who completed the questionnaire, just five offered to take part in an interview, and only two of these five actually completed an online interview. However, because of the nature of the feedback which I received from these two interviewees, it was possible to 'snowball' to potential additional interviewees, through contact details provided by the original interviewees, and through this method a further seven participants contributed to the interview research.

Interviews and Interviewing

The effect of the interview on the respondent has been explored by a number of writers, more recently by those working from within an expressed feminist ideology. It is increasingly recognised that a respondent's contributions to an interview are elicited by the approach and attitude of the interviewer, by the respondent's own past experiences, by the respondent's own perception of their role within the interview, and by how they seek to fulfil this role in order to meet both their own needs, and the perceived needs of the interviewer. As Sinding and Aronson note, 'at one extreme, interviews allegedly empower, generate self-awareness, or offer a kind of therapeutic release for interviewees; at the other, they draw reproach for feigning intimacy with, and then abandoning, the people they engage' (2003: 95).

In this section the online format of the interviews is explored, to consider how this might have affected the research findings, together with the steps which were taken to ensure that interviewees were as comfortable as possible with the interview process. Bryman suggests that one of the earliest decisions that needs to be made concerns 'whether the

interviews should take place in synchronous or asynchronous mode' (2008: 642). I deliberately chose an asynchronous mode for both the transgender and service interviews, stressing within the participation agreement, that 'the interview will take place at whatever pace you feel comfortable with. You can respond immediately to a question, or you can leave your response for a little while, to consider the question further'. I wanted both myself and the participants to be able to take the time to consider replies and ideas, and to be able to reconsider what had already been said in the light of subsequent comments for, as Becker notes, 'the people we study often do not give stable or consistent meanings to things, people and events' (1996: 5).

In the light of these concerns that people may not always express themselves clearly and consistently, and that the researcher may not always understand exactly what the interviewee is saying, allowing both the interviewer and the participant to check and comment further on what has already been said in the interview throughout its creation, appears to add further validity to the final record.

An example of the benefit of having the ability to further reflect was apparent in a comment which one interviewee made when asked 'was there a reason why (in the survey questionnaire) you chose not to describe your biological sex?' Their reply that ...

Josie: 'I do not regard (my) biological sex as the one I am now and for me (it) is an irrelevance'

... seemed somewhat opaque, but the next day she added:

'I had a further thought about biological sex, and having been on hormones since 199x, the chemical make-up of my body resembles in no way the former me'.

It is possible that this helpful additional comment, made somewhat later in the interview process, may have been lost in a traditional face to face interview in real time.

Fontana and Frey note that 'almost all interviews, no matter what their purposes (to describe, to interrogate, to assist, to test, to evaluate) seek various forms of biographical description' (2000: 647), (although, as noted above, this was not the primary intention of these interviews, even with the transgender participants). They refer to Gubrium and Holstein's (1998) suggestion that 'the interview has become a means of contemporary storytelling'. Life accounts are not simply straightforwardly accessed and reproduced from

neatly filed memories: they are to a greater or lesser degree constructed or reconstructed at the time of exposition. As Holstein and Gubrium explain: 'in the 'vessel-of-answers' approach, the image of the subject is passive (but an) activated subject pieces together, before, during and after assuming the role of respondent' (2004: 145). Kvale's definition of an interview as 'a soft social technology for biographical reconstruction and reconfirmation of a fragile self' (2006: 493) seems to combine and reflect the multi-faceted aspects of interviewing very beautifully.

Allowing the respondent this element of construction within their answers seems to be one of the key elements of a qualitative approach to interviewing, for, as Bryman points out, in qualitative interviewing 'rambling' or going off on tangents may be encouraged, (interviewers) can ask new questions' that follow up on respondents' replies, or 'vary the order (or) even the wording of questions' (2008: 437).

I deliberately chose a semi-structured interview format in order to allow me to focus on the social care aspects of transgender interviewees' experiences, rather than using an unstructured interview which might have elicited fuller life stories, although this still allowed me to 'go off on tangents' if this felt potentially worthwhile. For example, in reflecting on the value of web sites for transpeople, one interviewee noted that:

Ciaran: 'after a few bad experiences online seeking fellow trans-people I'd now rather get on with things the best I can'.

I was intrigued by this reply and my response therefore sought more information 'to explain a little more about these experiences' together with a comment that:

'the trans community is often suggested as the main source of advice and support in the early stages of coming to terms with trans issues or planning transition etc. so it would be really helpful to have an idea of when this can go wrong'.

The reply I received wasn't one that I had anticipated:

Ciaran: 'I set up a profile on (two websites) explaining that I was the only trans in my small minded town and was looking to have general chat with others at any stage of their transition ... but the only replies I got were of a sexual nature'.

A semi-structured approach was also used with the service interviews which allowed me to explore apparently tangential issues in detail too. For example, one interviewee referred to a local service for elderly transgender people, and I was able to follow this up by asking for more detail on the service together with a contact name. This then led me to a website for the group, through which I was able to make contact with members of the group themselves.

Roulston et al draw attention to the issue of 'difficult questions', when they highlight the situation of a student who was interviewing about racial incidents and experiences at school: 'It just came from out of the sky ... I think that this (difficult) question would be important to use in a second interview after we had established a rapport and trust' (2003: 656). Being online, I had believed that I would have to establish this sense of rapport and trust through rather different means than the eye contact, facial expression and body language that facilitate such relationships in face to face interviews, and because of this, that it might take somewhat longer to build up such trust. But in the example above, although the issue of sexual propositioning did indeed come 'from out of the sky' it was mentioned in only the second response that this interviewee had given, so, sometimes at least, the sense of rapport and trust seemed to have been established quite quickly.

What factors might have facilitated this sense of rapport? It seems important that interviewees had already volunteered themselves for interview at the end of the survey process, before finally agreeing to the interview via a participation agreement, which clearly stated standards of confidentiality and storage of information. This also contained a brief explanation of my own background in social care services. I believe that one reason I did this was because I was keen to appear competent, trustworthy and suitably experienced in my role as interviewer. Hannah Avis, in an analysis of her role as interviewer writes that 'what seemed to be required was a construction of character that conveyed confidence and credibility while being involved and co-opted into both the process and product of research' (2002: 195). Bryman notes that 'there is evidence that prospective interviewees are more likely to agree to participate if their agreement is solicited prior to sending them questions and if the researcher uses some form of self-disclosure' (2008: 642) (I had already ensured that the S.T.A. made it clear when circulating the previous survey that I was transgender). Avis also notes that 'the building of rapport necessitates some disclosure by the person initiating the interview so that disclosure from

the person responding can follow ... this reciprocal disclosure punctures the boundary surrounding the researcher' (2002: 197). Self-disclosure of my transgender status with the service interviewees had come when I first met with the A.D.S.W. group in Stirling, in March 2012, to explain the purpose of the interviews, and my own background as a former contracts manager to a local Council.

To this notion of rapport, I would also add that the sense of security and safety for transgender people, which came from being able to be interviewed within their own home, without the need to go out in public, at a convenient time of their choosing, was probably also a significant factor in interviewees feeling relaxed enough to correspond (often at some length) about their thoughts and experiences (it was notable how many responses to questions were written in the late evening or the early hours of the morning). But perhaps too, my way of responding to comments and information may have been facilitative: I tried to acknowledge as many of the issues which were raised in the interviews as possible, even if they weren't all directly addressed, and I also sought to appropriately reassure interviewees that what they were saying was valuable to the research, and to link ideas as coherently as I could, so that the interview process wouldn't seem disjointed (Gadd notes that 'coherence is often striven for during biographical interviews (but it) is neither always achieved by interview participants nor readily apparent to the interviewer' (2004: 386). I explained how I felt about what they said – when it moved me, or touched me, for example, to make explicit in words what might have been more obvious in a one-to-one situation through facial expression or body language. I also tried to write in full sentences that made clear grammatical sense to try to avoid misunderstandings that might lead to confusion or even drop out.

Rubin and Rubin indicate that: 'in both ordinary conversations and interviews ... participants work out ways to acknowledge when they understand (and) ask questions or look puzzled when they don't' (2005: 108). Because in the online situation, such puzzlement can only be evident on the printed page, I sought to reassure participants that they could take ample time to explore and express their 'knowledge, views, understandings, interpretations, experiences and interactions' (Mason, 2002: 63). On several occasions I sought further information after an initial response, and sometimes the interviewees queried the meaning of a question too. When there was an unexpected delay in a response to a question from an interviewee, I sometimes sent a follow up email in case

difficulties within the question might lead to non-response or drop out. For example, after an unexpected two day silence from someone who had previously replied to my questions very promptly, I followed up a question about long-term illness by asking that:

‘As I’ve not heard back from you for almost forty eight hours, I wonder if the last question that I asked was a little too personal or difficult to answer for you? If this is the case, then please ignore it – there is absolutely no need to answer any question that you’re not comfortable with’.

I quickly received a response which explained that, due to the interviewee’s shift pattern, they had been working for the last consecutive eight days, hence the delay. They then responded with a three paragraph answer to the question.

I sent questions either singly or in small batches of two or three related questions, asking interviewees to respond ‘in your own time’. Bryman (2008: 642) notes how Bampton and Cowton (2002) argue that small batches of questions ‘took pressure off interviewees to reply quickly, gave them the opportunity to provide considered replies ... and gave the interviewers greater opportunity to respond to interviewees answers’. Bryman (2008: 642) also quotes Mann and Stewart (2000: 138/9) who suggest that although the respondent in asynchronous interviews is more likely to drop out, since the interviews can be very protracted (this did sometimes happen in my own interviews, although most drop out occurred at the beginning of the online process) ‘in fact a relationship of mutual trust can be built up (which makes it) easier for a longer-term commitment to the interview to be maintained, but also makes it easier for the researchers to go back to their interviewees for future information or reflection’. I was very conscious of this commitment from each of the interviewees who saw the online interview through to its conclusion, usually after an exchange of between ten and fifteen emails.

Bondi makes a distinction between empathy and identification, defining empathy as ‘the capacity to understand the experiential frame of reference of another without losing an awareness of (its difference from) one’s own’ and distinguishes this from identification, which she defines as ‘a process through which the psychoanalytic subject absorbs and incorporates aspects or attributes of others, metabolising this material to generate his or her own identity’ (2002: 65/68). Perhaps the process of identification is more likely to occur when the interviewer and interviewee have commonality already. So, for example, as a

transgender interviewer it was probably easier for me to identify with other transgender people's ideas and experiences, although I think that I also sought to retain a sense of appropriate distance in the interviews, whilst still retaining empathy. I believe that I was also able to show empathy to statutory and voluntary service interviewees too, because of my understanding of the way they worked, from my own background in social care contracting.

Goodrum and Keys examine the nature of participation further when they explain that 'when discussing a difficult situation, a respondent may offer the quick synopsis version, or a much lengthier account' (2007: 253). I found that this varied from interviewee to interviewee, and seemed more a reflection of consistent style throughout the interview than a reflection of a change of style when discussing something sensitive. Some interviewees gave terse but thoughtful replies throughout, others went into great detail, although usually still responding to my questions and comments in a manner which, at times seems to have approximated to Kvale and Brinkman's idea of 'collaborative interviewing where 'the researcher and the subject approach equality in questioning, interpreting and reporting' (2009: 34).

Kvale has already been quoted as saying that 'the power dynamics in research interviews ... tend to be left out in literature on qualitative research' and that 'referring to the interview as dialogue is misleading' (2006: 483) as it does not conform to the notion of a truly equal platonic seeking of joint understanding. Ten years earlier Kvale noted that 'the conversation in a research interview is not the reciprocal interaction of two equal partners (but) a definite asymmetry of power' (1996: 126). He explored how the interviewer, who 'defines the situation, introduces the topics of conversation, and ... steers the course of the interview' appears to benefit most from this asymmetry. Kvale and Brinkman, while listing a range of ways in which power asymmetries arise (the interview as a one-way, instrumental, and manipulative dialogue, where the interviewer has a 'monopoly of interpretation') also raise the possibility of 'counter control', where 'in reaction to the dominance of the interviewer, some subjects ... withhold information ... talk around the subject matter ... question the interviewer ... protest at ... questions or interpretations ... or, in rare cases, withdraw from the interview' (2009: 34). From the experience of one or two of these interviews, I would add: 'using the interview to raise concerns by bringing up a topic that is not necessarily directly related to the one raised by the interviewer'. For

example one interviewee unexpectedly raised their concerns about how the outcomes of this research might be used, within a quite detailed statement on the difficulties of transgender people making their voices heard within local government, a not unreasonable comment on an issue that had not however been part of my initial agenda.

I sought to consider the notion of power carefully prior to and during the interviews for both the transgender and service interviews. I tried not to take too directive a manner, especially when interviewees brought up subjects and issues which they themselves wanted to pursue. However, both I and the interviewees, were aware, from my quoting directly from their individual survey responses that the interviews were structured around these survey responses, and, as noted above, I was keen to keep the interviews on track around social care issues, and not to let the interviews become an exposition and review of a person's life history.

As noted above, interviews of transgender individuals proved somewhat more forthcoming when compared to interviews with representatives of the statutory and voluntary sector. One further example of power relationships needs to be considered, in relation to these latter interviews in particular. Smith notes a range of research where 'it has been variously argued that 'elite' groups are more difficult to penetrate than other groups', but she goes on to suggest that she is 'wary about the use of the term 'elite' since 'power exists in a variety of modalities (which) can be negotiated, and are neither constant nor inscribed' (2006: 645). I might have been concerned by the 'elite' nature of the A.D.S.W. Contracts Officers group, or indeed the co-ordinators of voluntary sector groups, had I not previously been a member of the A.D.S.W. group in the past, and had responsibility for liaison and negotiation with the voluntary sector for a number of years in earlier employment. Nonetheless I found it hard to get detailed responses from some members of both these groups, although their referring me to other sources of information did compensate for this somewhat.

I increasingly came to the conclusion that one of the main reasons for the paucity of detailed information from the statutory sector was that the information being requested appeared to be either largely unavailable or not known, and that some representatives of the voluntary sector perhaps viewed their support to transgender people as not falling within the remit of 'social care services'. Very occasionally, where a statutory or voluntary representative provided links to additional relevant documents, or where an individual

voluntary organisation with their own webpage was identified within a survey or interview I was able to follow up and build on the limited information provided in interviews by online research, and where this is the case, this is indicated in the research findings and discussion chapters.

Lastly, I sought to end each interview positively, thanking the participant for their 'thoughtful and helpful responses' and offering the opportunity to contact me with any 'further comments or thoughts which you would like to share on any of the issues which we have covered in this series of emails'. Endings are not regularly discussed in the academic literature within the context of qualitative interviewing, but Sinding and Aronson's comment is relevant again, confirming that interviewees should not be left to feel abandoned by the people who have engaged them in discussion (2003: 95). That this applies particularly to members of vulnerable groups was a concern of which I was very aware as the conclusion of each of the ten interviews with transgender people was reached. I ended each of these ten interviews with the phrase 'take good care of yourself', which, in the context of the often powerfully emotional terrain which we had covered together over several days, was genuinely felt, and I believe, was not inappropriate.

Data Analysis

As noted within the section on grounded theory above, the detailed responses from the first transgender questionnaire and the ten online interviews to transgender people were analysed in a manner consistent with a grounded theory approach. The key issues which appeared repeatedly in responses and comments, were identified by reading and re-reading the transcripts and highlighting potential sub-themes (from the interviews) and themes (from the questionnaires) as they appeared. This enabled the development of a flexible agenda for the subsequent second questionnaire, around seven main social care themes which were derived from the forty five sub-themes, as indicated below:

Social Care Themes from Questionnaires (in bold type)

Social Care Sub-Themes from Interviews (in ordinary type)

Issues Related to Coming to Terms with Being Transgender

Clarifying biological sex, gender and gender identity differences
Scottish (legal) concepts of sex and gender and those of other countries and cultures
Self-acceptance – coming to terms with being transgender, transsexual, bi-gender, etc.
The physical and emotional consequences of puberty
Distinguishing between helpful and harmful information, and that ‘in between’ (on the internet etc)
Sexual responses to online seeking of like-minded transgender people
Clarifying and choosing between options including transition
Re-negotiating or ending relationships with spouses/partners

Support with Transitional Issues

Reliable information re the transitional process for MtF and FtM
Forward planning for the ‘real life test’ and for transition
Support during the ‘real life test’
Support during the transitional process including the GIC process
Access to services if living outwith the Central Belt
Transitioning in small communities without anonymity
Waiting times to see a G.I.C. specialist
Length of time between G.I.C. appointments
Decision making over surgery (e.g. FtM ‘bottom half’)
Waiting times for surgery (over and above those associated with the ‘real life test’)
Coping with surgery, and post-surgery recovery
Having someone to talk to about hormonal issues

Support to Family in Coming to Terms with Being Transgender

Meeting the needs of partners through provision of information and emotional support
Meeting the needs of family members, particularly immediate family, through the provision of info and emotional support, from a neutral perspective, family support groups etc
Supporting families in the ‘loss’ of a son, daughter, husband, wife, future grandchildren etc
Addressing non acceptance by some family members, including ‘splits’ into family factions or being disowned by some family members

Addressing generational and religious Issues

Gossip: 'whispering/pointing, knowing my business and posting horrible things online'

Assistance with Documentation During/After Transition

Reliable information re documentation changes including timing/order

Persistent use of wrong gender terminology by organisations, particularly NHS

Applying for and submitting evidence to meet the standards of the G.R.C. (and coping with rejection)

Coming to terms with the dilemma of the G.R.C., and, for some, the 'lie' of the G.R.C.

Support with Health Problems or Disability linked with Gender Identity or Gender Role

Having someone to talk to when things get difficult – 'not just your mum' or your partner

Support after incidents of societal rejection/abuse

Mental health issues linked with gender/transgender (eg not having a penis as FtM)

Mental health issues linked with societal rejection/verbal and physical abuse– anxiety and panic attacks – Samaritans

Negative media perspectives on transgender

Support with Long-Term Physical or Mental Ill health, Disability or Problems Related to Old Age

Long-term illnesses being linked to transgender/transition/hormones

Emotional issues ('nerves') being linked to 'poor emotional health' linked with being transgender

Post-Transitional Issues

Negotiating family gatherings: birthdays, Christmas etc.

Re-negotiating family relationships ('dad, you're going to be a grandma')

The dilemmas of being 'Proud to be Trans' and living by 'stealth'

New gender related life skills and choices

'Being the same person' you always were, in a new gender role

'Belonging to the human race' (again)

New intimate relationships

Worrying about future children getting teased

Many of the themes and sub-themes which were raised by individual transgender and service interviewees are exemplified by quotes reproduced directly within the research findings chapters, adding additional detail and further perspective on the findings of the research questionnaires. For example, in relation to the main survey data for sources of advice and support in helping to undertake transition, and the value of social work support at such a time (tables nineteen and twenty), individual comments from interviewees suggested that the source of advice and support may well be affected by the proximity of the nearest G.I.C or surgical facilities:

Ciaran: 'it's not ideal that my nearest G.I.C. involves a 200 mile round trip and I have to travel to London for operations'.

... or concerns about the attitudes of support staff from within (for example) small rural communities ...

Lucy: 'we have a small population and a resultant small local mental health team who to a great degree reflect the inherent local prejudices'

Similarly, in relation to data about local service provision (tables three and four) the service interviews added valuable insight into a lack of knowledge that some respondents felt about such data ('we don't even know how many transgender people are within our population') or about the work being done to meet such needs ('Although it is recognised by experts in equalities that there is a requirement for services such as (those) discussed above, I am unaware of much work being done in this area locally').

The juxtaposition of data from each of the surveys, with interview responses was thus an essential part of the data analysis process and the synthesis of the data, and it is in this way that the research findings have been presented, throughout the research findings chapters.

Some quotes from the online interviews appear in the discussion chapter, particularly where they illustrate an aspect of the discussion. Occasionally quotes are used as an integral part of the discussion (for example the series of quotes within chapter seven

regarding transgender access to binary gendered generic services). To avoid unnecessary duplication, comments included in the discussion chapter are not usually replicated in the research findings chapters. However, they are of course also considered as research data in their own right and not just as aids to the discussion in which they appear.

Reflexivity

Bryman notes the importance of insight into the personal 'significance of the researcher for the research process' (2008: 680), raising the notion of reflexivity, a point of view also encountered within feminist research (e.g. Yeandle, 1984).

I have suggested that information might be deeply considered, discussed and re-constructed over months, years, decades as it evolves in status and within the memory. Roulston et al's view has also been noted, of the qualitative interview as 'a site in which interviewers and interviewees co-construct data' (2003: 645). I believe that such processes are part not just of the interview process but of the survey process too – for, in choosing questions to construct each survey, or possible alternative answers to a question, my own personal views of what may or may not be appropriate, are likely to be consciously or unconsciously influential.

Mason takes this further when she draws a distinction between interpretive and reflexive scrutiny of interview transcripts. The former is concerned with 'what you think they mean, or possibly ... what you think you can infer' whilst the latter is concerned with 'your role and your interface with the interaction'. She explains that choice of these 'readings' of interviews, 'will of course be related to your stance on whether knowledge is constructed or excavated' (2002: 78).

I believe that as interviewer and survey writer, I cannot be free from prejudice and bias, and just as I played a role in co-constructing the responses of the interviews in which I took part, by posing questions which determined the direction of the interview (no matter how sensitive I tried to be to the interviewee's perspective) so I affected the outcomes and the subsequent interpretations of the surveys by both overt and hidden agendas too. Kvale and Brinkman speak of the need for 'reflexive objectivity in the sense of being reflexive about one's contribution as a researcher to the production of knowledge (where) ... objectivity ... here means ... striving for sensitivity about one's prejudices' (2009: 242).

So, what were the biases and prejudices which I brought to this research, and how might they have affected the processes and the outcomes (and the ways in which these were presented)?

Firstly, I have managed and quality-assessed services in social care since 1980, and have supported, represented and fought for the rights of disabled people and people with mental health problems, throughout my career. It would be difficult for me to undertake research into social care services for another oppressed, disadvantaged and minority group (which is how I perceive transgender people) without my having a sense of the rights of this group to equality of perception, respect, and treatment by others, both as individuals and as a group.

Secondly, as a transgender person, some sixteen years post transition, I empathise with other transgender people from a sense of shared experience which has seen me in the past striving to make sense of life as a transgender child and young person, and subsequently as an adult, and to fulfil expectations of myself, and obligations to my partner and to my children, in my original gender role. I have subsequently undertaken gender reassignment and experienced the social exclusion which this brings, the loss of friends of many years standing, and the abuse and derision of some members of the public. I have grown to understand that being transgender and undertaking gender reassignment are likely to leave one more socially adrift than 'living the lie' of staying in one's original gender role, and that for those who do undertake the transition process, it is largely a medical solution to what is also, I believe, a societal or social problem, which is only very slowly being addressed and resolved. And so, in undertaking research into social care services for transgender people, I believe that I brought implicit empathy to this group of people which was nonetheless monitored by the constant awareness of 'reflexive objectivity' (for example by regularly recording observations and ideas within my own personal journal, which subsequently often found their way into my research).

Perhaps it would be helpful to explore the influences of my social care background and my transgender status on this research, to seek to bring out some of the overt and hidden agendas which may have influenced me from the beginning of the research process:

An example of the influence of my former role in social work on this research is, I believe, apparent from the way in which I chose to seek out knowledge of local provision of specialist transgender services and support to transgender people within generic services. As a former contracts manager for social care services, I had reason to believe that the most effective 'way in' to these services was not, as might have seemed obvious, through a letter to each Director of Social Work for 'cascading' to appropriate departments and their

staff, but rather more directly, through the A.D.S.W. Contracts Officers network. I knew from experience (and from having belonged to the group in the past) that each member of this network has responsibility for liaison both within and outwith social work departments with all local providers of social care from private, voluntary and statutory backgrounds, and therefore that these were the key people who should be aware of transgender support within their own locality.

The nature of reflexive objectivity within my role as interviewer, from both a social worker/mental health worker perspective and from an understanding of a transgender perspective from personal experience, might also be illustrated from examples from one of the interviews with transgender people, which followed the first questionnaire:

In one of the interviews, an early question asked about the nature of the category of 'long-term sick and disabled' within which the participant had identified themselves:

Lucy: 'I have acquired brain damage due to being the victim of an attempted murder ... since then I have suffered personality changes ... absences and hallucinations ... I am prone to severe depression, can withdraw from social contact for extended periods. ... I can sometimes be aggressive so avoid people and stressful situations ... I have had episodes of thinking about self-harm'.

I wanted to explore the nature of the mental health problems which the interviewee believed were linked most specifically with being transgender, but, as a former mental health worker, I felt that it would be inappropriate to do this without my first acknowledging and empathising with the breadth of the interviewee's experiences and their sense of the reality of their past experience, whilst also seeking to relate their responses both within the survey, and these within the interview, to their transgender status :

'I am so sorry. It is quite shocking to read the damage which has been done to you, both physically and mentally, that has affected your social life too. After reading your response, I needed to pause before going on with this interview, as I was aware that I needed to assimilate what you have so honestly explained, before asking further questions. Later in the questionnaire you speak of bipolar disorder and epilepsy. You also explain that your 'day to day activities are limited a lot by a mental health problem or disability linked with being transgender'. Are you able to

distinguish between the assault-linked mental health problems/disabilities you describe, and those which you link to being transgender? Would you be able and willing to discuss and explore this topic further?’

I received a reply of over a thousand words to this follow up question, in which the interviewee sought to disentangle the mental health issues linked with the assault and other non-transgender issues, from those which she linked directly with being transgender and the responses they received to this from the general public and from support services. I believe that my experience of working with people with mental health problems, and my belief that all issues raised by clients need to be acknowledged, if not always followed through, was important in helping me to make progress within this interviewee’s complex and distressing history.

From that point in the interview I was able to use my experience as a transgender person, and of the support which I myself had received in the past, to continue to explore some of the key (and to a greater or lesser extent universal) experiences that the interviewee had experienced as a transsexual:

‘Once again, of course, I have taken the time to assimilate as much as possible of what you have said in your email before replying. I can well understand how the stream of major life events which you describe has resulted in such low trust of others, particularly those in authority and how this has led to withdrawal from life and cutting yourself off. I was able to smile at your sense of humour when you wrote ‘(I) left hospital with a diagnosis of brain injury, a supply of hormones and a referral to a gender specialist!’ ... but was ... saddened by your description of how ‘my problems really started as this point. I went home and openly changed gender. (My local town) in 19xx was not a welcoming place for transsexuals, I was spat at, beaten up, refused service in shops (including M&S) because of my gender change, humiliated in public, had excrement pushed through my letterbox’.

Did the hospital doctor's referral prove useful, and did you receive any support in the short or long-term from such a specialist source? Are you receiving such gender specialist support at present? If you have received/are receiving such support, how ... was this useful to you?’

Grinyer notes both the importance of acknowledging the role of emotion in the research process and 'what may be less frequently addressed ... the pre-existing relationship that the researcher has with the research topic' (2005: 2/3). Self-awareness of these issues needed to be reflected on, for while being transgender might have provided me with some insight into the transgender person's experiences, it also brought with it an empathy or identification which needed to be acknowledged, and where appropriate, guarded against.

In a further example, I tried throughout the pilot focus group discussion to show empathy with the difficulties which the transgender individuals described, some of which I recognised from my own experience. However, I drew a clear line in terms of not sharing my own experiences. For example, at one point in the discussion, an older member of the group spoke about her experience forty years ago:

Agnes: 'I remember when I first tried to transition which was when I was living up in (a UK location) back in the seventies. Amongst medical staff there seemed to be an abysmal lack of knowledge and sympathy. I mean the GP that I went to just seemed to be dumbfounded but did say we'll try and find someone that does know something about it and I got through to Dr xxx up in (another UK location) and he spent his time trying to sort of talk me into aversion therapy to get me out of it'.

This recollection evoked memories of my own experiences, some forty years ago, where on my seeking to discuss my growing insight into my condition, both the University Psychiatrist and my GP, having no knowledge of transsexuality, wanted me to self-admit to a mental health hospital ward for 'observation', which I declined to do. Had I been a member of the group, it would have felt very appropriate to be able to share this with Agnes, so that she didn't feel quite so isolated in her experiences (the rest of the group were significantly younger, no older than their late forties).

Instinctively, however, I felt (and still feel) that such sharing would be inappropriate in a research context, and would perhaps leave me feeling vulnerable for having shared too much of my personal history. On a simple human level though, I regret not being able to do so, for I think Agnes would have been grateful for such an expression of empathy. It seems that one of the main outcomes of reflexivity might be to better perceive and appreciate such dilemmas. The boundary between appropriate empathy and inappropriate sharing seemed instinctively clear to me, and I am conscious that this has probably been shaped by

my experiences within social work, as well as by my experience as a researcher. I have found an extraordinary intimacy within these research relationships, extraordinary because it is one-sided, rather than based on mutual disclosure. That this is similar to that of the one-sided disclosure within a relationship based on counselling or other modes of social care support can be noted, though the differing purposes of supportive and research relationships seem very clear. As Kvale and Brinkman indicate: 'both a therapeutic and a research interview may lead to increased understanding and change, but the emphasis is on knowledge production in a research interview and on personal change in a therapeutic interview' (2009: 41).

Values and Ethical Issues

Crow et al note that the issue of informed consent is 'particularly important in research involving members of groups that are commonly characterised as 'vulnerable' because of their perceived openness to coercion, exploitation or harm by more powerful others' (2006: 84). It seems reasonable from the fragile social position of transgender people that they might be viewed as 'vulnerable'.

Because of concern that interviewees and pilot focus group members might disclose a degree of personal information about which they might later feel uncomfortable, it was important to me to ensure that participants felt able to decline to answer particular questions, or to decline to take part in or to withdraw from an interview or survey without any loss of face, and to understand and agree confidentiality boundaries within which the research was undertaken and the research findings shared. The importance of this approach was apparent at the beginning of the pilot focus group, when, after making notions of confidentiality and freedom of choice to participate in the research very clear, two potential participants felt able to withdraw from the discussion.

Throughout this research separate participation agreements for service representatives and transgender individuals were drawn up for each of the survey questionnaires and online interviews, covering issues of confidentiality and ethics. These were based on the principles of the University of Edinburgh's School of Social and Political Science (S.S.P.S.) Research Ethics Policy and Procedures (2012), and the detailed level two and level three ethical assessments which were required prior to undertaking the research, following an initial level one self-audit of risk. Ethics review forms were then completed as a level two submission: this higher level of scrutiny was required because the research was on a 'sensitive topic' involving a vulnerable group and the possibility of involvement of young people or children. These forms were subsequently rewritten at a level three level of ethical risk, when the level two assessment indicated more serious potential risks, including 'the potential for physical or psychological harm to the investigator or participants'. The proposals were further revised following a meeting with the S.S.P.S. Ethics Committee in January 2012. The main ethical issues which were raised for further consideration within this meeting were the vulnerability of the client group, particularly if transgender children

under 16 took part in the research, and the need for further reflexive exploration of my role in the research process.

The issue of young people was a complex one. A lower age limit of 13 was established for the research, based on the minimum age of a number of Scottish support groups for young people. For example Beyond Gender and LGBT Youth are support groups which provide support to 13 to 25 year old transgender people, while Mermaids offers support to transgender children as young as 12 years of age. It was agreed with the S.S.P.S Ethics Committee that should a young person aged 12 years seek involvement in the research through Mermaids or another Scottish support group, this request would initially be discussed with my supervisors and subsequently, if necessary with the S.S.P.S Ethics Committee.

It was noted at the S.S.P.S Ethics Committee meeting of January 2012 that there was no clear legal requirement to obtain parental consent for this age group: the Age of Legal Capacity (Scotland) Act 1991 defines 16 as the age at which a child becomes an adult, but below the age of 16 children can still consent to certain treatments, procedures etc. (Scottish Government, 1991). It was agreed that informing parents and asking their permission to approach the child was normally good practice (particularly as the Children (Scotland) Act 1995 notes a parental responsibility for guidance to the child up to the age of 18) but that there are sometimes circumstances in which this is not appropriate (Scottish Government 1995). It had been explained at the S.S.P.S Ethics Committee meeting that children's rights perspectives never cede giving consent as such to the parent rather than their child.

However, in accordance with the belief that the agreement of parents to their child being interviewed was more likely to be in the child's best interests, the original default position for the research was slightly amended so that young people under the age of 16 who sought to participate in individual interviews would usually be expected to do so with the agreement of their parent/guardian, using an interview agreement form drawn up (and agreed with the researcher's supervisors, and if necessary with the S.S.P.S Ethics Committee) in accordance with a children's rights centred approach, with an emphasis on parental *agreement* to the interview taking place, rather than on formal *consent* to the child's participation. The agreement form would contain a clause to indicate that, whilst greatly preferable, the agreement of a parent to an interview was not essential, if the

participation of the child in an interview was viewed by the child to be in their best interests.

It was recognised that a young person under the age of 16 might still express interest in being interviewed as part of this research where parental agreement to the interview was withheld, or whilst requesting that the agreement of their parent/guardian should not be sought (perhaps because a parent was unaware of their child's transgender status). It was therefore agreed that, providing adequate support appeared to be in place through an appropriate support group, each request should be discussed with the researcher's supervisors (and if necessary with the S.S.P.S Ethics Committee), so that an appropriate decision in the best interests of the young person could be reached and acted upon.

It was also noted that it was possible that a young person under the age of 16 who identified as transgender might wish to be interviewed in the presence of or with the assistance of their parent/guardian/carer or a support worker/gender identity counsellor etc. and it was agreed that this request would be respected.

It was also possible that some parents might actively seek to be included in the research by completing a questionnaire, or by seeking an interview individually, or with their son or daughter as part of the research. It was agreed that such involvement would be encouraged in the interests of providing as wide and accurate a picture of provision/need for social care services, for transgender children, and for their parents and families.

Concerns about the rights of people with disabilities and mental health problems to take part in the research were also considered prior to the circulation of the first survey. For the purposes of the research the same guidelines noted above regarding age of consent applied, as the Adults with Incapacity (Scotland) Act 2000 clearly states that 'for the purposes of this Act ... 'adult' means a person who has attained the age of 16 years'. However, the Act does also indicate that 'unless the context otherwise requires', in the case, for example, of a young person aged 16 with a learning disability seeking to be involved in the research, it would be necessary to ensure that the young person had mental capacity to take part (Scottish Government, 2000).

Possible disclosure of child abuse had also been discussed with the S.S.P.S Ethics Committee even though it was not anticipated that this research was likely to lead to the disclosure of information about child abuse or neglect, or other information that would

require the researcher to breach confidentiality conditions agreed with participants. At the S.S.P.S Ethics Committee meeting of January 2012 it had been explained that it was good practice to anticipate the possibility of disclosure of child abuse or neglect, and to be clear about the steps which might be taken in the event of such disclosure. Guidelines for a possible response to such disclosure were provided by a member of the Committee, noting 'a moral responsibility to ensure that following disclosure, children are adequately supported'.

A clause was subsequently included within each of the transgender participant agreements (i.e. for both the survey and interview participants) explaining that information would only be shared with others 'where the participant has identified themselves and they or someone else appears to be in immediate danger of serious harm'. Where disclosure of immediate danger of serious harm was made and the identity of the participant had been revealed, particularly where the participant was aged under 18 (in accordance with National Guidance for Child Protection in Scotland paragraph 24, which notes that 'for the purpose of this guidance, a child is taken to mean under the age of 18') (Scottish Government, 2010a), it was agreed that the individual scenario would be discussed with supervisors (and, if necessary, with the S.S.P.S Ethics Committee) prior to taking agreed, appropriate action.

Because of the close knit networks and communities within which some transgender people are supported, concerns about the confidentiality of information shared within interviews and surveys led to this information being carefully anonymised throughout this thesis. It is believed that personalised information included in a quote or description might enable the respondent to be identified within their own transgender community (real-life or online) and so any identifying references (to locations, dates, other individuals etc.) have been systematically anonymised.

Hines notes a 'large response to requests for participants' many of whom 'spoke of "speaking out" and "putting the record straight"' (2007: 200), which led to a concern that participants might put upon or anticipate an unspoken duty on behalf of myself as the researcher to aid in this speaking out. Becker suggests that it may be that 'we have acquired some sympathy with the group we study', which does not seem unreasonable, but he goes on to argue that this may be 'sufficient to deter us from publishing those of our results which might prove damaging to them' (1967: 239).

I was aware that I needed to accurately reflect a wide range of perspectives, from those of transgender people to social care providers, taking into account my status as researcher.

In the introduction to the actual survey questionnaire I therefore stated that the research 'will seek to present a range and balance of views from the perspectives of a wide range of transgender people and service providers'. Some participants may have been disappointed or even hurt that their point of view was balanced by including the contradictory views of others, or that I have not personally been seen to support a particular point of view.

Similarly, my own position as a transgender person carrying out the research needed to be considered. I sought to make my transgender status clear when each of the surveys was disseminated, for example by openly acknowledging this when I met with the members of the A.D.S.W. Contracts Officers group in Stirling in March 2012, just prior to the services survey going live. Similarly, I made my transgender status clear very early in my opening statement to the pilot focus group, representing a conscious decision to be open about this to group members:

'Most of us I guess as transgender people have had support from various health care services in our time'

I was very aware too of the issue of safety – of both the transgender people who participated in this research, and of myself, as a transgender person too. Craig et al note, 'potentially risky situations may sometimes be avoided by asking respondents in advance about preferences and expectations' (2000: p.2). So, for example, the venue for the pilot focus group was chosen (by the local transgender group) to ensure that the participants felt both safe within, and, as far as possible, in travelling to and from, the venue. But, even as I met two of the participants outside this venue, prior to the focus group, their gender status was queried by a passer-by, which led to an uncomfortable interaction. This was one of several factors (which included widespread evidence of abuse to transgender people in public) which led to my decision to restrict participation to online surveys and interviews, so that neither the participants nor myself faced any potential difficulties of this sort, as a consequence of travelling for the requirements of the research. I feel that this decision very likely reduced stress levels for both participants and myself throughout the research process.

The methods and approaches I brought to this piece of research into transgender issues are underpinned by values which reflect an understanding and empathy for transgender values (for example, a belief in the rights of transgender people to express their sense of their gender without fear of ridicule, abuse or violence). The chosen context for the research is based around a belief that to address transgender issues within a bi-gender research literature and methodology would be ethically questionable, and so the research has been firmly placed within the transgender literature whilst noting its relevance to the wider literature on gender.

This decision is influenced by earlier research developments by feminist researchers who have shown sensitivity and awareness of interviewees' needs, feelings and vulnerabilities, as evidenced for example by Sinding and Aronson (2003: 113). In a discussion of research and feminist values, Reinharz (1992: 79) quotes Jayaratne (1983) who suggests that 'if some of the traditional procedures used to produce (quantitative) evidence are contrary to our feminist values, then we must change those procedures accordingly'. While I have not, of course, sought to emulate a feminist research methodology, I have tried, in my consideration of the vulnerabilities of transgender people in public, to develop a research methodology which was sensitive to the needs of transgender people.

There is a further, though linked, ethical concern that needs to be acknowledged within this section: Kvale notes that 'the power dynamics in research interviews ... tend to be left out in literature on qualitative research' and that 'referring to the interview as dialogue is misleading' (2006: 483). The online interviews were, I believe, an opportunity to meet participants with few obvious status differences other than those of interviewer and interviewee. As Kvale suggests, however, such a simple status difference is potentially a source of a power imbalance which itself may lead to ethical concerns. These are simply noted here, but were discussed more fully earlier in the section on interviews above.

Lastly, one ethical issue which was not covered by the participation agreements, is that of a reward. I felt uneasy about offering a reward for participation within each of the three survey questionnaires (four, including the pilot survey) or within each of the online research interviews, in case it was seen, if not as a bribe, then as an incentive. I wanted participants to become involved in the research if possible because of motivation to do with the subject matter, rather than because of external motivators (though each individual's motivators still remain, of course, unclear).

I had however had a number of 'transgender badges' made up to give away at the end of the pilot focus group and most people seemed pleased to take away one or two of these, even though they were a relatively small token of appreciation. I had 100 of these made up in 2011 and gave most of them away at conferences and seminars as I soon became concerned at the ethical implications of giving them away in a research setting, because, of course, not every transgender person would wish to wear such a badge, and I felt that giving them away might mix political and research issues.

Because of these ethical concerns, I subsequently sought to show my gratitude simply through a sincere thank you in writing at the end of each survey or interview.

Chapter Summary

The chapter began by analysing the three research questions, and in particular the evolution of versions of the first two of these questions, within the context of ontology and epistemology, while exploring both interpretivist and realist aspects of the questions. The subjective and developmental nature of terminology was then discussed particularly in relation to descriptors chosen for inclusion in the two questionnaires for transgender people.

A discussion on the evolutionary nature of knowledge was followed by a section on the choice of mixed methods to underpin the research. This led to a consideration of grounded theory, which was an important aspect of the data analysis of the questionnaires and interviews, leading to the identification of forty five sub-themes and seven main themes. It was explained that these were of value not just in the analysis of the data, but also in the formulation of the second transgender questionnaire, which explored these themes and sub-themes in further detail.

The section on the research process covered the work that was undertaken for each of the six main phases of the research: the pilot study in the north of England, the two questionnaires to transgender people, the questionnaire to voluntary and statutory social care services, and the online interviews with transgender people and with representatives of the voluntary and statutory care services. The questionnaires were discussed in terms of their structure, sampling and distribution, and the analysis of their data. The interviews were discussed in relation to a number of key concepts, including their asynchronous, semi-structured online format (and how this may have affected rapport, empathy and power dynamics) the role of myself and the interviewees as co-constructors of data, and the differences between the interviews with transgender participants, and those with representatives of the statutory and voluntary service sectors.

The last two sections of the chapter contained an exploration of the importance of reflexivity, and of values and ethical issues to the research. Reflexivity was noted from both the perspective of myself as a transgender individual, having experienced a number of the issues raised by transgender participants in the surveys and interviews, and as a former social worker and contracts manager, particularly in relation to the research relating to the

service sector surveys and interviews. The values and ethical section covered the complexities of informed consent, particularly in relation to under 16's in Scotland, (even though this did not subsequently become an issue in the research itself), and the decision to place this research within the context of a transgender research literature and methodology, which sought, for example, to provide a sense of safety and confidentiality to all participants, by allowing them to fully participate in the research from the safety of their own homes.

Chapter Three: Research Findings (Part One)

Surveys and Interviews with the Statutory and Voluntary Sectors

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Introduction

In this chapter the main findings of an analysis of collated results are outlined for the twenty questionnaire responses from the survey of statutory and voluntary agencies (survey three), and the nine respondents who contributed interview material from these statutory and voluntary agencies.

Four key themes structured the data from the questionnaires and interviews and these form the basis of the research findings covered within this chapter:

Dedicated/specialist social care services to transgender people

Generic social care services to transgender people

Staffing and training

Policy Statements and Staff Guidelines

Comments from the twenty respondents included within the text (and, in the following research findings chapters, comments from the seventy six transgender respondents) have been made anonymous, with no personalisation. Comments by the nine interviewees (and in later chapters, by the ten transgender interviewees) have also been anonymised but with the addition of a suitably gendered pseudonym.

Very occasionally in this chapter, online information has supplemented that provided in response to a survey or interview question. This is clearly indicated within the text.

A summary of the main research findings discussed in this chapter can be found at Appendix Seven.

The Location of the Organisations

Public sector questionnaire respondents and 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, the two largest cities in Scotland, 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:

Argyll & Bute (2), Central, Central (Lothian), Dumfries and Galloway, Edinburgh, Glasgow, Inverclyde, North East (2), Perth & Kinross and Scottish Borders.

Voluntary sector questionnaire respondents and interviewees 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:

Edinburgh/Lothian, Edinburgh and Glasgow, Forth Valley and Tayside, Galloway, Glasgow, Lothian and Strathclyde (2).

Dedicated/Specialist Social Care Services to Transgender People

Although limitations in numbers of statutory and voluntary responses have inevitably meant that an extensive overview was not possible of services to transgender people across Scotland, it was clear from the sample of statutory and voluntary groups that responded to the survey, and those respondents who subsequently took part in interviews, that statutory organizations surveyed were much less likely to commission and/or to provide such services compared to voluntary organizations.

The numbers of dedicated/specialist services provided or commissioned by the twelve statutory organizations surveyed were therefore rather more limited in their availability, compared to the eight voluntary organizations (table one).

Table One: Services to Transgender People Commissioned/Provided by Statutory and Voluntary Services (Survey Three)

Type of Support Service	Number of Statutory Sector Responses (n = 12)	Number of Voluntary Sector Responses (n = 8)
Informal drop in group (mainly social support)	3	1
Group support meetings	2	7
Regular group meetings (with guest speakers etc.)	2	5
Telephone support	1	2
Online support	1	4
Individual advice and support (by appointment)	1	2
Social events	1	3
Transgender Advocacy Events	0	1
Not applicable: no dedicated/specialist services	7	0
Don't know	2	0
Other	2	4
Total Responses (‘select all that apply’)	22 (12 respondents)	29 (8 respondents)

It is clear from table one that the most available services appeared to mainly consist of support groups and group meetings together with social and online support.

A comment from a statutory sector survey respondent suggested the main underlying reasons for the reliance on voluntary sector commissioned service provision: a lack of knowledge within the statutory sector about numbers of potential clients, and also about what constitutes appropriate dedicated services:

‘... my area has not developed specific transgender services. We don't even know how many transgender people are within our population so this might well be an important gap. However I am not even clear as to what specific or dedicated services might be useful or necessary’.

Limited provision/commissioning of transgender services by some statutory organisations for such a relatively small minority group may be understandable where alternative voluntary service provision exists. However, the absence of knowledge of services provided by others, and/or of the need for such services suggests a break in Coulshed's chain of community profiling (1990: 65) which may stymie attempts to meet the needs of local transgender populations, because of inadequate policy development.

Some voluntary sector support services were aimed at specific sub-groups of transsexual people, focusing for example on the separate transitioning needs of MtF or FtM transsexual people, or of younger or older transgender people. In some areas transgender support appears to be only available through broader LGBT services (one statutory organisation representative noted the provision of ‘an LGBT Youth Group co-ordinated by the Council's Education & Children's Service’) highlighting Browne and Lim's concern that services to “LGBT” (may be confined) to the interests of the particular groups of ‘L’ and ‘G’ (2010: 621/622). Despite these misgivings, the Scottish Executive provides guidance for local authorities in Scotland on ‘how to improve policy and practice in relation to ... LGBT people’ containing a useful checklist for policy and planning (2006: 1, 18/23).

One voluntary sector survey respondent explained:

Rebecca: ‘Many trans people first contact a support group before going onto mainstream services’.

In a subsequent interview she went on to describe the service that her organisation provided in some detail, at one point suggesting a link between group attendance and the transition process.

Rebecca: 'Our group meets once a month for a support meeting and this gets around five to fifteen trans-women present. We had nine trans-women at the last meeting ... we also meet some months for a social event and this gets around two to nine trans-women. We also have online interest with a Yahoo group of forty five members and most have been to the group at some time in the past. They must be trans-identified to join this and the number has been slowly increasing over the last three years. Our Facebook page has one hundred and twenty seven fans but these vary in motivation (and) interest ... our group is mainly a general chat with tea and coffee so the members can discuss current issues with transition progress. This is also a kind of social event with peer support from the others. The meetings are not really structured because we don't (have) any funding or time to organise visitors'.

Some groups circulated leaflets (because 'we believe that care professionals want to provide the best for those they care for and will therefore be open to information and support' or had an online presence, or 'give presentations to health and social care staff'.

Some voluntary sector services included work on transgender rights and support with transphobia and discrimination which, despite the misgivings of one representative that 'none of this transgender equality work is really actually direct provision of 'social care services'', still fits well with B.A.S.W.'s ethics statement linking the relationship between social work, social change and principles of human rights and social justice (2012: 6). Similarly another respondent explained their work 'to raise awareness and understanding of ... discrimination': it appears that the provision of care support may be intertwined with furthering the rights of this minority group.

One statutory sector interviewee mentioned a local voluntary group which supports older LGBT people:

Rachel: 'The focus of the group was the health and social care services received by older LGBT people and to raise awareness of how they could be improved. The group is now self-funded (with) support from (the local) Authority and was constituted in 2011. The group have a web presence'.

The funding of transgender support groups was not straightforward. Some groups appeared to be largely 'self-funded', though some local authority support was also evident. One example of partial funding support enabled a local authority staff member to work

with a voluntary local group, via a 'Health and Social Care partnership', and additional online information indicated that one organization was supported by lottery funding. However, one survey respondent alluded to a network of 'unfunded transgender peer support groups' in their area of Scotland. Whilst this reinforces Hines notion of 'transgender practices of care' (2007: 156), the respondent indicated that local 'dedicated/specialist transgender services are under-funded' with 'even less provision of ... resources' (in the rest of Scotland), highlighting the limited degree of statutory commissioning, provision of, or support to such services. Through additional online research an example of a group which worked under the auspices of a larger registered charity was also noted.

The 'older LGBT' group's local authority contact explained that:

Rachel: '(The local) Health and Social Care partnership supported me attending (the LGBT group's) meetings in the first year to provide advice and support, and the partnership also funded and provided staff time and expertise (for) the production of life story recordings with members of the group which could be used to raise awareness among health and social care professionals ... the collection is now based at the health library (of a local) hospital and (is) thereby accessible to all health and social care authorities in Scotland and beyond'.

Asking respondents to indicate how many local dedicated/specialist transgender services were available to adults, children and family members indicated that such local services were mostly available within the voluntary sector, to transgender adults and (less often) to family members, with local transgender children's services notably limited (table two) although one organization explained that 'we have assisted over ten young people under age 16 via assisting their teachers, educational psychologists, social workers or parents to support them':

Table Two: Numbers of Transgender People/Family Members using Locally Commissioned or Provided Dedicated/Specialist Transgender Service(s) (Survey three)

Number of Service Users	Number of Statutory Sector Responses (n = 12)			Number of Voluntary Sector Responses (n = 8)		
	Children	Adults	Family	Children	Adults	Family
0	5	4	5	8	0	3
1-5	1	1	0	0	1	2
6-10	0	0	0	0	3	1
11-20	0	0	0	0	1	0
21+	0	0	0	0	3	1
Total Responses	6	5	5	8	8	7
Total Respondents	6	5	5	8	8	7

Despite some evidence of family support, the need for further local support to transgender children and young people, to families, including the children of transgender adults and the parents/families of transgender children and young people was noted.

Despite comments from statutory staff evidencing some good examples of close liaison between statutory and voluntary agencies, statutory authorities' awareness of local voluntary sector dedicated/specialist services was not evident from four of the ten local authority respondents. In contrast six of the seven voluntary sector respondents to this question indicated that they were aware of other organisations providing dedicated/specialist transgender services locally (table three).

Table Three: Local Service Provision To Transgender People by Alternative Organisations
(Survey three)

Type of Support	Number of Statutory Sector Responses (n = 12)	Number of Voluntary Sector Responses (n = 8)
Informal drop in group (mainly social support)	5	3
Group support meetings	6	5
Regular group meetings (with guest speakers etc.)	2	4
Telephone support	2	2
Online support	4	5
Individual advice and support (by appointment)	3	1
Social events	4	3
Transgender advocacy events	1	3
Not applicable: no dedicated/specialist services	0	0
Don't know	4	1
Other	0	2
Total Responses (‘select all that apply’)	31 (10 respondents)	29 (7 respondents)

In response to a further question about identifying missing or inadequate local dedicated/specialist services to transgender people or their families, respondents identified a need for additional local services to transgender children and young people at a similar level as the need for additional services for children of transgender adults. In addition a slightly higher level of need for transgender adults and for the parents/families of transgender children and young people was noted, suggesting that there may be a widespread need for additional services across all these categories (table four):

Table Four: Additional Necessary Dedicated/Specialist Services to Transgender People/Families (Survey three)

New or additional dedicated/specialist services needed	Number of Statutory Sector Responses (n = 12)	Number of Voluntary Sector Responses (n = 8)
Transgender children and young people	3	2
Transgender adults	4	2
Parents/families of transgender children and young people	4	2
Children/families of transgender adults	3	2
Adequate transgender services currently provided	0	0
Don't know	7	2
Total Responses (‘select all that apply’)	21 (11 respondents)	10 (5 respondents)

However, over half (seven of eleven) of the local authority representatives did not know what additional dedicated/specialist services were needed for transgender people (and members of their families) locally, whilst two of the five voluntary sector respondents indicated a similar lack of knowledge. No respondents indicated that ‘adequate transgender services (are) currently provided’.

Clarification of the types of additional services that may be required suggested that telephone support was one of the most needed local services by both statutory (five) and voluntary (four) respondents. It is possible that the LGBT (Centre for Health and Wellbeing) Helpline Scotland may meet some of this need, (though this is currently a limited service, available for just two afternoons/evenings weekly).

Despite group meetings for transgender people being identified as the main source of support (table one) further groups were identified as a necessary *additional* local service by four (a half) of the voluntary sector respondents. This suggests that many adult transgender individuals are still not able to access this most widely available quoted source of support. Group support meetings for transgender adults were also identified as needed by three of the statutory sector respondents.

A need for additional services to transgender children and young people was also evidenced, (despite support from organisations such as LGBT Youth Scotland). There is also an absence of direct support from gender identity clinics in Scotland to transgender young

people under the age of 16 as the Scottish Gender Reassignment Protocol (summarized in Appendix Three) indicates. G.I.C. input to these young people is only available via the Tavistock Centre in London (Scottish Government, 2012a: 16). One voluntary sector survey respondent was explicit about the services needed for young transgender people:

‘Family support, mental health support and fast access trans-knowledgeable youth counselling, support for education service providers, initiatives to reduce transphobic bullying in schools, confidence building events and sports and wellbeing opportunities (especially trans-specific swimming sessions). Residential weekends bringing together transgender children and young people under 16 to enable them to make friends, be in a majority rather than a minority among young people for once and take part in activities to increase self-esteem, while their parents/families are able to learn more about supporting them, advocating on their behalf and (to) meet others in similar situations’.

The range of responses recorded when both statutory and voluntary respondents were asked to clarify the services needed locally for transgender adults was supplemented by a thoughtful comment by the same voluntary sector survey:

‘Mental health support and fast access trans-knowledgeable adult counselling and couples counselling (for when person has come out as trans in an existing relationship), initiatives to reduce transphobic harassment in public services (especially mainstream social care services), confidence building events and sports and wellbeing opportunities (especially trans-specific swimming sessions), re-employment support for trans people who are unemployed’.

These comments about necessary adult services broaden the range of potential services significantly, and several of these suggestions (and the concern about transphobia in social care services) are explored further within the following chapters of this thesis. A statutory sector survey respondent also added an insightful comment about possible joint working for the provision of dedicated services to transgender people:

‘I feel, given that I work in a small authority with a small population, that it would be beneficial for three/four authorities to work together to provide dedicated specialised services for transgender people and their families’.

This notion of small authorities working together is supported by the findings summarised in Appendix Two, where estimates of the potential transgender population in each Council area have been calculated, based on the incidence figures of Wilson et al (1999) and Reed et al (2009). The very low estimated populations, in particular in some rural areas, do indeed suggest benefits from pooling resources within neighbouring statutory and voluntary agencies, and local authority areas.

However, the notion of planning for services which was discussed at the beginning of this section, raises concerns again:

Rachel: 'Although it is recognised by experts in equalities that there is a requirement for services such as (those) discussed above, I am unaware of much work being done in this area locally ... however it may be that such work is being done in the larger cities (in Scotland).

Stephen: 'At present I am unaware of anyone looking at this area of work specifically within adult services, either within the public or voluntary sector. The Council has recently undergone a review of its approach to equalities and I hope that the role I now play can help feed into this process to try and take this forward. The difficulty at present is a 'chicken and egg' one - people are not identifying this as an area of 'unmet need' within the transgender community so it is difficult to know how to take this forward appropriately when there is no demand. However, I acknowledge that the reason people may not be coming forward is because they do not feel confident that existing services are designed appropriately to offer the level of support they need. I hope that pieces of work like this research will help fill that gap and allow this to be moved higher up the equalities agenda'.

Although this comment highlights a concern that the transgender community is not identifying services as an 'area of unmet need' the concept of 'chicken and egg' does however appear to lack a little credibility as the main reason for not exploring the possibility of developing dedicated transgender services, if basic information about transgender incidence and potential need/services are not being collated at an earlier stage of the planning process.

Generic Social Care Services to Transgender People

One of the concerns which was expressed within an online leaflet of a group of older LGBT people was that:

‘discrimination can make accessing services particularly difficult and may lower expectations of receiving the same consideration as others in ... social care settings (resulting in a feeling of being) isolated and disconnected from the rest of society’.

Morrow and Messinger describe this process succinctly when they speak of ‘systems of oppression ... bolstered by prejudice, cultural myths and stereotypes that privilege one group over another and assign a stigmatized identity and lesser value to the subordinate groups’ (2006: 50), reflecting, for example, the ‘fear of discrimination or prejudice’ within end of life care by LGBT people noted by Lienert et al (2010: 8).

One of the ways in which commissioning or provider agencies appear to have sought to ensure that such ‘systems of oppression’ do not limit availability or access, is to review generic services to ensure that they are fully accessible by minority groups. So, for example, an interviewee from the statutory sector noted that ‘transgender people are one of the minority groups that are listed to be considered when conducting an E.I.A.’ (Equality Impact Assessment). However a survey respondent from a voluntary sector provider of services commented that they believed that:

‘there is a lack of trans-awareness among generic social care services in Scotland which means that they are often unaware of the barriers to accessing their services which can be faced by transgender people’.

The research findings showed quite limited implementation of formal methods of ensuring or even facilitating access to generic social care services by transgender people indicating, for example, that only one statutory agency had reviewed all adult generic services for access by transgender people whilst half of the respondents did not know if such reviews had been undertaken (table five). In the case of children’s services it appeared that either none of these had been reviewed, or the respondents did not know of such reviews. Just one respondent from a voluntary agency said that any generic adult social care services had

been reviewed regarding accessibility by transgender adults. This was a housing support service within which one transgender adult was currently living.

Table Five: Service Reviews for Access to Generic Social Care by Transgender People (Survey three)

Reviewed provision for transgender adults to fully ensure access to all generic adult social care services	Number of Statutory Sector Responses (n = 12)	Number of Voluntary Sector Responses (n = 8)
All generic adult social care services have been reviewed	1	0
Some generic adult social care services have been reviewed	2	1
No generic adult social care services have been reviewed	2	2
Not applicable : no generic social care services are provided	0	3
Don't know	6	2
Total	11	8

Of the three statutory organisations that had reviewed some or all of their generic adult social care services to ensure that they were fully accessible by transgender adults, one commented that the outcome of the reviews was a ‘wider awareness of issues which may affect individuals at point of contact’.

One statutory sector interviewee described the complex procedures which are undertaken to develop equality impact documents which can then highlight the needs of transgender people:

Rachel: ‘(My local authority) instigated processes for conducting Equality Impact Assessments (E.I.A.’s) at the end of 20xx. In Community Care this was designated as part of my role given my background in human rights and equality. I engaged in specific training on E.I.A.’s with (the local) Health Board. I then took the agenda forward within Community Care (for) all policies, procedures, projects, services ... (to include commissioning and decommissioning of services) and strategies. Where it is appropriate (to undertake) an E.I.A. as part of our consultation process these are recorded along with the evidence, and they are monitored, reviewed and assessed. I report back areas of concern to the Social Care Practice Governance Board for Community Care. I also inform the Board of reviews and their outcomes ... and I engage with corporate services ... transgender people are one of the minority groups that are listed to be considered when conducting an E.I.A.’.

However, more detailed consideration of the equalities assessment process did little to reassure that the needs of transgender people were being fully considered at the time of completion of such an assessment, for as one respondent noted:

‘the low uptake of services will mean that in all likelihood there will have been no significant impact being considered. Services would have been assessed as treating individual needs as they arise’.

Statutory agencies were unable to provide information about the approximate numbers of transgender adults or children/young people who were being supported across a wide range of generic social care services, although Whittle’s (2005) discussion of the implications of sharing information regarding transgender status may be pertinent here in validly restricting the availability of such information.

One interviewee explained that difficulties may arise in developing and implementing an equality impact assessment programme when there is a low uptake of services by transgender people – with a resultant ‘no significant impact’ being recorded:

Stephen: ‘Our equalities impact assessment programme has recently been integrated into an "integrated appraisal toolkit" which includes issues such as an environmental impact assessment as well ... I suspect the low uptake of services will mean that in all likelihood there will have been no significant impact being considered. Services would have been assessed as treating individual needs as they arise’.

However, some statutory organisations appear to be actively seeking to ensure that a valid transgender perspective is included in equality impact assessments:

Matt: ‘I have had a quick look at some of (the Equality Assessments) and (they) rate the possibility of impact on transgender groups as low. I think there is a lack of knowledge about issues facing transgender groups. I have asked a representative of a transgender group to give me information about how council functions may impact on her life and she has replied with a detailed report ... I have been using the report to inform officers within (my local) council of possible impacts and I hope that we will see better informed E.I.A.’s in the near future ... I haven’t had

responses to the questions raised in the report as such. However I can answer some of them:

I was recently asked to assist a colleague from children and families with an impact assessment regarding adoptions and fostering. The needs of transgender children and parents are addressed in the current procedures and have been for some time.

As for (transgender) disabled people and (transgender) people in residential care I don't think there are measures in place but I have forwarded the report to staff in community care and I will ensure that this is taken into account the next time policies or practices are reviewed or new ones put in place'.

One respondent indicated that a generic children's social care service had been reviewed for accessibility by transgender children, saying that this applied to child protection and family support services and support for children with disabilities, and that, although no transgender children were currently receiving a service, the key transgender inclusion outcome of the review was that the organisation was in the 'process of receiving training for transgender persons – this is part of (the) standard that we are undertaking'.

Another agency developing policies for children's services linked issues of access to services with anti-bullying and equalities guidance for schools and social work services, though there appeared to be very little explicit information about the specific needs of transgender children and young people, and the practical and pragmatic support which they might need, within this guidance. Similarly, it appeared that links with equalities guidance and potential indicators and consequences of transphobia, as evidenced by Lienert et al (2010) were also lacking in adult services. Indeed, there was very little evidence of attempts to identify and specify the difficulties which may be experienced by transgender people in accessing any of a range of services, within apparently largely generic equality policies.

One statutory survey respondent added a further comment:

'I feel that there is little attention paid to LGBT clients ... this is more likely down to a lack of understanding and a lack of person-centred focus, as well as pressure on commissioning staff to make savings / refusal of management to change age-old service provision that is seen to 'work effectively'.

The impression of limited awareness of transgender service need in the statutory sector is countered at least in part by the comment of one interviewee for whom the issue has clearly led to quite careful consideration:

Alana: 'As I attended courses, seminars and workshops I became increasingly aware of the needs of transgender people, relating an increased understanding of transgender issues, and a working knowledge of service development ... with access to learning and engagement with national organisations, for example, LGBT Youth Scotland, LGBT Domestic Abuse Project, and witnessing a change in legislation, policy and practice. The needs of transgender people in relation to gender based violence has become embedded in all local developments and is a strategic priority in (our) Violence Against Women's Strategic Priorities 2012-2015. Personal communication with those who have direct experience of accessing health, social care and specialist services has really helped me understand more. Spending time with services and supporting them to think about their transgender policies, has also enabled me to be more sensitive to the philosophical and practice challenges which arise from a traditional model and understanding of gender based violence'.

Some of the additional comments which this interviewee made and the issues that she raised are quoted and discussed within chapter seven, in a section entitled 'underpinning attitudes to transgender'.

Staffing and Training

Eight statutory and four voluntary sector respondents indicated that there were no full time equivalent staff providing dedicated/specialist support to transgender people within the respondent's organisation. Indeed, there were very few full or part time staff employed for dedicated specialist support to transgender people within either the statutory or voluntary sectors (table six). One voluntary sector respondent explained that 'most support for trans people is voluntary and run by untrained trans people themselves'.

Table Six: Numbers of Staff Providing Dedicated/Specialist Support to Transgender People (Survey three)

Number of full time equivalent staff providing dedicated/specialist support	Number of Statutory Sector Responses (n = 12)	Number of Voluntary Sector Responses (n = 8)
None	8	4
1	0	1
2	0	1
3	0	0
4	0	0
5 or more	0	0
Don't know	4	1
Total	12	7

An additional comment from a statutory sector survey respondent suggested that more generic LGBT workers might be in place: 'We have two Equalities Strategists that do work on LGBT, but I was unaware of that until today!'

However statutory staff had received more training in working with transgender people than their voluntary sector counterparts. Dedicated/specialist staff at four voluntary organisations had received no training in transgender issues. One of the reasons for this may be the paucity of funding to support groups.

It was unclear whether staff and volunteers from the voluntary sector meet regularly, locally or nationally, or liaise informally or formally to support each other, although one voluntary organization had two dedicated transgender equality staff in post who had access to an extensive literature on transgender matters, and had been able to attend a range of conferences and other transgender related events (table seven):

Table Seven: Training to Staff Providing Dedicated/Specialist Support to Transgender People (Survey three)

Number of days training provided to staff providing dedicated social care support to transgender people	Number of Statutory Sector Responses (n = 12)	Number of Voluntary Sector Responses (n = 8)
None	2	4
Up to one day, in house training	2	0
Up to one day, external training	3	0
More than one day, in house training	0	1
More than one day, external training	0	2
Not Applicable: there are no staff employed for dedicated social care of transgender people	2	0
Don't know	4	0
Other	2	3
Total (‘select all that apply’)	15 (11 respondents)	10 (6 respondents)

Three additional comments from voluntary sector respondents to this question provided valuable information about the status of ‘staff’, not all of whom are actually employed:

‘All staff are part-time volunteers’.

‘Personal experience (is) shared by those who attend’.

‘The two dedicated transgender equality posts are held by staff who have extensive experience in transgender-specific equality work and long-term involvement in the Scottish, UK and European transgender community activism movement. They have also participated in various Scottish, UK and European transgender equality conferences and community debates and studied a wide range of transgender academic, medical, legal and community articles and books’.

It was not clear if and how the broad experience described in this latter comment was shared with other staff and volunteers across Scotland.

Four (a third of) statutory respondents said that none of the generic social care staff in their organisation had received training in transgender issues, while four respondents said that generic social care staff had received up to a day of training. One voluntary sector respondent said that generic social care staff had received more than a day of external training (table eight):

Table Eight: Training to Staff Providing Generic Social Care Support to Transgender People (Survey three)

Number of days training provided to staff providing generic social care support to transgender people	Number of Statutory Sector Responses (n = 12)	Number of Voluntary Sector Responses (n = 8)
None	4	4
Up to one day, in house training	1	0
Up to one day, external training	3	0
More than one day, in house training	0	0
More than one day, external training	0	1
Not applicable : there are no staff employed for generic social care of transgender people	0	1
Don't know	4	0
Other	0	0
Total	12	6

More voluntary sector than statutory sector organisations had identified future provision for unmet training needs for transgender issues (table nine):

Table Nine: Future Provision for Unmet Training Needs for Transgender Issues (Survey three)

Future Provision for Unmet Training Needs	Number of Statutory Sector Responses (n = 12)	Number of Voluntary Sector Responses (n = 8)
Future training provision to meet current unmet need has been identified	0	3
Future training provision to meet current unmet need has not been identified	3	1
Future training provision is not required as all staff are currently appropriately trained	0	0
Don't know	6	2
Other	2	2
Total	11	8

Two statutory sector survey respondents added further comments:

‘Training provision will be arranged as and when need arises’.

‘This area has been looked at as part of the wider equalities agenda and policies/procedures reflect that. The attempts at specific Transgender Awareness

Training were hoped to be a starting point to address specific service/policy gaps but need to be taken forward. Any specialist advice with regards to this would be welcomed.'

Two voluntary sector survey respondents also added further comments:

'Future provision to continuously update and expand dedicated staff knowledge of transgender issues has been identified. Also future provision to ensure mainstreaming of the dedicated staff's knowledge to non-trans-specific staff posts in other parts of the organisation has been identified.'

'The Transition Support Service ... will provide greater provision of groups, befriending and training for volunteers' (although the extent of this additional group provision was not disclosed).

That some statutory organisations may already be taking steps to make staff aware of the needs of transgender people is apparent from two interviewees' responses to a question about training in transgender issues for generic services:

Stephen: 'The services targeted for this training were frontline housing advice services and our access team (first point of contact for adult social work referrals), as essentially they are the main routes in for our services for either housing tenants, homelessness clients or adult social care service users. The targeting was on the basis that ... if those services were given a level of awareness then it would theoretically improve the way services were delivered/offered if people needed to access them from the transgender community. The training was two half day sessions and approximately fifteen staff attended each session. Our service commissioned it following an initial session which was given to key equalities contacts in different parts of the Council'.

Rachel: 'We were greatly supported a few years ago by 'Fair for All – LGBT Health Scotland ... one of their development officers came ... to (our region) and took part in diversity training (which) we were providing to health and social care staff'.

Staff Guidelines and Policy Statements

Guidance/Guidelines for Staff

Written guidelines/guidance for staff providing dedicated/specialist service provision were not in place for half (six) of the statutory organisations represented by respondents. The other six respondents did not know if such guidelines were in place.

No voluntary organisation had written guidelines/guidance in place for staff who provide dedicated/specialist service provision to transgender people. One voluntary sector survey response commented on guidelines within transition support services:

‘When we had a person in post to develop more clearly social care related services as part of the Transition Support Service (TSS) project, they were working on the creation of additional specific written guidance relating to provision of social care type services. As we are now sub-contracting the TSS service ... the TSS service (provider) uses their well-established written guidelines’.

Two statutory respondents said that there were written guidelines/guidance in place for staff who provide social care services to transgender people within generic service provision, while four said that these were not in place and half (six) of the respondents did not know if such guidelines were in place.

Five respondents from the voluntary sector said that their organisation did not have written guidelines/guidance in place for staff providing social care services to transgender people within generic service provision.

Policies and Policy Statements

Policy statements were largely absent for generic and dedicated/specialist services, within both the statutory and voluntary sectors. Just one statutory respondent said that their organisation had written policy statements in place for the provision of social care services to transgender people within dedicated service provision. Seven statutory respondents said that their organisation did not have such policy statements in place and three did not know the answer to the question.

No voluntary sector respondent said that their organisation had written policy statements in place for the provision of social care services to transgender people within dedicated service provision. Six said that such policy statements were not in place, and two that they

were not applicable as they did not provide dedicated/specialist services to transgender people.

Three statutory organisations said that they had policy statements in place for the provision of social care services to transgender people within generic service provision. Five respondents said that their organisation did not have such policy statements in place and four did not know the answer to the question. These policy statements for generic services, though few in number, appeared to be quite evenly spread across the range of adult and children's services.

Four comments seemed to confirm this:

'Generic equality policy covers all aspects of social care'.

'As far as I understand it the equality policy sits across all services'.

'Generic equality policy covers all children's services'.

'The equality policy should apply across all services'.

Five voluntary sector respondents said that their organisation did not have written policy statements in place for the provision of social care services to transgender people within generic service provision and two said that they were not applicable as they did not provide generic services to transgender people.

Another interviewee explained that:

Stephen: 'each individual service in the Council should also have an (Equality Action Plan) which feeds into the overall Council Equalities Plan'.

One statutory sector interviewee described the complex process of developing a suitable equality plan for transgender children and young people. She explained that 'some of the key points of this advice, including references to transgender will be appearing in guidance to special schools and residential units and will include reference to gender change and gender uncertainty in young people'.

A colleague added:

Colin: 'I suspect our intention to produce a mainstreaming plan in the future will promote further work to ensure transgender people and others who share protected characteristics are explicitly mentioned in such general documents'.

However the online current guidance for these respondents' local authority appeared to include only a generalised statement:

'that certain individuals and groups in society experience disadvantage, prejudice or discrimination on account of their age, disability, ethnicity, gender, gender change, looked-after status, pregnancy or maternity, religion or belief, sexual orientation and socio economic status or any combination of these (and that) ... we use the legal definition of 'equalities' which gives protection to people who have specific characteristics - for example being gay, lesbian or bisexual or from a minority ethnic group or disabled or old. It also includes boys and girls and *anyone undergoing gender change*, as well as those of particular faith groups. The Equality Act 2010 defines these as 'protected groups' (UK Government, 2010)' (italic added).

It seems likely from the four comments above that other 'generic equality' policies are no more specific although one statutory sector interviewee developed these ideas further, making the important distinction between a well-meaning generalised policy, and the service that a transgender person might receive as a result of the implementation of such a policy at an individual level:

Sophie: 'Our (Equality Action Plan) process is not as far progressed as we would like. When new or amended policies are planned it is usual for a group of people to consider the (Equality Action Plan), and certainly gender/ transgender is one of the headings ... that we consider. However we do not at this stage (and may never) have transgender service users or potential service users who inform this process, just primarily officers learning from each other and sharing experiences ... within social work as we tend to deal with things on a very individual basis. I would hate to think that a transgender service user would experience poor service as a result of us not taking account (of) their needs. However I cannot say that at this stage things are better for them as a result of the (Equality Action Plan) process'.

One representative of a statutory organisation appeared to be actively seeking to ensure that concerns regarding transgender perspectives were included in equality discussions:

Matt: 'There is a "Choose Life" working group here which looks at suicide prevention and the group have taken on board the high level of suicide attempts among the transgender group. It will be difficult to prove but at least people are now asking whether the high levels of suicide rates are in any way linked to the lack of openness in this area with regards (to) issues around the LGBT community. There is at least one case I know of where the suicide appears to be linked to the individual's reluctance (to) coming out.'

I was at a meeting yesterday of the Scottish Councils Equality Network, which represents equal opportunity officers from all Scottish Councils. Most of the meeting consisted of group work around equality outcomes to be set by the councils. The SCEN is looking to set generic outcomes for all councils. One of the ones adopted yesterday was reducing the number of suicides among the transgender group ... It was recognised that it will be difficult to find evidence to develop the most effective approach. But participants felt that local authorities will need to create an environment where transgender people feel that it is safe to engage with their local authorities and that we have to send a clear message that we want to support the transgender community'.

These findings recall Coulshed's suggestion of the pre-cursor to service provision being 'information gathering (leading to) a community profile by which ... needs and present resources are assessed' (1990: 65). Such information gathering, from which policies and policy statements might be expected to be developed, does indeed appear to be, at best, at an early stage for many statutory agencies, although partially balanced by greater knowledge of current services and future service need by voluntary sector representatives (tables three and four).

Chapter Summary: Key Findings

In this chapter the research findings relating to dedicated/specialist and generic social care services to transgender people, staffing and training and policy statements and staff guidelines have been reviewed.

The limited provision or commissioning of such services by statutory organisations, and their limited awareness of local voluntary sector transgender service provision and of local transgender service need were key findings. More extensive voluntary sector provision and awareness was largely dependent upon poorly funded groups of volunteers, who, as with their statutory sector counterparts, had access to limited training, service guidelines or policy statements.

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 and wider access to group support were identified as necessary additional services.

Equality impact assessments were felt to inadequately facilitate service provider awareness of, detailing or planning for the needs of transgender people, suggesting that many generic services are ill prepared to meet these needs, despite evidence of some initiatives to improve awareness.

Where levels of local transgender support need may be small, it is proposed that 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.

A more detailed summary of the research findings covered in this chapter is included within Appendix Seven.

Chapter Four: Research Findings (Part Two)

Surveys and Interviews with Transgender People (One)

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Introduction

This chapter presents the first section of the findings from the collated results of the forty seven questionnaire responses to the first survey of transgender people (survey one) and the twenty nine questionnaire responses to the second survey of transgender people (survey two) (who self-selected to participate in the surveys via the Scottish Transgender Alliance mailing list), together with responses from the ten transgender people who took part in online interviews (who self-selected to be interviewed at the end of the first survey). In addition to the main questionnaire data from these 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. The results of these cross-tabulations are referred to throughout each of the following research findings chapters.

The seven key themes that emerged from the findings from the surveys and interviews of transgender people are listed below. The findings outlined within this chapter are linked to the first two of these seven key themes (highlighted in bold).

Issues relating to coming to terms with being transgender.

Support with transitional issues.

Support to family members in coming to terms with being transgender.

Assistance with documentation during/after transition.

Mental health problems linked with gender identity or gender role.

Support with long-term physical or mental ill health, disability or problems related to old age.

Post transitional and societal issues.

The chapter begins with a consideration of the attribute data which was collated at the beginning of each of the two surveys for transgender people.

A summary of the main research findings discussed in this chapter can be found at Appendix Seven.

Preliminary Data: Attribute Information

Before considering the research findings which relate to the main themes of this chapter, responses to the attribute information which was included at the beginning of each of the two surveys are firstly considered, to help understand a little more about the sample of people who responded to these surveys.

Every one of the forty seven people who took part in survey one was of White origin. Asian, African, Caribbean, Black, Arab, Mixed or Multiple Ethnic Groups were not represented at all. This question did not form part of survey two. The Scottish Household Survey report indicates that 'the majority of adults (96.3%) are of white ethnic origin' (Scottish Government, 2013: Section 2) meaning that the remaining 3.7% (2.5% of whom are of Asian ethnic origin) are unrepresented in survey one. This finding raises concerns that transgender people from ethnic minorities may not have had access to the two surveys, and/or that they do not have access to transgender support services too. Ethnic minorities are represented in at least some other studies, for example that of Rubin whose twenty six interviewees included those who identified as of 'mixed descent, ethnic hybrids' (2003: 6/7).

Twenty eight (60%) of the participants of survey one gave Scotland as their country of birth, fourteen (30%) were from England, and five (10%) were born elsewhere in the world. This question was not included in survey two. All of the participants in both surveys stated that they were resident in Scotland at the time of completing the survey.

The ratio of biological males to females was 2:1 (26:13, survey one) and 6:5 (12:10, survey two) somewhat different from the S.H.S. national ratio of 12:13 (Scottish Government, 2013). The imbalance of the first survey fits reasonably with Gires' finding of the ratio of referrals to the Glasgow G.I.C. of 63% biological males to 37% biological females, although the ratio of the second survey fits better with the ratio of male to female in the rest of Europe which is almost equal (Reed et al, 2009: 17). Gires suggest that a more equal balance is likely in time within the United Kingdom too, as FtM transsexuals become more visible. Why there should have been such a difference between the ratios in the two surveys is unknown, though the finding that biological males outnumbered biological females in survey one within the age groups 46 to 55 (by 9:1), 56 to 65 (by 6:0), and 66 and

over (by 6:1) with biological females outnumbering biological males in the age group 16 to 25 (by 6:1) suggests an emergence of younger FtM transgender people that appears to be in line with Gires' prediction.

That such a FtM emergence might be linked with gender transition is supported by the cross tabulation of current gender role with age group for survey one, which indicated that transgender people 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 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.

However, 'current gender role' does not necessarily reflect the completion of a binary transition from male to female or vice-versa. This is evidenced by the finding that, whilst biological sex in survey one reflected a 2:1 male to female ratio (26:13), with six participants describing this as 'intersex' (one) or 'other' (five), the ratio for current gender roles in survey one was approximately 3:4 male to female (15:21), with ten participants describing their current gender role as 'transgender' (seven) or 'other' (three). Four biological males and two biological females described their current gender role as transgender, with one of each describing their current gender role as 'other'. Of the five respondents who described their biological sex as 'other', two described their current role as male, two as female and one as 'transgender'. The person who described their biological sex as 'intersex', described their current gender role as 'other'.

Biological sex in survey two reflected a 6:5 male to female ratio (12:10), whilst seven participants described their biological sex as 'intersex' (two) or 'other' (five). The ratio for current gender roles in survey two was in this case the inverse of the biological sex ratio, being 5:6 (10:12) male to female, with seven participants describing this as 'transgender' (three) or 'other' (four). Two biological males described their current gender role as 'transgender' while one biological male and two biological females described their current gender role as 'other'. However, as in survey one, of the five respondents who described their biological sex as 'other' two described their current role as male, two as female and one as 'transgender'. Of the two people who described their biological sex as 'intersex', one described their current gender role as 'other' and one as female.

Caution is therefore noted in linking the cross tabulations of biological sex with those of gender role which appear within these results findings chapters; they are however included because of the insight which they give into the links between a number of the research questions in surveys one and two and respondents' current gender status. Distinctions of biological sex are also retained however, as comparisons between biological sex and gender role are often necessary for further clarity, but also because they allow for direct comparison with alternative surveys such as those by GIREs, S.H.S., etc.

Cross tabulation indicated that biological males once again outnumbered biological females in the age groups 46 to 55 (by 6:0) and 56 to 65 (by 2:0), whilst biological females again outnumbered biological males in the age group 16 to 25 (by 6:1) (survey two).

The age range of the forty seven participants in survey one was quite evenly spread across the five central age categories covering the age span sixteen to sixty five. However, the age range of the twenty nine participants in survey two was rather more unevenly spread, with the age groups 26 to 35 and 56 to 65 represented by quite low numbers of participants (table ten). No-one under 16 was represented in either survey, and only three transgender people aged 66 or over were represented in survey one, and none in survey two. This compares with those under 16 comprising 17% of the Scottish population, and those over 60 comprising 23% of the Scottish population (Scottish Household Survey, Scottish Government, 2013: Section 2).

Table Ten: Age of Participants (Survey One and Survey Two)

Age (grouped)	Survey One (n = 47)		Survey Two (n = 29)	
	Number of Respondents	Percentage of Respondents	Number of Respondents	Percentage of Respondents
Under 16	0	0	0	0
16 to 25	9	19	7	24
26 to 35	8	17	3	10
36 to 45	9	19	7	24
46 to 55	11	24	8	28
56 to 65	7	15	4	14
66 or over	3	6	0	0
Total	47	100	29	100

Cross tabulation of age with gender identity indicated, as might be anticipated from the cross tabulations of age with biological sex and current gender role described above, that

those who described this as male were more likely to be younger (six out of six were in the age groups 16 to 25, 26 to 35 and 36 to 45) than those who described their gender identity as female (ten out of eleven were in the age groups 36 to 45, 46 to 55, and 56 to 65).

In survey one, 47% (twenty two of forty seven) of the participants lived alone, whilst almost a third (fourteen) lived with their husband/wife/partner (with (three) or without (eleven) children) (table eleven). In survey two 38% (eleven of twenty nine) of the participants lived alone, while fairly similar percentages of participants lived with their husband/wife/partner (with (three) or without (seven) children).

The S.H.S. report noted that ‘about a third (34%) of households in Scotland contains only one person, made up of single adults (19%) and single pensioners (15%)’ (Scottish Government, 2013: Section 2). Given that older people are poorly represented in the current research findings, this makes the contrast between the percentage of transgender people living alone and the percentage of single households within the general population all the more notable, particularly as the percentage of adults living alone across Scotland is rather less than the percentage of single households. The average household size was, for example, 2.17 people in 2010 (General Register Office, 2012b).

Table Eleven: Home Circumstances (Survey One and Survey Two)

Home Circumstances	Survey One (n = 47)		Survey Two (n = 29)	
	Number of Respondents	Percentage of Respondents	Number of Respondents	Percentage of Respondents
I live alone	22	47	11	38
I live with one or more friends	3	6	2	7
I live with my husband/wife/partner	11	24	7	25
I live with my husband/wife/partner and my/our children	3	6	3	10
I live with one/both of my parents	5	11	3	10
Other	3*	6	3**	10
Total	47	100	29	100

*Other: Survey One: ‘I live alone with my children’, ‘I stay with friends when they have space’, ‘With one child (in twenties)’.

****Other:** Survey Two: 'I live with my mother in my home', 'I live with my mother, father and grandmother', 'me and my children'.

In survey one, where the ratio of biological males to females was 2:1, a cross tabulation of biological sex and home circumstances showed that the number of biological males living alone significantly outnumbered biological females living alone by 18:1. In survey two however, (where the ratio of biological males to biological females was 6:5) biological males living alone outnumbered biological females living alone by a ratio of just 4:3.

Cross tabulating current gender role with home circumstances indicated that, for survey one, four participants in a male role, twelve in a female role, five in a transgender role, and one 'other' were living alone (twenty two in total, (47%) from forty seven participants). A three way cross tabulation of current gender role, home circumstances and gender role preference, 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.

In survey two, the number of those living alone were three (male role), six (female role) and two (transgender role), a total of eleven (38%) from twenty nine participants. A three way cross tabulation of current gender role, home circumstances and gender identity indicated that five of the six people living in a female role described their gender identity as female (one described it as 'other') while only one of the three people living alone in a male role identified with a male gender identity (two described this as 'other').

Cross tabulating age with home circumstances for survey one indicated that all seven of the participants aged 56 to 65, were living alone, which is significantly higher than the national figure of 15% for single pensioners (S.H.S., Scottish Government, 2013: Section 2)

Employment figures indicate that nineteen (40%) of the forty seven participants in survey one were employed or self-employed. These participants consisted of 54% (fourteen) of the twenty six respondents who described their sex as biological male and 38% (five) of the thirteen who described their sex as biological female, which compares with national percentages of 58% for men and 49% for women (S.H.S. Scottish Government, 2013, Section 5, Table 5.1). A further 24% (thirteen) of the participants of survey one described themselves as 'long-term sick and disabled', compared to the national average of 5% who are 'permanently sick or disabled' (S.H.S. Scottish Government, 2013, Section 5).

Table Twelve: Employment Status (Survey One (n = 47))

Employment Status	Number Of Responses	Percentage of Responses	National Percentages*
Employee	16	30	58
Self-employed or Freelance	7	13	7
Registered as Unemployed	5	9	7
Retired	5	9	6
Student	7	13	10
Looking after home or family (children or other dependants)	1	2	6
Long-term sick or disabled	13	24	5
Other	0	0	1**
Total Responses (‘select all that apply’) (47 respondents)	54	100	100

* Results from 2012 Scottish Household Survey (Scottish Government, 2013: Section 5)

** unable to work due to short term ill health

Cross tabulating age with employment (survey one) indicated that four of the nine participants aged 16 to 25 and three of the eleven participants aged 26 to 35 were students. Three others aged 16 to 25 were either registered unemployed (two) or long-term sick or disabled (one). Over half (nineteen) of the thirty five participants across the age categories 26 to 35, 36 to 45 and 46 to 55 years were employed or self-employed, whilst a little over a third (eleven) of the thirty one participants across the categories 36 to 45, 46 to 55, and 56 to 65 years were long-term sick or disabled.

Cross tabulating home circumstances with employment indicated that 30% (seven of twenty three) of people living alone were long-term sick or disabled, the highest proportion of any category except ‘other’ (two of three): ‘I live alone with my children’, ‘I stay with friends when they have space’, ‘with one child (in twenties)’. This contrasts with the 16% of solo living, working age men and 14% of solo living, working age women who are permanently sick or disabled across Scotland (Jamieson and Simpson, 2013: 251).

Cross tabulating biological sex with employment indicated that the ratio of biological males to biological females with long-term sickness or disability was in the ratio 3:2. However biological males outnumbered biological females responding to survey one by approximately 2:1. The percentage of biological males with a long-term sickness or disability was 20%, and of biological females was 27%, whereas the national percentage for those who are ‘permanently sick or disabled’ for males is 6% and for females is 5% (S.H.S.,

Scottish Government, 2013, Table 5.1). That, as suggested earlier, current gender status does not necessarily correspond to transition status, is evidenced by a three way cross tabulation indicating that, of the five of thirteen (38%) of those with a long-term sickness or disability with a female gender identity, three had changed their role to female, whilst two were in the process of changing role. Similarly, of the three of thirteen (23%) who had a long-term sickness or disability with a male gender identity, just one had changed their role to male, whilst two were currently changing role. Lastly, of the remaining five people (38%) with a long-term sickness or disability, who described their current gender role as 'other', two said that they would like to change their gender role, one was in the process of doing so, one responded 'other' and one had developed an androgynous gender role.

Whether the high incidence of long-term sickness and disability might be linked with transgender people living alone is not clear, but Jamieson and Simpson explain that 'older people living alone are more likely than those living with others to report poor health status and low levels of psychological health and quality of life', although 'extensive social contacts and support from families and others beyond the household' may counterbalance these detrimental effects (2013: 159). That the number of biological males living alone (who were more likely to be living in a female gender role) greatly outnumbered biological females (who were likewise more likely to be living in a male role) in survey one by 18:1, raises further concern for their mental health, particularly given that 'excellent ... support within the birth family ... is primarily the case for trans-men and not often for trans-women' (Whittle et al, 2007: 69), and, it is hypothesised, the transitions of biological males may be within less well developed social networks than those of biological females.

Twenty five of the forty seven participants (53%) of survey one had a degree or postgraduate qualification. Twelve participants had professional qualifications, with a ratio of 4:1 biological male to female. Overall, 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%, which compares with the 27% of the Scottish population who have a degree or professional qualification, where 'there was little difference between (the percentages of) men and women on the highest qualification they held' (S.H.S. Scottish Government, 2013: Section 7). The lower percentage of transgender biological females with such qualifications may perhaps be explained by their preponderance in younger age groups.

Issues Related to Coming to Terms with Being Transgender

Biological Sex

Twenty six of forty five (58%) respondents to survey one described their biological sex as male, and thirteen (30%) described this as female. In addition, one person described themselves as intersex, whilst five described their biological sex as 'other': 'original biological sex female, present biological sex male', 'female on the forms', 'born male but always refer to myself as female', 'I describe my gender as female but for these purposes I'm a MtF TS', 'assigned female at birth, now viewed generally as male'.

A higher proportion of participants in survey two described their biological sex as female: twelve of twenty nine (41%) participants in survey two described their biological sex as male, and ten (35%) participants described this as female. Two people described themselves as being intersex. Three others commented that:

'at birth my biological sex was female but I have subsequently undergone gender reassignment from female to male so I do not consider it accurate any more to say my biological sex is simply female (although I also recognise it is not fully male either)'.

'female trapped inside a male body'.

'I consider myself female in all aspects, the sex assigned at birth is of no relevance to me now'.

Two comments from the online interviews help to clarify the degree to which some individuals have given careful thought to this complex issue, drawing attention both to the legal concept of sex as defined by birth certificate (particularly following the issuing of a gender recognition certificate) and the degree to which the physical body responds to hormonal changes during transition:

Josie: 'I do not regard (my) biological sex as the one I am now, and for me (it) is an irrelevance. My sex is female and always what I wanted to be, I really disliked being classed (as) 'male', and it is my fervent wish to have my birth certificate changed to reflect what is the true reflection of myself ... having been on hormones since 1999, the chemical make-up of my body resembles in no way the former me'.

Sarah: 'I'm the same sex I always was - female - and tend to view the treatment I receive for this thing called gender dysphoria, as being corrective treatment for a birth-defect. Effectively, my body doesn't produce enough oestrogen itself and that had developmental consequences for me. The bit of me that is who I am is female and everything else is plumbing'.

Bearing in mind the complexity of identifying biological sex and the links between gender and biological sex noted in the literature review, these comments suggest the possibility, through hormonal adjustment, of altering at least one criterion for one's biological sex. That post-transition hormonal transgender bodies may no longer conform to 'standardised' biological divisions of male and female appears to be reflected legally, for 'one's acquired *gender* becomes the *sex* in which one is recognised in law' (Whittle and Turner, 2007: 3, 5, 16/18, italics original).

Gender Identity

Brill and Pepper, in their handbook on the transgender child, quote a young teenager who graphically details coming to terms with their transgender status:

'Increasingly I felt that something was wrong with me. I didn't know what it was. It seemed to get much worse whenever I was in the locker room changing for gym. Somehow being around all those girls made me feel horrible about myself ... I responded to this by not going to school. My parents didn't know. When they found out they were really worried ... they sent me to therapy. Over the next few months my therapist and I began to think I was a lesbian. But somehow it just didn't fit. It helped for a few months, but then the depression was back. Finally we started to explore my gender. I was completely freaked out. I totally felt like a guy. I had always felt like a guy. But there was no way I was going to be one of those weird transgender people' (2008: 66).

Puberty, as might be predicted, presents its own additional challenges:

Suzie: 'Thinking about puberty and the drastic effects on our future lives ... is very confusing and upsetting'.

The following account by one of the interviewees within the current research shows similarities with the quote by Brill and Pepper, particularly in the sense of 'difference', with deeply disquieting concerns about gender undermining a coherent self-identity:

Abigail: 'Initially I had no understanding of my gender at all. All I knew was that when I looked in the mirror, I didn't really recognise the boy I saw there. I didn't understand this at all, and it frightened me. At the same time I knew that there was no-one I could talk to about this ... after a couple of years I found myself having to admit to myself that I would be much happier being a girl. This frightened me even more and filled me with unbearable shame. This was in the mid-sixties, way before the time trans-people had any visibility at all ... all I could do was try to be "normal". This meant trying to split off my feminine self from me and do all I (could) to suppress her. This was a terrible time. I lost myself. One way of understanding my life since then is as a long attempt to recover my identity ... as a human being'.

Such stories are far from uncommon within the research literature, describing childhoods blighted by self-doubt about a core gender identity that most children take for granted. Another interviewee from the current research indicates how the notion of being 'in the wrong body' provided an explanation for her feelings:

Amy: 'I have known from (the) early age of 7 years old that ... something was not right with the way my body looked. Why was it not the same as my sister's body? ... I ... had to endure feelings of suicide ... before seeking help through my GP ... to explain my feelings that I am a female in a male body'.

Whittle has suggested that 'transsexual people will, without exception, say that they have always known that something was wrong' (2000: 19), describing dysphoria from an early age. For example, Ladin notes that 'I started as a six-year-old, tormenting myself for not being the boy my parents thought I was' (2012: 13), while Rees explains that the sense of wanting to be a boy pervaded his childhood as a girl to such an extent that it resulted in a sense of normality, for 'it did not occur to me that my female peers didn't want to be boys, nor did I consider that I was destined for womanhood myself ... I was therefore, until puberty, happily unaware of the problems to come' (1996: 28). Connell, meanwhile, suggests that lifelong trauma may not always be the case, for in a discussion of a lengthy

interview with a transitioned transsexual, she notes, this ‘narrative differs from the run of transsexual life stories in *not* reporting early episodes of gender doubt, contradiction or cross dressing’ (2010: 15, italic original). As has been noted within the literature review, the dual-role transvestitic phase of some transsexuals perhaps represents a discrete response to a deeply personal dilemma. Mid-life transition suggests a more fundamental reaction to a previously imitative lifestyle, internalised to a greater or lesser extent, whilst externally conforming to the gender role of apparent biological sex.

Even after a lifetime of such considerations, the wide range of gender terms with which some of the research respondents identified was perhaps an indicator of the complexity of feeling a sense of belonging with any single descriptor of gender identity. Whilst the percentages of those from surveys one and two who described their gender identity as male (24% and 21%), female (45% and 38%), or transgender (20% and 14%) were reasonably comparable, the percentages of those who chose the ‘other’ category differed from 11% in survey one to 27% in survey two, with these respondents preferring terms such as ‘third gender’, ‘intergender or gender queer’, ‘gender fluid’, ‘polygender’, ‘queer or transgender’, on ‘a continuum’ or ‘somewhere in between’ (table thirteen). Such choices are reminiscent of the apparent rejection of the binary implicit in Kusalik’s reflection that ‘I am perfectly comfortable ... not choosing a fixed identity location: my own gender in particular is still mysterious to me’ (2010: 55).

Table Thirteen: Gender Identity (Survey One and Survey Two)

Gender Identity	Survey One (n = 47)		Survey Two (n = 29)	
	Number of Respondents	Percentage of Respondents	Number of Respondents	Percentage of Respondents
Male	11	24	6	21
Female	20	45	11	38
Transgender	9	20	4	14
Other	5*	11	8**	27
Total	45	100	29	100

*Other (survey one): 'third gender', 'a continuum', 'transsexual female', 'genderqueer or intergender (non-binary) not specific (androgynous)', 'don't really relate with gender anymore'

**Other (survey two): 'genderfluid', 'genderqueer', 'intergender or genderqueer', 'masculine androgyne', 'polygender', 'queer or transgender', 'somewhere in between', 'very possibly male still but it is complicated'

Even with only three categories plus 'other', the range of terms chosen by participants in both surveys to describe their gender identity became very wide. One of the interviewees was able to describe the long-term difficulties of coming to terms with their gender identity simply yet powerfully:

Andrew: 'I did not understand that I was transgender until I was thirty nine years old. I always knew I was different but it was only when I saw a documentary of a transgender female to male person on TV that it became clear to me what was different about me and my feelings and I immediately started to look for help'.

This notion of a sudden clarity over one's transgender identity is not uncommon in the literature. Rees, for example, notes that 'in 1969 ... I chanced to see an article in the Times of London which described the condition of transsexualism. It was a moment of enlightenment; at last it all fitted into place. I was transsexual' (1996: 30).

When respondents to survey one were asked to indicate all the gender descriptors with which they identified from a much wider range of options, 55% (61) of responses identified with primarily binary gendered categories including male, female, trans-male and trans-female. However, 20% of responses (23) identified with the term 'transgender' and 7% of respondents (8) chose options including bi-gender, a-gender, and poly-gender (table fourteen).

The findings of table fourteen, and the 'other' categories of table thirteen, reflect Cohen-Kettenis and Pfäfflin's (2010) observations, on the study of Bockting from 2008, in which 'the more classical binary view of transgenderism', reflected in responses such as 'female to male' and 'male to female', was extended to include additional descriptives such as 'in-between and beyond', 'shemale' bigender/two spirit', 'third gender', 'genderless' etc.

Table Fourteen: Gender Descriptors (Survey One (n = 47))

Gender Descriptor	Number of Responses	Percentage of Responses
Male	14	12
Female	22	20
Transgender	23	20
Transsexual	13	12
Trans-man, trans-male, transgender male, transsexual male, FtM (or similar)	13	12
Trans-woman, trans-female, transgender female, transsexual female, MtF (or similar)	12	11
Bi-gender, a-gender, poly-gender, fuzzy gender, androgyne, gender outlaw, transcender (or similar)	8	7
Cross-dresser, transvestite, drag queen, sissy (or similar)	4	3
Other*	4	3
Total Responses (‘select all that apply’) (47 respondents)	113	100

*Other: ‘All or none of these’, ‘intersex’, ‘other’, ‘transgender community member’

As participants were able to choose more than one of the whole range of descriptors, several frequently preferred combinations became evident: ‘male/transgender/trans-man’ appeared (sometimes in conjunction with other descriptors such as transsexual) on nine occasions. The combination of female and trans-woman appeared on ten occasions, six of which also included the term transsexual.

Cross tabulation of age with the gender categories from table fourteen showed an increased likelihood for trans-men, trans-males etc. to be in younger age groups than trans-women, trans-females etc. in line with earlier findings. In addition, younger participants were more likely to choose the more recently adopted descriptor ‘transgender’, while the term ‘transsexual’ was more evenly chosen across age groups (table fifteen). This trend of increasing use of the term transgender perhaps reflects a gradually increasing adoption of Feinberg’s original conception (1992) of an alliance of ‘all individuals who were marginalized or oppressed due to their difference from social norms of gendered embodiment’ (Stryker and Whittle, 2006: 4) within a younger generation.

14% of biological males and 26% of biological females chose the more recent term ‘transgender’, and perhaps unsurprisingly therefore, more respondents in a current male

role (who were more likely to have transitioned to this role) identified with the term transgender. However, biological males were slightly more likely to describe their biological sex as 'transgender' than biological females. The older term transsexual was one with which both younger and older participants appeared to identify (but which, when cross tabulated with biological sex was rather less often chosen by (mainly younger) biological females (6%) than (mainly older) biological males (14%)). Four people identified as 'cross-dresser, transvestite, drag queen, sissy or similar', all in the age groups 46-55, 56-65 or 66 and over (table fifteen):

Table Fifteen: Cross Tabulation of Gender Descriptors with Age (Survey One (n = 47))

Gender Descriptor	Number of Responses within Age Range						
	16 to 25	26 to 35	36 to 45	46 to 55	56 to 65	66 or over	No Answer
Male	6	3	2	3	0	0	0
Female	2	2	5	8	4	1	0
Transgender	6	4	4	3	3	2	1
Transsexual	4	2	1	4	2	0	0
Trans-man, trans-male, transgender male, transsexual male, FtM (or similar)	5	4	2	1	0	0	1
Trans-woman, trans-female, transgender female, transsexual female, MtF (or similar)	2	0	2	6	2	0	0
Bi-gender, a-gender, poly-gender, fuzzy gender, androgyne, gender outlaw, transcender (or similar)	0	2	2	1	2	0	1
Cross-dresser, transvestite, drag queen, sissy (or similar)	0	0	0	1	2	1	0
Other	0	0	3	1	0	0	0
No Answer	1	0	0	0	0	0	4
Total Responses ('select all that apply') (47 respondents)	26	17	21	28	15	4	7

That transition doesn't necessarily bring a simple binary resolution to the notion of one's gender identity is exemplified by a further quote from one of the online interviewees:

Sarah: 'Most of the time, I identify solely as cis-female - as just a woman like any other. If having transitioned is relevant in some way I feel is important, (I) identify as a woman who's transitioned - but never as transsexual as that was a process I went through to me, not an identity. As an activist, I positively identify as transgender - possibly with the MtF TS (transsexual) descriptor if it seems relevant to helping others understand where I'm coming from. Mostly I describe myself as having a dynamic gender-identity, simply because it can change so much. One other thing I use to describe why I'm interested in some 'boy' things is to identify as a tomboy - well a femme-tomboy to be accurate - because that puts my pre-transition life into a context I'm comfortable with. The only bit that doesn't change is that I always, always, always, identify myself as a woman before anything else'.

It is unclear whether respondents' identification with non-binary gender categories translate into non-binary gender roles too: just two respondents who described their gender identity as transgender said that they had developed a bi-gender or androgyne role to match their gender identity, suggesting that Ekins and Kings' (2006) state of 'transcendence' and Bornstein's (1994) conception of gender outlaws, are identified with by only a small minority of those who seek to/are able to match their gender identity and gender role in this way. Ekins and King suggest that those who transcend make use of the same erasing, substituting, implying and concealing procedures as those that migrate or oscillate, but that their meanings are redefined in the light of transcending (2006: 181).

The notion of bi-gender or androgyne role is of course subject to definition and clarification. Does this involve choosing non-binary gender clothing, names, behaviours etc. across a wide range of gendered parameters, or are just a few 'statement' parameters chosen to indicate difference about the person's gender? Would such a self-definition be matched by how other people see the transgender person, in a binary gendered world? Bem, in a paper outlining a sex-role inventory that deliberately takes into account androgynous characteristics, suggests that the 'sex-role dichotomy has served to obscure two very plausible hypotheses ... that many individuals ... might be *both* masculine and feminine, *both* assertive and yielding, *both* instrumental and expressive – depending on the situational appropriateness of those various behaviours; and conversely that strongly sex-typed individuals might be seriously limited in the range of behaviours available' (1975: 155). Transcendence or androgyny may therefore prove, for some individuals at least, to

be perhaps a mentally healthier option, for as Goffman suggests, in a broader discussion of stigmatising conditions, 'the stigmatised individual can come to feel that he should be above passing, that if he accepts himself and respects himself he will feel no need to conceal his failing. After laboriously learning to conceal, then, the individual may go on to unlearn this concealment ... it should be added that in the published autobiographies of stigmatised individuals, this phase in the moral career is typically described as the final, mature, well-adjusted one' (1968: 125).

Gender Roles

Twenty four (52%) of the forty six respondents to survey one described their *original* gender role as male, thirteen (28%) as female, and six (13%) as transgender, while three people described their original gender role as 'other': ('I was assigned female but didn't pass as female very well', 'limited', 'male 18yrs, gender queer 21yrs, female 8yrs').

Fifteen (33%) of forty six respondents described their *current* gender role as male, twenty one (46%) as female, and seven (15%) as transgender, while three people described this as 'other': 'Strangers probably take me for female but that's not deliberate and I am often challenged because my speech or behaviour contradicts it', 'all and none of the above', 'varied' (survey one).

Three of the six participants of survey one who described their original gender role as transgender now described their gender role as male, while three remained transgender. One of the 'other' participants now described their gender role as female, while two remained as 'other'. Of the twenty four participants who described their original gender role as male, 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 almost 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 over a half of those with an original female gender role had not transitioned to a male role.

These figures again suggest that a note of caution is needed in using current gender role as the only baseline for discussing the research findings, and for this reason biological sex (although as has been noted, not necessarily straightforward to define), and gender identity

are also included alongside current gender role, throughout these research chapters, as baselines for discussion and interpretation of the findings.

Ten (35%) participants of survey two described their current gender role as male, twelve (41%) as female, three as transgender, and four people described their current gender role as 'other' (one more than in survey one): 'gender neutral', 'Goth, which isn't gendered in the standard way', 'masculine female', 'mixed depending on circumstances'.

Cross tabulating age with current gender role for survey one indicated that those who described their current gender role as male were more likely to be younger than those who described their current gender role as female.

That changing gender role isn't always 100% successful is summarised by one interviewee:

Amy: 'How difficult it is to be seen as the gender we transition to, especially as I am a late transition in my 50's! Years of testosterone hormone poisoning in my body has given me unwanted masculine features which are upsetting for me to try living with'.

This comment also suggests that changing gender role may, for some transgender people, mean hiding their gender origins, and this is brought into focus by a comment from another interviewee:

Abigail: 'There is a real dilemma here: I am actually very proud of being a trans-woman and do not wish to "go stealth" or conceal this. Nonetheless, for my own safety it is generally very important my trans-identity remains unperceived. Because my transition had to be quite a public affair, everyone I work with knows perfectly well I am trans. As to other interactions - shop assistants, waiters, bar staff etc. etc. it is of no importance to me whether people perceive me as trans. The crucial thing is to be treated with consideration and respect.'

The number of years for which participants of the original transgender survey lived/have lived in their original gender role varied (for forty respondents) from fourteen years to seventy two years, with a mean of 34.3 and a median of 34.5 years, suggesting that the majority of transsexual respondents had probably not transitioned until at least their mid-thirties (although the recent emergence of younger FtM migrants has been noted). The

median age for presentation for treatment within the most recent Gires report was 42 years (Reed et al, 2009: 15).

The number of years in which participants have lived in their current gender role varied from 1 year to 28 years, with a mean of 7.3 and a median of 5 years: experience within the transitioned gender role, for transsexual respondents, therefore appeared relatively short compared to the time spent in their original gender role.

Support with Coming to Terms with Gender Identity and Being Transgender

When seeking support in coming to terms with gender identity, assistance from transgender support groups, and, by implication, other transgender individuals/volunteers, was more consistently highly valued (table sixteen) than any other source of support (although it must be noted again that not all respondents have access to such groups).

Table Sixteen: Importance of sources of advice or support in helping come to terms with gender identity. (Survey One) (n = 47 : 47 respondents)

Importance of Sources of Advice and Support Regarding Gender Identity (1=highest importance, 11=least importance)

Source of Advice or Support	1	2	3	4	5	6	7	8	9	10	11
a.Close Friends	13	9	2	4	3	2	1	0	0	1	10
b.Family Members	10	7	8	2	3	2	0	3	1	1	9
c.Colleagues at Work/ Line Manager	4	3	2	1	2	4	0	3	2	5	15
d. Transgender Support Group	17	5	3	4	4	2	1	1	1	2	3
e.General Practitioner	5	3	8	3	6	5	2	0	3	1	9
f.Gender Specialist at GIC	13	1	6	2	4	3	1	2	1	3	9
g.Speech Therapist	6	1	1	1	1	5	2	3	3	1	17
h.Health Visitor or District Nurse	0	0	1	1	1	3	4	1	2	2	25
i.Counsellor or Psychiatrist	10	2	6	4	3	1	3	4	0	3	9
j.Social Worker	1	0	0	1	0	2	3	2	2	4	23
k.Carer/PersonalAssistant/SupportWorker	2	0	1	2	1	2	0	1	1	3	25

Please note that colour coding has been used throughout these research findings chapters to indicate the strength of responses in the six multi-dimensional tables (tables sixteen, twenty, twenty three, twenty six, thirty one and thirty four), indicating the numbers of people choosing a level of importance from highest to lowest for each source of advice or support:

Deep red represents highest importance and is used for scores of 16 or above in the five left hand columns, followed by orange (scoring 11 to 15) and yellow (scoring 6 to 10).

Deep blue represents least importance and is used for scores of 16 or above in the five right hand columns, followed by mid blue (11 to 15) and light blue (6 to 10).

It was evident, from a three way cross tabulation, that eight of the nine respondents in a current male gender role and with a male gender identity, rated transgender support groups in the three highest categories for support with gender identity issues, (with no respondent rating transgender support groups in the three lowest categories for such support). Conversely, of the thirteen respondents in a current female gender role, and with a female gender identity, just five rated transgender support groups in the three highest categories, with two respondents rating them in the three lowest categories. It is not clear why there should be such a difference in these quite distinct sets of ratings, and why transgender groups appear to have been less likely to have met the needs of MtF rather than FtM individuals regarding understanding their gender identity or transgender status.

Gender specialists at the G.I.C., and counselors or psychiatrists were also rated quite highly by some respondents as a source of support regarding gender identity, but almost equal numbers of respondents rated these sources as being of very low importance too. It would be helpful to understand these divisions better, but there was little direct evidence to indicate why such potentially useful sources of support and information received such polarised ratings. A three way cross tabulation with current gender role did not suggest significant differences in the way FtM or MtF respondents perceived support with gender identity or being transgender from gender specialists, counsellors or psychiatrists.

Morton has suggested that generic psychiatrists and counselors are not always able to give the best support to transgender people because they lack specialist knowledge (2008: 11/18). At least one respondent felt that they needed to 'jump through hoops' with gender specialists at gender identity clinics to receive the support they sought, but whether or why

this contributes to undervaluing support to better understand ones gender identity is unclear. It is possible that for some transgender people, attendance at a G.I.C. represents a step towards gender reassignment rather more than assistance with understanding of the nature of their gender or transgender, perhaps confirming Morris' view that 'patients with gender disorders do not want therapy ... they want surgery' (2007: 91).

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. Unlike the similar finding above with regard to ratings of transgender support groups, there is evidence in the literature that family support is perhaps less likely to MtF people than to those who undertake a FtM transition (see for example Whittle et al (2007: 69)).

Similarly, a further three way cross tabulation indicated that 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. This appears to reflect earlier research which suggests that FtM individuals may have stronger friendship networks than MtF people (see for example McNeil et al, 2012: 88, Hines, 2007: 99/100).

In response to a question about the stage in life when they might have appreciated assistance with understanding of gender identity, one interviewee responded:

Suzie: 'Around my late teens would have been better, in regards to everyone (then) being less aware of the gender confusion that I had when I was that age. (I would have appreciated) any information regarding support & counselling through a person who had knowledge of trans issues, even if they themselves were not trans. There is more awareness now, especially (through) the internet'.

The notion of an individual's sense of their gender identity not always falling within the binary was recorded by Ellis and Symonds, as long ago as 1897: 'Ever since I can remember anything at all, I could never think of myself as a girl ... when I was 5 or 6 years old I began to say to myself that whatever anyone else said, if I was not a boy, at any rate I was not a girl. This has been my unchanged conviction all through my life' (quoted in Prosser: 1998; 147). A very similar perspective is noted by an interviewee within the current research:

Abigail: 'I have never had a female or male identity. All I can tell you was that I always felt different, not feeling as (if) I belonged either to men or to women, and that this tormented me. My sense of being 'third gender' evolved. Crucial was the fact that I came across an account of the Two Spirit people of the Native Americans in about 19xx. The discovery that people like me did exist in other cultures where we (were) accepted and allowed to live freely was incredibly important'.

The 'Two Spirit' people to which Abigail refers, are the berdache – 'male berdaches have been documented in nearly 150 North American societies. In nearly half of these groups, a social status also has been documented for females who undertook a man's life-style' (Roscoe, 1996: 330). Roscoe argues that the berdache occupied a third (or fourth) gender role, for 'a dual gender model fails to account for many of the behaviours and attributes reported for berdaches' (1996: 338), and that 'the berdache gender entailed a pattern of differences encompassing behaviour, temperament, social and economic roles and religious specializations – all the dimensions of a gender category ... with the exception of the attribution of physical differences' (1996: 370). Herdt explains that the (Catholic and Christian) Spanish and Anglo- Americans who came across the berdache in Native North American tribes from the 16th Century onwards, expressed 'dismay, disgust, anger or at the least, ridicule' so that 'in the colonial period, it is reported that the perfect berdache would pass as a person of the opposite sex in order never to be detected' (1996: 64).

A continuing example of people living within a (now legally acknowledged) third gender role, is found in the hijras of India, who, as Nanda explains, 'pose a challenge to Western ideas of sex and gender. The cultural notions of hijras as "intersexed" and "eunuchs" emphasise that they are neither male nor female, man nor woman. At a more esoteric level, the hijras are also man *plus* woman, or erotic and sacred female men' ... (who) ... 'lead their daily lives within their own social communities as individuals, hijras exhibit a

wider variety of personalities, abilities and gender characteristics and also vary widely in the relation of the private self to culturally defined roles' (1996: 373).

It seems that exploration of the notion of transgender may indeed benefit from the examples of berdaches and hijras, whose individual and group roles, within or outwith their own communities, provide examples of adoption of gender categories outwith the binary.

Table Seventeen: The value of advice, information and support regarding gender identity, and being transgender, through a better understanding of biological sex, (trans) gender identities and gender roles. (Survey Two: n = 29)

Would you value advice, information and support on understanding gender identity, being transgender etc.?	Number of Respondents	Percentage of Respondents
I would value this advice, information and support greatly	10	35
I would value this advice, information and support a little	3	11
I don't know how much I would value this advice, information and support	2	7
I would not value this advice, information and support very much	1	4
I would not value this advice, information and support at all	1	4
Not applicable : I do not need this advice, information and support	11	39
Total	28	100

Evidence for widespread need for help in understanding ones' gender identity, biological sex, and transgender status is contained within table seventeen above: of the twenty eight respondents to a question concerning the value of advice, information and support on gender identity and being transgender, from a suitably trained and experienced social worker, ten (35%) respondents said that they would value this support greatly, and three others (11%) said that they would value this support a little. A cross tabulation of this question with information about age of respondents to survey two indicated that nine of the ten people who said that they would value this information greatly, were in the age groups 36 to 45 and 46 to 55.

Cross tabulation with current gender role indicated that 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 or even clarity to one's personal sense of gender identity or of being transgender.

Incidentally, it is important to note that one of the two respondents in survey one who explained that they were 'happy to spend some time in the opposite gender role but I don't want to do this permanently' indicated that they 'valued/would value/would have valued such advice' - gender identity issues may not necessarily be the prerogative of transsexual migrants.

A further question clarified that, while just two participants were receiving this support at present from a social or care worker, eight people (29%) indicated that they have received this assistance from a social or care worker in the past, six of whom valued the assistance greatly. Three others indicated that they were currently receiving this assistance from another source, whilst two had received it from another source in the past, and two other people added that they receive support 'from my gender specialist and my GP' or 'through the Sandyford, Glasgow'. In total therefore, seventeen of twenty eight 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.

Twenty two (82%) participants indicated that they were not receiving such support at present. Sixteen people (57%) noted that they have not received such assistance in the past. In total eleven of the twenty eight respondents had never received such support.

One interviewee made clear the complexity of the factors relating to a conflict of gender identity, for which some outside assistance may be so crucial:

Andrew: 'If there had been a trained social worker I could have talked to I would have done so. I simply wanted to make sure I was on the right path and that the feelings I had about my body were genuine. A trained social worker would have been able to explore those areas with me. It was hugely confusing which steps I needed to take in which order. A trained social worker with knowledge about local possibilities would have been a massive help. If the service of a trained social

worker would have been available at an earlier time of my life I may have contacted them to explore why I was feeling different and possibly would have transitioned a lot earlier in my life. Even if a trained social worker would have been unable to offer direct support, it would have been possible for them to refer (me) to another professional’.

Some interviewees, at least initially, as might be anticipated (see for example Downing: 2013), relied on the internet to explore their sense of personal identity, but as one interviewee explained:

Ciaran: ‘The only information that I could find about trans was online and I started looking into it (in my late teens) but I was confused about the limited information’.

Valuable information appears more readily available in 2015, for even a simple Google search of the words ‘transgender Scotland’ or ‘transsexual Scotland’ brings up the website of the Scottish Transgender Alliance as the first option displayed in each case. Even typing the terms ‘transgender’ or ‘transsexual’ into Google brings up Wikipedia’s entries on both terms as first option, though the second option for transsexual, the impressive sounding ‘transexual.org’ (apparently set up by an individual and currently inactive for the last five years) contains startling unverified statements such as ‘it is apparent that some fifty percent of transsexuals die by age 30, usually by their own hand. This morbidity is known as the 50% rule’. This statistic, which of course has been picked up and discussed by others online, appears to be a fabrication for which there is no academic verification. Perhaps a society only gradually developing online computer literacy needs time and experience to distinguish between the (presumably mostly well-meaning) opinions and statements of individuals which are so widely available online, and the carefully verified data on websites by organisations like the S.T.A. The example above highlights the need to ensure that such organisations and their websites continue to promote a high profile, not least to provide valid and meaningful information to transgender people themselves, but also to a wider public for whom misunderstanding and ignorance may be the precursors of prejudice, discrimination and transphobia.

What comes across most from the range of respondents’ experiences is that different individuals sought to come to terms with their gender identity in their own time, within their own evolving lifestyle. Some survey respondents sought to address their difficulty

individually within their teenage years or twenties. Others got married and perhaps found some comfort and stability in partnership. Still others were reassured by knowing that 'people like me did exist in other cultures where we (were) accepted and allowed to live freely'. But some had to 'endure feelings of suicide', until at some point their situation crystallized, and 'it became clear to me what was different about me and my feelings, and I immediately started to look for help'.

Support with Transitional Issues

Transition Status

For many men or women the notion of undertaking a journey from one gender role to another might seem inexplicable – why put at risk the social status associated with one's biological sex and initial gender role, painstakingly developed over a lifetime, opening up the very real possibility of rejection by family, friends, colleagues, neighbours, acquaintances, and wider society? Jan Morris' concept of an 'ineradicable conviction' (1974: 15) of a sense of identity and of belonging to a different gender than to the one initially assigned, gives some notion of the depth of this need to change. However as Goffman notes, in a broader discussion of stigma, 'it is very difficult to understand how individuals who sustain a sudden transformation of their life from that of a 'normal' to that of a stigmatised person can survive the change psychologically; yet very often they do' (1968: 158).

Winterson entitled her autobiography 'Why be Happy When you Could be Normal?' reflecting the response of her mother when she explained her lesbianism to her (2011). The parallels with the search for greater happiness by many transgender people seem evident – one can choose to continue living a 'normal' life, hiding and sublimating one's inner conflict, or one can choose to seek an inner happiness, despite the likely change to a social status which has been perhaps taken for granted until one comes out and transitions, very much in the public eye.

Many transgender writings describe an incompatibility between inner gender identity and outer gender role and biological sex. However Jeffreys notes that 'women do not 'define' their gender identity' (2014: 145), and one suspects that the vast majority of men do not do so either, for gender identity appears so inextricably bound up with everyday lives, social roles and biology that few perhaps feel the need to question or even consider it, thereby accepting it as an integral part of their everyday existence. But, as Erhardt suggests, the condition in a transgender person is an involuntary one (2007: 6) that often appears very early in life, and one for which the transgender person has few choices, other than how to deal with a dilemma which may affect each waking moment, each thought, each action. For some at least therefore, the choice of matching gender identity with gender role

becomes an increasingly necessary option for the resolution of an otherwise lifelong gender dysphoria.

A little over a half (57%: twenty seven of forty seven) of respondents to survey one said that they had changed their gender role to match their gender identity. Two and three way cross tabulations indicated that thirteen biological males, five biological females and five of 'other' or unspecified biological sex had completed a transition to the (in the main) alternative binary gender role; six biological males and three biological females were in the process of transition, and two of each biological sex said that they would like to change their gender role to match their gender identity. Two biological males and one biological female said that they had developed a gender role which reflected a bi-gender identity as both male and female, and one intersex person said that they had developed a gender role to reflect their androgyne gender identity (indicating at least four of forty seven, or 9% of 'transcenders' in the survey), taking the total of those who had changed their gender role to match their gender identity to twenty seven (table eighteen).

Adding those who would like to change their gender role to match their gender identity (four), and those who were in the process of changing their gender role to match their gender identity (nine), gave a total of forty of forty seven people (85%) who indicated that they fell within a 'migrating' category. Two participants were 'happy to spend some time in the opposite gender role' but didn't want to do this permanently (suggesting that as few as 4% of participants in the survey saw themselves as 'oscillators'), while five (11%) described themselves as 'other'. These figures compare with Rosser et al's 'internet study of the transgender population in the United States', which showed a much lower percentage of migrators (44%), a higher percentage of oscillators (18%), a much higher percentage of 'other' (29%), plus a further 9% who described themselves as drag queens or drag kings (2007: 58) (see also table fourteen above).

Table Eighteen: Cross tabulation of biological sex with transition status descriptions. (Survey One: n = 47)

How Would You Describe your Biological Sex? (number of respondents)

With Which of the Following Statements do you Most Agree?	Male	Female	Intersex	Other	No Answer	Total	%
I am happy to spend some time in the opposite gender role but I don't want to do this permanently	2	0	0	0	0	2	4
I would like to change my gender role to match my gender identity	2	2	0	0	0	4	9
I am in the process of changing my gender role to match my gender identity	6	3	0	0	0	9	19
I have changed my gender role to match my gender identity	13	5	0	3	2	23	49
I have developed a gender role which reflects my bi-gender identity as both male and female	2	1	0	0	0	3	6
I have developed a gender role which reflects my androgyne gender identity as neither male nor female	0	0	1	0	0	1	2
Other	1	2	0	2	0	5	11
Totals (47 respondents)	26	13	1	5	2	47	100

Cross tabulating age with transition status indicated that there was a tendency for participants who had changed their gender role to match their gender identity to be in older age groups, peaking at 46 to 55 years, (where biological males outnumbered biological females by 9:1). Fifteen of the twenty seven (55%) of those that had already transitioned were biological males mostly in older age groups, peaking at 46 to 55 years. There was a fairly even spread across age ranges 16 to 25 through to 66 and over, of those who were in the process of such a gender role change.

Two and three way cross tabulations of current gender role with transition status and age identified four people in a transgender role who would like to change this to match their gender identity. Of these four people, two were biological females under the age of 35 and two were biologically male over the age of 56. Three people in a current male role, four in a female role, and two in a transgender role were in the process of changing their gender role to match their gender identity. Seven people in a current male role and fifteen in a female role said that they had changed their gender role to match their gender identity, whilst one person in each of the current male and female role categories said that they had developed a gender role which reflected their 'bi-gender identity as both male and female'.

As noted above, the period spent in transitioned gender roles, with a mean of 7.3 and a median of 5 years, is relatively short compared to the period spent in the original gender role. In the context of gender as a 'condition actively under construction' (Connell, 2009: 5), these figures suggest that most migrating transgender people's experience in their transitioned gender role will have been significantly shorter and less reinforced than that of their original gender role. Reinforcement may also have been affected by the degree to which they were able to live a full social life in their transitioned role, and/or because of non-acceptance or transphobia - factors which appear more likely to affect MtF than FtM transgender people (Whittle et al, 2007: 8).

Twenty nine respondents had undertaken the twelve month 'real life test' referred to above, as part of the transition process, and, presumably, to be accepted by their G.I.C. for further support, including reassignment surgery. Eight of these were now living in a male gender role, eighteen in a female gender role, and three in a transgender role (survey one).

Abigail: I began the process called "the real life test" - in which you are supposed to start living full time as a woman. This has the hugest implications in every aspect of your life, again, without support. Anything, absolutely anything, would have been welcome'.

No one had undertaken this and not completed it, or had completed it and then reverted to living in their original gender role. The finding that six people (five of whom were in the predominantly biologically female age groups 16 to 25 or 26 to 35) had undertaken gender reassignment without undertaking a real life test, raises the possibility that some younger

transgender people were transitioning without meeting this G.I.C. requirement, and therefore perhaps had done so without G.I.C. support.

Cross tabulating age with 'real life experience' in survey one indicated that there was a tendency for an increase in the numbers of participants who have undertaken this step, as part of gender reassignment, as age increases, through age groups 26 to 35 (three of eight), 36 to 45 (seven of nine), up to age 46 to 55 (ten of eleven). Four people explained that they were not able at present to live full time in a different gender role, although this would be their preference.

Support with Making Plans for the Future

The notion of a social or care worker to help a transgender person to move beyond an understanding of gender and transgender and assist them with 'making plans for the future, including perhaps planning for a gender role transition', is explored within table nineteen which indicates that 37% (ten of twenty seven) of respondents would greatly value such advice, information and support from a suitably trained and experienced social worker:

Table Nineteen: The value of advice, information and support regarding making plans for the future, including perhaps planning for a gender role transition (Survey Two: n = 29)

Would you value advice, information and support to help you to make plans for the future, including perhaps gender transition?	Number of Respondents	Percentage of Respondents
I would value this advice, information and support greatly	10	37
I would value this advice, information and support a little	3	11
I don't know how much I would value this advice, information and support	3	11
I would not value this advice, information and support very much	1	4
I would not value this advice, information and support at all	0	0
Not applicable : I do not need this advice, information and support	10	37
Total	27	100

A cross tabulation of this question with age data from survey two indicated that half of those who said that they would value this support greatly were in the age group 46 to 55

years, and the other half were aged 16 to 45. Seven of the ten people who said that they would value the support greatly were biological males (of a total of twelve biological males), with just two biological females (of a total of ten biological females) saying this, though three other biological females said that they would value this information a little. These numbers were, as anticipated from earlier data in the research, almost exactly reversed when cross tabulated with gender identity. Of the ten people who said that they would value advice greatly on making plans for the future, including perhaps for a gender transition, six were currently in a female role, three in a male, and one in a transgender role. Surprisingly perhaps, 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 uncertain.

Three participants indicated that they were currently receiving advice, information and support regarding making plans for the future from a social or care worker, and two others indicated that they were currently receiving this assistance from another source. Six people (22%) indicated that they have received assistance with making plans for the future from a social or care worker in the past, five of whom valued the assistance greatly, whilst two had received assistance from another source.

One interviewee explained the value of such information and advice:

Suzie: 'Counselling is very important. Information is important (too) but using it the right way is relevant to deciding to transition. Talking to someone puts things into perspective (allowing you to make) the right decisions "for yourself" and not (be) confused about how you feel and (by) what others think you should do'.

Twenty two (82%) participants indicated that they were not receiving such support at present and eighteen people (67%) said that they have not received such assistance in the past. In total therefore, thirteen 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.

Support with Undertaking a Transition

Often within a short period of time and with little opportunity to practice the social skills of the gender of transition, a transgender person, if they are to feel comfortable in a different

or opposite gender role, needs to consider and adjust/re-learn speech and use of language, appearance (e.g. clothing, hair-style, make up, posture), and perhaps most importantly, to consider how these will affect their social role and status within their family, their network of friends, employment, and within wider society.

But of course this brief summary of some of the issues which both MtF and FtM transgender people might need to consider at the time of transition inevitably fails to encompass the wide range of behaviours which people who have lived a lifetime in one gender or the other have learned to make, elicit, and accommodate, and which need to be quickly mastered if newly adopted behaviors are to be acceptable within the expectations of a newly adopted gender role. These expectations are likely to vary too, within the company of men, women, or in groups of mixed gender (and/or mixed ages etc.), and within the varying degrees of intimacy which define and clarify our relationships and interactions with those that feel closest, and those that seem most superficial - complicated too by notions of sexuality and sexual attraction.

Brown and Rounsley summarise this process when they suggest that a transgender person 'cannot simply emerge "full blown" as the other gender. They must rebuild themselves psychologically, socially and interpersonally' (2003: 127).

Close friends were rated of highest importance by twelve respondents as a source of support regarding gender identity, although eleven respondents rated their close friends as being of lowest importance too (table twenty). Almost twice the numbers of participants rated friends in the three highest importance columns than the three columns of lowest importance, suggesting that this may actually be a strong source of support to the majority of those transitioning.

However, a further three way cross tabulation indicated that eight 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 transition issues (with just one respondent rating close friends in the three lowest categories for such support). Conversely, of the fourteen respondents in a current female gender role, and with a female gender identity, only a little under a half (seven) rated close friends in the three highest categories for support with transition issues, with four respondents rating them in the three lowest categories. These

findings reinforce the earlier data which indicate the tendency for friends to be rated less highly for support with gender identity issues by MtF than by FtM people.

Table Twenty: Importance of sources of advice or support in helping to undertake transition (Survey One) (n = 47 : 40 respondents)

Importance of Sources of Advice and Support Regarding Gender Role Transition
(1=highest importance, 11=least importance)

Source of Advice or Support	1	2	3	4	5	6	7	8	9	10	11
a.Close Friends	12	3	6	1	2	2	0	0	1	0	11
b.Family Members	6	7	3	2	2	2	3	3	0	1	10
c.Colleagues at Work /Line Manager	3	2	4	3	2	3	1	2	1	3	12
d. Transgender Support Group	14	3	6	2	1	1	2	0	1	2	5
e.General Practitioner	4	6	4	1	6	5	1	0	2	1	8
f.Gender Specialist at G.I.C.	10	3	4	3	3	1	1	3	1	2	9
g.Speech Therapist	6	0	3	2	0	3	2	4	1	2	11
h.Health Visitor or District Nurse	1	0	0	0	1	2	0	2	2	4	22
i.Counsellor or Psychiatrist	6	4	5	1	4	2	3	0	0	4	8
j.Social Worker	2	0	0	1	1	1	1	1	4	2	20
k.Carer/PersonalAssistant/SupportWorker	2	1	1	0	0	1	2	0	0	4	22

(for key to colour coding, please see table sixteen above)

Comments within the literature review on the uncertainties of family support (Whittle et al 2007) are illustrated by the finding that family members were rated of least importance by ten participants as a source of advice or support during transition, whereas just six rated them as of the highest importance. However, overall, more family members received higher ratings of importance than of lower importance.

A three way cross tabulation indicated that 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 transition issues (with just one respondent rating family members in the three lowest categories for such support). Conversely, of the fourteen respondents in a current female gender role, and with a female gender identity, just two rated family members in the three highest categories, with four respondents rating them in

the three lowest categories. These findings reinforce the earlier data which indicate a tendency for family members to be rated less highly for support with gender identity issues by MtF than by FtM people.

When asked to rate sources of advice or support in order of their importance, transgender support groups were rated within the three categories of highest importance by over a half (twenty three of forty) of respondents as a source of advice regarding 'helping you to make the transition', with 20% (eight of forty) people rating them within the three least important categories too. Members of support groups were perhaps most likely to have undertaken gender reassignment themselves, and may well have been able to show an extraordinary degree of empathy and compassion for other transgender people at a very vulnerable time in their lives.

A comment from one transgender interviewee evidenced their willingness to provide such support to others:

Amy: 'I still attend my gender support group meeting ... to help others in their transition as I can answer any questions about gender reassignment surgery.'

It must again be noted, however, that not all respondents have access to such groups:

Ciaran: 'I would have liked to (have) been able to speak to someone further into their transition but after a few bad experiences online seeking fellow trans-people I'd now rather get on with things the best I can ... since I started my transformation ... I have still never met another trans-man or trans- woman'.

A three way cross tabulation indicated that seven of the nine respondents in a current male gender role and with a male gender identity rated transgender support groups in the three highest categories for support with transition issues, (with no respondent rating transgender support groups in the three lowest categories for such support). But, as with issues of gender identity above (although perhaps even more surprisingly) of the thirteen respondents in a current female gender role, and with a female gender identity, only six individuals rated transgender support groups in the three highest categories, with four respondents rating them in the three lowest categories. Once again, it is not clear why transgender groups appear to have been less likely to have met the needs of MtF rather than FtM individuals regarding support with undertaking a transition.

The Scottish Transgender Alliance's Transition Support Service may also be a source of support, and other group sources were also noted:

Abigail: 'Late on in the process, the LGBT health centre began a group to help people in transition, run by a trans-woman psychologist. This was so helpful.'

A quarter of the forty respondents rated gender specialists at a G.I.C as their most highly valued source of support regarding helping to undertake a transition, and overall more respondents rated them of higher than of lower importance, although nine rated them as their least valued source of support. One reason for this was touched on by one interviewee who commented:

Sarah: 'Ten weeks of support during a transition process that can take years is not a significant amount of contact over a long enough period'.

Another interviewee observed:

Luke: 'An appointment roughly every six months at times hasn't been sufficient'.

Another interviewee commented on the difficulties of accessing their G.I.C. and surgical facilities:

Ciaran: 'It's not ideal that my nearest G.I.C. involves a 200 mile round trip and I have to travel to London for operations'.

A three way cross tabulation indicated that three of the ten respondents in a current male gender role and with a male gender identity rated the G.I.C. in the three highest categories for support with transition issues, (with just one respondent rating the G.I.C. in the three lowest categories for such support). Conversely, of the fourteen respondents in a current female gender role, and with a female gender identity, seven rated the G.I.C. in the three highest categories, with four respondents rating them in the three lowest categories.

A further three way cross tabulation also indicated that three of the ten respondents in a current male gender role and with a male gender identity rated counsellors or psychiatrists in the three highest categories for support with transition issues, (with three respondents rating counsellors or psychiatrists in the three lowest categories for such support). Conversely, of the fourteen respondents in a current female gender role, and with a female

gender identity, eight rated counsellors or psychiatrists in the three highest categories, with just three respondents rating them in the three lowest categories.

From additional data described above, it may be that FtM individuals are more likely to find sources of support 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.

More GP's appear in the three highest importance columns than in 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 highlighting Whittle et al's finding that 21% of GPs did not want to help transgender people (2007: 16).

One interviewee noted the 'hoops' that need to be negotiated in order to receive surgery, which may partially answer concerns noted in the literature review, that transitioning transgender people may over conform, particularly in their early experiences of cross dressing:

Lucy: 'I have had two brushes with gender specialists. My first was in 19xx with a consultant who to put it bluntly was an arrogant bastard who hated transsexuals and let you know he did! To attend his clinic one had to appear wearing what he thought women should wear, that is dress like vicars' wives! You could always tell when it was his (clinic) as there would be a line of vicar's wife wannabees lined up in a row in the waiting room. If you wore trousers you were politely told that women did not wear trousers and that men did and you were warned not to attend future consultations wearing them. If you wore jeans you were sent straight home and a letter sent to your GP telling them that as far as he was concerned you were not transsexual and to withhold hormone treatment'.

This interviewee went on to describe her experiences at another gender identity clinic some years later:

Lucy: 'My experience of gender services second time round was quite interesting. I saw a consultant, and the first time we met I appeared dressed and looking like a woman, he was most displeased as to quote him 'I tell you when you can start

dressing as a woman', he was less than impressed when he found out that I'd been on hormones and anti-androgens for a year. However once we had spoken for a while and understood my journey to date he was actually a good listener and source of sensible advice. I found gender clinic mark two a lot less onerous than first time round and yet other trans people complain about how bad it is - they weren't round (then) ... sure it's a bit regimented and strict. So what, you're asking for major irreversible surgery. What else would you expect?'

Once again, the value and validity of information obtained via the internet was questioned:

Kay: 'Simply having access to reliable information is valuable and a support worker who could recommend providers and trustworthy information, or useful contacts, in the transition process. This would be greatly appreciated as the Internet is dubious at best for this'.

Although table twenty suggests that only a few participants felt that their workplace was a source of advice and support, for some transgender people, transition was greatly aided by support from work colleagues:

Kay: 'Both my work and friends have been wonderful. They are not knowledgeable on transgender at all, and so can't help in that respect, but the support, encouragement and warmth has been desperately critical, especially from work. I feel much sympathy for folk without this support'.

The idea of support from a social care worker to help transgender people 'during a gender role transition or the 'real life test'' was explored within a question in survey two (table twenty one), which indicated that ten (37%) of twenty seven participants would greatly value assistance from a suitably trained and experienced social worker during a gender role transition or the 'real life test', with a further four participants saying that they would value this a little. The same number (ten, 37%) of participants said that they did not need such assistance:

Table Twenty One. The value of advice, information and support during a gender role transition or the 'real life test'? (Survey Two: n = 29)

Would you value advice, information and support to help you during a gender role transition or 'real life test'?	Number of Respondents	Percentage of Respondents
I would value this advice, information and support greatly	10	37
I would value this advice, information and support a little	4	15
I don't know how much I would value this advice, information and support	2	7
I would not value this advice, information and support very much	1	4
I would not value this advice, information and support at all	0	0
Not applicable : I do not need this advice, information and support	10	37
Total	27	100

One interviewee explained that such a support role might also be helpful during the waiting period before transition, when G.I.C. support was not yet available (an issue first noted within the pilot study):

Kay: 'I have also got in touch (with the G.I.C.) by email and letter simply asking for advice with my transition such as where to go for voice therapy or laser treatment and have never even had my communication acknowledged ... An experienced social worker or care worker during this waiting period could have provided advice at least, and even just the emotional support so as not to feel isolated'.

Another interviewee explained why a social worker perspective would be helpful for what is often viewed essentially as a medical process:

Lucy: 'I think a trained social worker would be a good step as a means of de-medicalising 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. Sure you need a medical input for some things like hormones, however a good social worker is every bit as good and a lot less tarred with the medical brush'.

A cross tabulation of this question with age data for survey two showed that eight of the ten people who would value this assistance greatly during a gender role transition or real

life test were in the age ranges 36 to 45 and 46 to 55, with the remaining two people being from the age groups 16 to 25 and 26 to 35. 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 one, for which advice and support may be needed for some time after the initial 'transformation' and adoption of the opposite binary role.

Two participants indicated that they were receiving this support from a social or care worker at present, and one indicated that they were currently receiving this assistance from another source. Five people (19%) indicated that they had received advice, information or support in the past from a social or care worker, each of whom valued the assistance greatly, whilst two had received it from another source.

Twenty four (89%) participants indicated that they were not receiving such support at present, and nineteen people (70%) said that they had not received such assistance in the past.

In total therefore, ten of twenty seven respondents had either received support during a transition in the past, or were receiving it at present, from a social or care worker, or from another source.

Individual Experiences of Seeking Information/Support about Transitioning

In the absence of other forms of assistance it is not surprising that some transgender people looked for information and support online, but with varying degrees of success:

Ciaran: 'I tried a couple of the websites printed on leaflets from the (G.I.C.) but the chat option was never open, so I tried some searches which didn't turn up much in common with what I was looking for. I set up a profile (on two websites) explaining I was the only trans in my small minded town and was looking to have general chat with others at any stage of their transition. I contacted a few people but the only replies I got were of a sexual nature ... one man was sending me messages of encouragement explaining his brother used to be his sister and they were originally from my town etc. so we exchanged emails and he suggested meeting up. I wish I

hadn't agreed and I was stupid/naïve enough to not tell anyone I'd even been online looking for someone to talk to'.

But some people were luckier and appeared to find support, and indeed friendship, online:

Amy: I (met) a wonderful girl on youtube (who) I will call Jan. I came across Jan's video by accident. After watching her video asking for friends and help, I sent a message of friendship to her, so two days later she invited me to be a friend and asked me for help with some questions about the processes of gender transitioning. I replied that I would do my best to help her with the questions she sent to me. Around a week later in November 20xx she got back to me with more questions about transitioning and also a little about herself...' (Amy went on to describe how a close friendship developed between herself and Jan in America, resulting in Jan coming to Scotland to live for three months, with Amy's support).

One interviewee explained about the difficulties caused by trying to address both the complexity and the cost of transition, whilst waiting for a gender identity clinic appointment:

Kay: 'My problem is knowing in what order to do what, on a limited budget ... should hormones take priority over voice coaching/electrolysis etc.? Pragmatic advice is what I am most lacking ... when the G.I.C. do finally deign to see me my priority would be to make a sensible road map of what needs to happen instead of my low budget DIY transition attempts at present'.

One interviewee picked up again on the length of time that transition takes, with a long waiting period before a first G.I.C. appointment, reflecting an issue raised within the pilot study focus group some months earlier. She commented that:

Kay: 'An experienced social worker or care worker during this waiting period could have provided advice at least, and even just the emotional support so as not to feel isolated ... I am still writing to the G.I.C. and trying to get seen, and I will certainly take any help when offered, mostly I feel because the specialist is the 'gatekeeper' to physical progression, certainly surgery, for those with no finance'.

Another interviewee noted six month intervals between appointments, as he waited for surgery:

Ciaran: 'At the G.I.C. ... once I started on the testosterone I was told I had to be seen every six months to "check in" ... I hope that once my bottom surgery is complete I will feel more comfortable in my own skin and get back to my proud, stubborn, hard-working self. I know "a penis does not a man make" but I'd feel more confident in my argument/defence when people try and tell me I'm not a guy'.

A further interviewee also noted a six month interval between appointments and the effect this has both on themselves and others:

Luke: 'I have attended a gender clinic. However an appointment roughly every six months at times hasn't been sufficient. I have always felt there should be some form of more regular interaction between these appointments to help cope a little better. For example when I first got my consultation for chest surgery I was told I would probably have to wait about two years to have the surgery done. I was completely devastated and (it) would have been beneficial to have some support during this (period) other than just my mum because you can't really explain properly how you're feeling to her - particularly since my mum normally starts crying when I get upset over this, because she is my mum. So, not to upset her I bottle up a lot of feelings that are only released twice a year'.

One further interview quote reinforced the notion of isolation at transition, and also raised the need to find support for other family members and some of the consequences of undertaking such a transition in public:

Abigail: 'I suppose the point was that at the time, apart from the rather infrequent appointments with the gender specialist, there was no support of any kind available at all. I managed to find support from other sources - from the simple straightforward acceptance of the lady who was doing my facial hair removal ... prior to my first appointment with the gender clinic - a huge concern was to find support for my family as well as for me, because this so profoundly affected them.

While I was dressing in a neutral kind of way, and as I started to go out dressed as a woman, people would frequently point, laugh out loud, and make very cruel remarks'.

Chapter Summary: Key Findings

In this chapter the research findings relating to biological sex, gender identity, gender roles preceded a discussion on transitional issues for transgender people.

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); 41% identified with transgender (14%) or 'other' categories (27%) including 'genderfluid', 'genderqueer', 'intergender', and 'polygender'.

A little over a half (57%: twenty seven of forty seven) of respondents to survey one had changed their gender role to match their gender identity. Thirteen biological males, five biological females and five of 'other' or unspecified biological sex had completed a transition to an apparently opposite binary gender role.

47% of participants of survey one, and 38% of participants of survey two were living alone, while 24% of survey one respondents described themselves as long-term sick or disabled.

Transgender groups were rated the most highly valued source of support re helping to undertake a transition for fourteen of forty (35%) respondents to survey one, although FtM respondents were more likely to rate transgender support groups in the three highest categories, both for this support and for issues of gender identity, than MtF individuals. The findings also indicated that FtM individuals are 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 more detailed summary of the research findings covered in this chapter is included within Appendix Seven.

Chapter Five: Research Findings (Part Three)

Surveys and Interviews with Transgender People (continued)

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Introduction

This chapter presents the second section of the findings from the collated results of the forty seven questionnaire responses to the first survey of transgender people (survey one), and the twenty nine questionnaire responses to the second survey of transgender people (survey two) (who self-selected to participate in the surveys via the Scottish Transgender Alliance mailing list), together with responses from the ten transgender people who took part in online interviews (who self-selected to be interviewed at the end of the first survey).

In addition to the main questionnaire data from these 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. The results of these cross-tabulations are referred to throughout each of the following research findings chapters.

The seven key themes that emerged from the findings of the surveys and interviews of transgender people are again listed below. The findings outlined within this chapter are linked to the third and fourth of these seven key themes (highlighted in bold).

Issues relating to coming to terms with being transgender.

Support with transitional issues.

Support to family members in coming to terms with being transgender.

Assistance with documentation during/after transition.

Mental health problems linked with gender identity or gender role.

Support with long-term physical or mental ill health, disability or problems related to old age.

Post transitional and societal issues.

A summary of the main research findings discussed in this chapter can be found at Appendix Seven.

Support to Family Members in Coming to Terms with Being Transgender

'In our culture, the family occupies a central role. For most people, the idea of life without some sort of family structure to provide a source of caring, comfort and emotional security is unthinkable. We tend to treat the role of the family and the value of what it does for the individual as some sort of self-evident, obvious truth.' (Murgatroyd and Woolfe, 1985: 15/16).

Whilst this quote suggests a somewhat idealized view of the family, for many people it may indeed represent a 'self-evident, obvious truth' of family structure and support at the heart of their lives and of Scottish society. But what happens when a family has to deal with the highly unusual event of a transgender person 'coming out', with a gender identity which is inconsistent with their apparent biological sex? Biblarz and Savci suggest that 'academic research on transgender people and their family relationships is almost non-existent. Because transgender people are undergoing a gender identification change, their families have to adjust to having a relative of another gender, and hence transgender people undergo a very different kind of coming out' (to that of gay, lesbian and bisexual people) (2010: 489).

One interviewee indicated that their family had been very supportive:

Andrew: 'I do have a very supportive family and my parents both understood that I needed to transition'.

However, it seems evident from some of the other findings of this research that some families found it hard to adjust to a transgender member coming out, leading to discord and in some cases to their potential isolation, as one interviewee recorded:

Sarah: 'I don't communicate with my father. 'You're no son of mine!' pretty much sums up his attitude in a dreadfully ironic way'.

The Scottish Social Attitudes Survey indicated that 'half (50%) (of respondents) say they would be unhappy about a relative forming a long-term relationship with a transsexual person' with an increased unhappiness indicated by those who 'attend a religious service once a week' (Bromley et al, 2007: 15). That such unhappiness is expressed by such a high

proportion of respondents, suggests a deep seated unease about the nature of transsexuality, which has been partially explored within family relationships by the Scottish LGBT Domestic Abuse analysis of transphobic behaviours (Roch et al, 2010: 15). As respondents to the current research have explained, such transphobia within the family may occur from a parent, sibling, or a member of one's extended family, and, as other research has shown, for transgender people who are parents, may also result in reduced access to their former partner and to their children: McNeil et al found that, of the 188 participants who were parents, 19% reported seeing their child(ren) less, 18% lost contact with their children, and 8% had custody issues. Only 17% found telling their children (about their being transgender) a positive experience (2012: 90).

It might be conjectured that a family's concerns about how society in general views transgender people, may be influenced by prejudice and transphobia, leading to embarrassment or shame. Fear of the family becoming a source of gossip, or of rejection by extended family members, neighbours, friends, colleagues and/or acquaintances might be part of the amalgam of these concerns. There may be other feelings too, of guilt or of loss (of a son or daughter, of a partner or of a parent). Accurate, factual information about transgender may not be readily available, or there may be no-one outwith the family with whom the subject can be discussed. Exceptionally, Benvenuto, in her account of her experiences relating to her partner's transition, displays a fairly comprehensive overview of transsexuality, including consideration of gender, gender identity, transgender and aetiology (2012: 157/166). For the child of a transgender parent, there may be a fear of being rejected or being made fun of by one's peer group, or by one's teachers. However Benvenuto suggests that the 'literature about the transsexual experience plays down or altogether omits the loss experienced by a child whose parent changes gender' (2012: 11).

Three interviewees shed light on how close and extended members of a family may struggle with the issue:

Ciaran: 'None of my family received support in the professional sense but they supported each other at times. I think my mum and my aunt ... would have benefited the most from additional support as they did struggle a bit to accept my decision. My aunt spent many hours trying to persuade me it was "just a phase and I would regret it" but once she realised how serious I was she vowed to support me no matter what. If they had had support they could have discussed how to deal

with nosy people quizzing them, to voice their disapproving comments and maybe help them understand how I was feeling mentally as I wasn't very good at vocalising my thoughts/feelings'.

Lucy: 'My mother had real problems with my gender change ... back then information was not readily available. She went to her GP to find out more. However he was not willing to discuss the matter, so she went to the library. However I gather they were most unhelpful, considering transsexualism as something weird and pornographic'.

Suzie: 'At the time of my transition, there was only the (G.I.C.) that I was aware of I think that they had a support group for both parties. Everyone needs support, not just people transitioning. Though my family were supportive at the time, I could not explain how I felt and make them understand'.

Relatives who Have Received Advice or Support about Transition

One of the most important findings was just how few families received support about their relative's gender role transition. Thirty (69%) families had received none at all:

Table Twenty Two: Relatives who Received Advice or Support About Transition
(Survey One: n = 47)

Advice or Support to Relative(s)	Number of Respondents	Percentage of Respondents
None of my family received advice or support	30	69
My parent(s) received advice or support	3	7
My sibling(s) received advice or support	1	2
My partner received advice or support	2	5
My child(ren) received advice or support	3	7
My wider family received advice or support	0	0
Not applicable: I am not making/have not made/do not intend to make a gender role transition	2	5
Other*	2	5
Total	43	100

*Other: 'would have been good if my mother hadn't had to deal with understanding all this herself when I was growing up'. 'My mum had psychologist support from children and young people's gender clinic and from Mermaids group, my dad and brothers were offered

but didn't accept support from the psychologist and gender clinic for children and young people'.

Of the forty three respondents to a question about advice or support to relatives, only two respondents' partners, three respondents' children, three respondents' parents and just one respondent's sibling had received support:

Cross tabulating age with this support to family members showed that the response 'none of my family received advice or support' was given by somewhat fewer younger people: nine of the seventeen people (53%) in the combined age groups 16 to 25 and 26 to 35, compared to sixteen of the twenty participants (80%) aged 36 to 45 and 46 to 55. Three young people aged 16 to 25 indicated that their parents had received advice or support, the only age group to report support to their parents. Three people across the combined categories 36 to 45 and 46 to 55 indicated that their children had received advice or support, and one person aged over 66 said that their sibling had received support. The partners of two people (one in each of the age groups 46 to 55 and 66 or over) had also received advice and support on this matter.

Cross tabulating current gender role with support to family members about transition, indicated broadly similar ratios of family members who had received no support for those respondents in current gender roles of male (ten of fifteen), female (fourteen of twenty one), transgender (three of seven) and 'other' (two of three).

One survey respondent commented on the scarcity of such support:

'My wife ... would have greatly appreciated an external source of knowledgeable discussion about the basic facts of transgender ... I think support workers for spouses are often overlooked.'

Two interviewees explained the difficulties for their partners and the possible role a social worker might have taken:

Andrew: 'My partner ... did not receive any support. She had many questions, some of which I could not answer. It was also difficult to be so wrapped up in my own transition and having to support my partner at the same time (who had the same sort of problem, having to come to terms with me transitioning and supporting me). My partner identified as lesbian and was suddenly confronted with members

of the public telling her she was heterosexual. Being a social worker herself I am sure she would have very much appreciated somebody to talk to who was not involved in my transition. There is very little support, even online, for partners and families. A social worker could have simply been available for a chat when things got difficult. We are both independent and strong people but knowing that there is somebody who can listen to your thoughts, who is not your partner, can be very helpful’.

Josie: ‘The involvement of my wife at an earlier stage of the ... process would have been beneficial ... (she) was only brought into the formal process on the last interview before my operation’.

Another interviewee described how her wife came to terms with the issue of transgender, and explained how both she and her wife found support through a web site forum:

Kay: ‘I was married when I came out, and my wife listened to what I had to say, but again would have greatly appreciated an external source of knowledgeable discussion about the basic facts of transgender. It was very emotional at first, and she (spent time) by herself ... to think. On her return she was very keen to engage in what was happening with me and she made a remarkable effort to research and (to) understand what transgender is. I know she also got frustrated by the lack of useful external information beyond porn and dating sites ... I think support workers for spouses are often overlooked. We have both used (a web site) enormously ... they have a forum section for spouses and partners and in the early days I know my wife found this helpful, to chat with other spouses of trans-people’.

Support to Family Members in Coming to Terms with Transition

Just fourteen respondents rated the importance of a range of sources of advice or support to family members in coming to terms with transition (table twenty three).

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. Lev suggests that ‘the clinical philosophy of most gender specialists has been

to view family members as extraneous to the process of evaluation and treatment' (2006: 263). Most respondents rated colleagues at work and line managers as of low importance as a source of support at this time. Five respondents rated social and care workers quite highly, though twelve gave very low ratings of importance.

Table Twenty Three: The importance of sources of advice or support in helping family members to come to terms with transition (Survey One) (n = 47: 14 respondents)

**Importance of Sources of Advice and Support to Family Regarding Gender Role Transition
(1=highest importance, 11=least importance)**

Source of Advice or Support	1	2	3	4	5	6	7	8	9	10	11
a.Close Friends	4	2	2	0	0	1	0	0	0	0	5
b.Family Members	2	2	1	0	2	0	0	0	0	0	6
c.Colleagues at Work/ Line Manager	1	0	2	0	0	0	1	0	0	0	7
d.Transgender Support Group	5	1	2	0	0	0	1	0	0	0	2
e.General Practitioner	4	1	0	0	1	1	0	0	0	0	4
f.Gender Specialist at G.I.C.	2	2	0	0	0	1	0	1	0	0	4
g.Speech Therapist	2	0	0	0	0	1	0	1	0	0	5
h.Health Visitor or District Nurse	1	0	0	0	0	1	0	0	1	0	6
i.Counsellor or Psychiatrist	4	1	0	1	0	1	0	0	0	1	3
j.Social Worker	2	0	0	0	0	1	0	0	0	1	5
k.Carer/PersonalAssistant/SupportWorker	2	1	0	0	0	1	0	0	0	0	6

(for key to colour coding, please see table sixteen above)

The absence of a clear, reliable and available source of advice is of particular concern as support to the immediate family of transgender people, to their partners or parents, or to their children or siblings is of such importance at a time when family support structures are likely to be most threatened. As the NHS/Glasgow University Survey found: '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 among ... respondents' (Wilson et al, 2005: 27). Some respondents clearly empathised with the needs of families at this time:

Lucy: 'I believe family members, parents and siblings need someone whom they can talk to, (to) find out more and discuss their fears and worries with. It must be quite a shock to suddenly find (that) a person whom you may have given birth to is not quite the person you thought they were. I think in this situation an experienced social/care worker would be perceived as a neutral person, someone who can be trusted with no particular axe to grind'.

Brown and Rounsley note that 'coming out to family members is usually much more difficult for transsexuals than coming out at work ... the thought of rejection by family members ... can be devastating ... there are few losses greater than that of the family bond' (2003: 167). Jeffreys quotes Erhardt's findings that 'initial reactions range from bewilderment and disbelief to shock and then embarrassment at the thought of others finding out' (2014: 85), whilst also recognizing Erhardt's perspective that 'it is extremely important ... to remember that being a person of transgender experience is involuntary. I have heard women who leave insist on believing that their partner was frivolously choosing a transgender lifestyle' (Erhardt, 2007: 6, from Jeffreys, 2014: 83). Family acceptance of a transgender member predicts greater self-esteem, social support and general status, so working through family difficulties at this time will almost certainly ensure better outcomes for both the transgender person and their family (Ryan et al, 2010: 205). Another interviewee commented on the potential value of family support groups:

Suzie: 'Someone who had an outside knowledge could explain transition from a non-judgemental view-point. Your family still expect to see the same person, regardless of the physical changes, emotional changes etc. We don't all follow the same path. Family support groups, if the families use them, can put the points across better than we can, about acceptance and respect. Families may feel more at ease, talking to other people (in a group) or a one to one talk'.

Although, as Hines notes, 'the partnering and parenting relationships of transgender people are ignored not just within sociologies of the family, but also within gender research' (2007: 127), it seems that advice and support from a professional, knowledgeable source is a much needed addition to existing services. This is supported by the feedback of twelve of twenty seven respondents within the current research who felt that their partner or other family member would value such support greatly (ten) or a little (two) (table twenty four). Seven respondents said that their partners or other family members did not need this support:

Table Twenty Four: The value of advice, information and support to help partners or other family to better understand about being transgender and/or the consequences of transitioning (Survey Two: n = 29)

Would your partner/ family value advice, information and support to understand your being transgender/making a transition?	Number of Respondents	Percentage of Respondents
One or more would value this advice, information and support greatly	10	37
One or more would value this advice, information and support a little	2	7
I don't know how much they would value advice, information and support	5	19
None would value this advice, information and support very much	2	7
None would value this advice, information and support at all	1	4
Not applicable : none need this advice, information and support	7	26
Total	27	100

A cross tabulation of this question with age indicated that four of the seven people in the age group 16 to 25 thought that one or more members of their family would value this assistance greatly, with one of the three of those in the age group 26 to 35, and five of the fifteen in the combined age groups 36 to 45 and 46 to 55 also saying this.

Of the ten people who thought that their family members would value transgender information/advice greatly, numbers were spread fairly equally between those who were biologically male and female, living in female and male gender roles respectively.

The need for support for the partners of those who transition from FtM within a lesbian relationship is also noted within the research, although one interviewee described the generally positive experiences of coming out to both his partner, and his partner's family:

Ciaran: 'I met my fiancée when we were (in our teens) and we're now (in our twenties). She just accepted it and carried on loving me for me but I think additional support or information booklets instead of the confusing information online would have made things easier for her too ... since our engagement I am always invited to family functions, we pop in once a week to the in-laws for a cuppy or stay for tea and they come over to our flat for cakes and a catch up. However I

think they would have benefited (from) some reading material, to better understand my position’.

Some interviewees’ families were clearly supportive, even without support themselves:

Andrew: My family did not receive any support. I do have a very supportive family and my parents both understood that I needed to transition. They, and my sister, said that I had always been a bit awkward and that it all made sense now. My grandmother and great aunt (both in their eighties!) also accepted quickly that I needed to transition’.

However, a further interviewee explained the problem of trying to deal with family concerns on their own, and the potential value of impartial support:

Kay: ‘The biggest battle with my family was in explaining what transgender is, and means: the difference between cross dressing, transvestites, androgynous and transsexual. Attempting to convince them that I am not a pervert in any way, that dressing as female is not a sexual thing at all for me, that it is identity and internal make up, not kink. This was a steep battle, particularly as my mum is a very strong Christian.

A support worker could have taken some of this basic explaining work off me, particularly because I was the subject issue ... my mum in particular was desperate to talk with a medical authority, and would not, and still does not, really believe I am serious. In many ways my explanation and interpretation of the transsexual landscape was treated with caution because I was trying to describe it in relation to myself and so was biased, whereas had an impartial, knowledgeable, external party explained it they would have been trusted instantly’.

Three people indicated that members of their family had received this assistance in the past from a social or care worker, whilst one respondent stated that:

‘Members of my family have received some advice from support groups and my gender specialist, and value this advice very much’.

Twenty six (96%) respondents to survey two indicated that their family members were not receiving advice and support to come to terms with a transition from a social or care

worker at present, whilst twenty two respondents (87%) said that members of their family had not received such assistance in the past.

Fourteen of twenty seven respondents said that they would value advice and information greatly (ten) or a little (four) to help partners, children and/or other family members better understand and/or address differences/disagreements or conflicts concerning being transgender and/or the consequences of transitioning (table twenty five).

Table Twenty Five: The value of advice, information and support to help partners, children and/or other family members better understand and/or address differences, disagreements or conflicts concerning being transgender and/or the consequences of transitioning (Survey Two: n = 29)

Would you value advice, information and support to help your family understand/address differences about your being transgender?	Number of Respondents	Percentage of Respondents
I would value this advice, information and support greatly	10	37
I would value this advice, information and support a little	4	15
I don't know how much I would value this advice, information and support	2	7
I would not value this advice, information and support very much	1	4
I would not value this advice, information and support at all	0	0
Not applicable : I do not need this advice, information and support	9	33
Not applicable : I have not experienced such family differences, disagreements or conflicts linked with being transgender, or transitioning	1	4
Total	27	100

Nine participants said that they did not need such advice and support, while just one respondent said that they had not experienced such family differences.

It is perhaps surprising that the percentages of biological males (42%, five of twelve) and biological females (30%, three of ten) who would greatly value this support do not differ more than they do. However, when those who would value such support a little are included, the percentages of biological males (58%, seven of twelve) and biological females (40%, four of ten) perhaps better reflect the notion of greater familial levels of acceptance of trans-men than trans-women found by Whittle et al (2007: 69), despite the relatively low numbers of respondents. Five of those currently in a male gender role said that they

would value such advice greatly (three) or a little (two), whilst seven of those currently in a female gender role said that they would value this greatly (six) or a little (one).

A cross tabulation of this question with age indicated that of the ten people who would value this assistance greatly, three (of seven) were in the age group 16 to 25, one (of three) was in the age group 26 to 35 and six (of fifteen) were in the combined age groups 36 to 45 and 46 to 55.

One person indicated that such assistance had been received in the past, and was valued greatly, whilst one other stated that: 'Members of my family value advice given from my GP and from my gender specialist'. Twenty six (96%) participants indicated that such support was not being received at present from a social or care worker, and twenty four people (89%) noted that such assistance had not been received in the past, whilst one survey respondent commented:

'The support was available for my dad but he refused to use it. The extent to which I would value this would depend on receiving a positive response as indicated by having any kind of (positive) relationship with him at all'.

Individual Experiences of Transition and Support to Family Members

Jeffreys quotes from Pepper who explains insightfully that, 'as children transition, so too must their families' (Pepper, 2012: xviii, quoted in Jeffreys, 2014: 98). One interviewee described the effect of his transition on his mother, and the knock-on effects of rejection from other members of the family:

Luke: 'My mum in particular found my transition very hard and she would have liked to talk to someone about this - particularly the rejection from her brother and his wife. They now ignore me at family gatherings etc. and she finds this very hard. Mum also felt that family help would have been good so my brother, sister and dad could have talked about what they were feeling. Although it was only me transitioning, everyone had their own thoughts and feelings on the matter'.

Another interviewee described the effects of a breakdown in the relationship with her father, and with other members of her family:

Sarah: 'I don't communicate with my father. 'You're no son of mine!' pretty much sums up his attitude in a dreadfully ironic way. Counselling could have helped him,

but I don't think he would have accepted it were it to have been offered ... I avoid any contact with the rest of my family ... generally my family would have to want to alter their attitudes towards me for counselling to even stand a chance of being helpful, and with the exception of my mother, I don't think they want to even acknowledge me as a family member, let alone include me'.

Rejection by his father was also the experience of another interviewee:

Ciaran: 'I think any form of family support/therapy from an appropriately trained person would be extremely valuable, especially when younger family members are involved. As for my father I'd like to think if the support was available a few years ago things might have been different but I'm so hurt and angry ... I'd find it difficult to forgive him if he suddenly had a change of heart/lobotomy.'

Another interviewee described her emphatic rejection by other members of her family:

Amy: 'You asked me if a specialist trained social worker would (have) helped some of my relatives come to accept and understand my transition from M-F? The answer is an emphatic no! I tried to explain to my brother five years ago and he just swore at me. He and his family do not acknowledge my existence; his son turns his head away from me ... he wanted my mother to tell me to leave ... home because I would be an embarrassment to him and his family by association ... however my mother and father said 'no' to him and have supported me'.

Two interviewees put down their thoughts on 'loss' – not just to themselves, but to members of their family too:

Sarah: 'I 'lost' my family long before transition (but) if anything, it's brought my mother and I closer'.

Ciaran: 'I know my mum struggled with the "loss" of a daughter/potential grandchildren and my 13 year old sister was also quite upset, but once they came to realise I was the same person inside and much happier they found it easier to move forward from those feelings'.

One interviewee noted religious reasons for her family's rejection:

Josie: 'My immediate family, mainly my mother and for that matter my mother in law, are of a very strong religious belief and to an extent what I have done was against their belief system and therefore (they) cannot accept it on that basis'.

Lastly, an interviewee explained the damage that can be done through non-acceptance:

Ciaran: 'Maybe if there had been someone my dad could have spoken (with) he wouldn't have publicly disowned me and proceeded to tell anyone and everyone he meets that know me only (by my male name) that I was in fact a "girl" and my real name was (original female name), which not only put the person in an awkward position but led to more people whispering/pointing ... and posting horrible things online'.

Assistance with Documentation During/After Transition

Support with Changing Documentation

Andrew: 'When I considered changing my documentation I first asked my GP but he had no help to offer. I then researched the topic online and found several contradicting sources'.

Abigail: 'There is a huge host of practical things – changing NHS card, NI number, passport, bank accounts ... the list is endless and I still haven't got to the bottom of it'.

Like the two respondents quoted above several interviewees and survey respondents explained that the formal process of changing name and gender with a wide range of organisations had proved a time consuming and at times frustratingly complex process, which almost certainly corresponded with a time of great potential personal stress immediately prior to, during or just after a very public gender transition.

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). As has been noted within the literature review, changing documentation is an essential part of the 'real life test' unless the transgender person is to face potential daily discord between gender-related documentation and gender attribution in daily life.

When asked to rate a list of sources of advice or support in order of their importance, transgender support groups were rated as of the highest importance by over half of participants (eighteen of thirty three) regarding 'helping you to change your documentation', with just four people rating them of low importance. Gender specialists at a gender identity clinic received mixed ratings from both high to low importance, although overall, more respondents rated their input as of higher than lower importance. Perhaps surprisingly, six respondents viewed GPs as the most important source of advice and support, although the same numbers placed GPs in the highest three columns of importance as in the lowest three columns. Social and care workers received very low ratings of importance in general:

Table Twenty Six: The importance of sources of advice or support in helping to change documentation (Survey One) (n = 47: 33 respondents)

Importance of Sources of Advice and Support Regarding Legal and Personal Documentation (1=highest importance, 11=least importance)

Source of Advice or Support	1	2	3	4	5	6	7	8	9	10	11
a.Close Friends	4	1	2	0	1	2	2	0	0	3	13
b.Family Members	3	1	0	2	4	2	1	0	0	3	14
c.Colleagues at Work/Line Manager	3	2	4	1	2	1	0	1	1	2	12
d. Transgender Support Group	18	3	1	1	2	0	0	1	1	2	4
e.General Practitioner	6	4	2	1	0	1	1	2	0	1	11
f.Gender Specialist at G.I.C.	9	3	4	3	1	1	0	0	0	1	11
g.Speech Therapist	3	0	0	0	2	3	0	1	1	2	14
h.Health Visitor or District Nurse	1	0	0	0	1	1	1	1	1	2	18
i.Counsellor or Psychiatrist	4	1	4	1	1	0	1	2	0	2	12
j.Social Worker	2	0	1	0	1	1	2	0	2	3	14
k.Carer/PersonalAssistant/SupportWorker	2	0	1	0	1	1	0	0	0	5	16

(for key to colour coding, please see table sixteen above)

A three way cross tabulation indicated that respondents in both male and female gender roles were fairly equal in their rating of transgender support groups in the three highest categories for support with documentation changes. Ratings of G.I.C. and G.P. support (the other main sources of advice and support on documentation issues) were similarly fairly evenly spread between those with male or female gender roles, with a slight tendency for respondents with male gender roles and gender identities to find G.P. support more helpful on this matter.

Table twenty seven below indicates that twelve (45%) of twenty seven participants said that they would greatly value assistance from a suitably trained and experienced social worker to help them ‘to change documentation prior to, during or following a gender transition’, with two participants saying that they would value this a little. Ten (37%) participants said that they did not need such assistance:

Table Twenty Seven: The value of advice, information and support to help to change documentation prior to, during or following a gender transition (Survey Two: n = 29)

Would you value advice, information and support to help change documentation prior to, during or following a gender transition?	Number of Respondents	Percentage of Respondents
I would value this advice, information and support greatly	12	45
I would value this advice, information and support a little	2	7
I don't know how much I would value this advice, information and support	2	7
I would not value this advice, information and support very much	1	4
I would not value this advice, information and support at all	0	0
Not applicable : I do not need this advice, information and support	10	37
Total	27	100

A cross tabulation of this question with age indicated that those who would value this assistance greatly were fairly evenly spread across most age ranges. 58% of biological males (seven of twelve) and 60% of biological females (six of ten), and half of respondents currently living in a male role (five of ten) and in a female role (six of twelve), said that they would value this information either greatly or a little. Two people indicated that they valued greatly the support that they were currently receiving. Six people (22%) indicated that they have received assistance with documentation in the past from a social or care worker, four of whom valued the assistance greatly, whilst three people indicated that they had received this advice in the past from another source.

Twenty five (93%) participants indicated that they were not receiving support from a social or care worker with documentation at present, and eighteen people (67%) noted that they have not received such assistance in the past.

For some interviewees the process of documentation has proved difficult and complex:

Luke: 'Because I had no help I ended up filling out the paper work three or four times over, which made what should (have) been a quick and simple process very hard. For some things like the bank it was straightforward, (whilst changing my) passport ... wasn't. I know of a lot of trans-people who have not a clue how to get

them. I only figured it out by googling it, which, as always, brought up completely useless information as well as helpful - I just had to figure out which was which'.

Andrew: 'When I considered changing my documentation I first asked my GP but he had no help to offer. I then researched the topic online and found several contradictory sources. Eventually I changed my name through an online service and then changed my driving licence so that I could use that as proof of ID when changing all my other documentation. I did not tick a box for either female or male as I was going to ask when handing in the form which box I legally need to tick. On handing over the form at the DVLA the woman quickly glanced at me and ticked "male". I left it at that, which means I now have a driving licence with a male marker although I have not legally changed gender'.

Abigail: 'There is a huge host of practical things - changing NHS card, NI number, passport, bank accounts ... the list is endless, and I still haven't got to the bottom of it all (insurance policies are a particular nightmare) where social work guidance would be invaluable. I feel I blundered through, and continue to blunder through, a hugely complex process with all kinds of practical implications I am almost completely ignorant of!'

Two interviewees noted difficulties with the Health Board amending its records to reflect their altered gender status:

Lucy: 'My main gripe is with my local health board who are obstructive and downright rude. In inter-board communications I am referred to as a 'male patient' even now. This makes me angry. I complain, the board apologises and then just simply carries on'.

Luke: 'I have also had numerous run-ins with certain departments of the NHS ... with some refusing to call me Luke or being called Miss Luke'.

One interviewee commented:

Kay: 'The documentation side has certainly been one of the more time consuming areas of personal research and bureaucratic embroilment. Again, there has been absolutely no help or advice from G.I.C., but fortunately the practical side is something relatively easily researched on the net. Changing the DVLA and tax

office were much simpler than I thought and as soon as I called up the tax office they were wonderful with it from the start ... changing name by deed poll was also quite straightforward. The banks were a bit of a fight, as were all the utility bills companies'.

She went on to add:

Kay: 'I do sometimes wonder why on earth something ... can't be done for people transitioning: as soon as an individual makes contact with the G.I.C. 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 ... this could be done by G.I.C., social and support workers or indeed almost any organisation ... (or) a known, vetted and recommended area of chat room/forum/guidance online etc. ... I think, regarding the question of social work helping individuals understanding documentation change, that it hinges on where we draw the boundaries of what social work entails'.

Gender Recognition Certificate

Twenty seven of forty seven (57%) of 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 cross tabulation of age with applications for a gender recognition certificate, from survey one, indicated a fairly even distribution across all age groups of those participants who had applied for and received a gender recognition certificate, with a similarly even spread across all age groups for those participants who had not applied for the certificate.

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.

Table twenty eight below indicates that fifteen (55%) of twenty seven participants of survey two said that they would greatly value assistance from a suitably trained and experienced social worker to help them ‘to apply for a Gender Recognition Certificate’. Eight (30%) participants said that they did not need such assistance:

Table Twenty Eight: The value of advice, information and support to apply for a Gender Recognition Certificate (Survey Two: n = 29)

Would you value advice, information and support to help you to apply for a Gender Recognition Certificate?	Number of Respondents	Percentage of Respondents
I would value this advice, information and support greatly	15	55
I would value this advice, information and support a little	1	4
I don't know how much I would value this advice, information and support	3	11
I would not value this advice, information and support very much	0	0
I would not value this advice, information and support at all	0	0
Not applicable : I do not need this advice, information and support	8	30
Total	27	100

A cross tabulation of this question with age indicated that those who said that they would value this assistance greatly were spread across the age ranges 16 to 25 (five), 26 to 35 (one), 36 to 45 (four) and 46 to 55 (five), just as with the documentation question above (table twenty seven), although overall numbers were a little higher at fifteen. 58% of biological males (seven of twelve) and 70% of biological females (seven of ten) (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 people indicated that they valued greatly the support that they were currently receiving from a social or care worker with applying for a Gender Recognition Certificate. Two people indicated that they have received this assistance in the past from a social or care worker, each of whom valued the assistance greatly.

Twenty five (93%) respondents to survey two indicated that they were not receiving such support at present, whilst twenty four people (89%) noted that they have not received such assistance in the past.

Individual Experiences of Applying for a Gender Recognition Certificate

One survey respondent (survey two) commented that:

‘Friends offered guidance to get GRC through the shortened process. The only support from health or social care was a brief letter from a private psychiatrist and a supportive letter from (my) GP confirming change of gender was permanent - for passport application. Having said that, this was (the) key to a smooth change of documentation’.

One interviewee explained that, in regard to her gender certificate:

Kay: ‘I am still mildly in the dark but feel it is such a long way off I don't need to think about it too much. I have not even been seen by the G.I.C. yet. I have been living full time as a woman (legally and documented) ... and I think that fills one criteria. The tax office has some good links to what needs to be done for the certificate’.

Another interviewee (after describing the detailed complex process involved in obtaining a gender recognition certificate) explained what she perceived as the benefits of the G.R.C., and, in particular, a new birth certificate:

Amy: ‘My new birth certificate has helped to confirm my gender identity legally as female for all purposes which will help in so many ways such as marriage, passport application and if I use the female changing facilities of sports and leisure centres, employment where it (is) sex specific, and health services such as being placed in a female ward in hospitals and treatments (such as) breast screening ... I (have) had practical experience already (when I was) admitted to ... hospital ... for six days ... I was placed in with other female patients and treated as such. Overall I am very happy with obtaining my birth certificate as female as it is important that my legal rights are protected’.

But one interviewee noted that, for her, the need to have such documents didn't necessarily make them valid:

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'.

There are two main potential issues here: Firstly, there is the statement 'I have to live as a woman' with the implication that no transgender alternative is available. Secondly, there is the statement about the birth certificate that 'I know it is a lie'. For some transsexual people the option of a birth certificate in their transitioned gender might be very much preferred, not least because, as one respondent noted, 'it is important that my legal rights are protected'. But some transgender people feel themselves to belong to neither one gender nor the other. For them, the documentation which supports a transition may feel as much a lie as the documentation which it replaces. It is hoped that in time a true transgender option might be available to such individuals, and for those who do not feel the need for, or who do not opt for, transition.

Chapter Summary: Key Findings

In this chapter the research findings relating to support to family members and with assistance with documentation have been reviewed.

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.

Cross tabulating current gender role with support to family members about transition, indicated broadly similar ratios of family members who had received no support, for those respondents in current gender roles of male (ten of fifteen), female (fourteen of twenty one), transgender (three of seven) and 'other' (two of three).

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.

Transgender support groups were rated as of the highest importance by over half of participants (eighteen of thirty three) as a source of advice regarding helping to change documentation.

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 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.

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

A more detailed summary of the research findings covered in this chapter is included within Appendix Seven.

Chapter Six: Research Findings (Part Four)

Surveys and Interviews with Transgender People (continued)

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Introduction

This chapter presents the third and final section of the findings from the collated results of the forty seven questionnaire responses to the first survey of transgender people (survey one) and the twenty nine questionnaire responses to the second survey of transgender people (survey two), (who self-selected to participate in the surveys via the Scottish Transgender Alliance mailing list), together with responses from the ten transgender people who took part in online interviews (who self-selected to be interviewed at the end of the first survey).

In addition to the main questionnaire data from these 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. The results of these cross-tabulations are referred to throughout each of the following research findings chapters.

The seven key themes that emerged from the findings from the surveys and interviews of transgender people are once more listed below. The findings outlined within this chapter are linked to the final three of these seven key themes (highlighted in bold).

Issues relating to coming to terms with being transgender.

Support with transitional issues.

Support to family members in coming to terms with being transgender.

Assistance with documentation during/after transition.

Mental health problems linked with gender identity or gender role.

Support with long-term physical/mental ill health, disability or problems related to old age.

Post transitional and societal issues.

A summary of the main research findings discussed in this chapter can be found at Appendix Seven.

Mental Health Problems linked with Gender Identity or Gender Role

Limitations to Day to Day Activities and Social Isolation

Mind, the mental health charity, explains on its website that 'the available evidence suggests that LGBT people have a higher risk of experiencing suicidal feelings, self-harm, drug or alcohol misuse and mental health problems such as depression and anxiety' (2014). Examples of such mental health problems have been described within the literature review chapter of this thesis, but it is important to stress in this introductory paragraph that the mental health issues which form the basis of this section are those which are thought to be linked directly with issues of gender identity and gender role. Sometimes a survey respondent to this research has made it clear that in their case they believed that mental health issues and transgender were not linked:

'I am not unwell because I am transgender'.

Sometimes the link may be unclear:

'I am not sure if my bipolar disorder is linked with being trans'.

Sometimes the two seem inextricably intertwined:

'I suffer from depression and anxiety especially in public places due to being verbally and physically abused for being transgender'.

This latter comment suggests one of the main reasons why transgender people have a higher risk of experiencing suicidal feelings and mental health problems: the effects of persistent stress linked with transphobia, which, when added to the difficulties of understanding one's own transgender nature, and of finding a way forward in life, may make life at times seem unbearable. Bockting et al noted 'the daily trials of living in a transphobic society' (2006: 70), and Whittle et al evidenced the early emergence of anti-transgender attitudes when they observed that almost two thirds of young trans men and almost a half of young trans women experienced harassment or bullying at school, not just from their fellow pupils, but also from school staff, including teachers. That a transgender person's GP may be unsympathetic may also be a significant contributory factor to their self-esteem, and rejection by one's family may also have a very detrimental effect too (Whittle et al 2007: 16, 17).

It is therefore reassuring to find that of the forty two respondents to a question asking about limitations in activities because of a mental health problem linked with being transgender, thirty (71%) said that their day to day activities were not limited in this way (table twenty nine). However, eight people said that their day to day activities were limited a lot and four said that they were limited a little because of such a problem.

Table Twenty Nine: Limitations to day to day activities because of a mental health problem or disability linked with being transgender which has lasted, or is expected to last, at least twelve months (Survey One: n = 47)

Degree of Limitation By Mental Health Problem or Disability	Number of Respondents	Percentage of Respondents
My day to day activities are limited a lot by a mental health problem or disability linked with being transgender	8	19
My day to day activities are limited a little by a mental health problem or disability linked with being transgender	4	10
My day to day activities are not limited by a mental health problem or disability linked with being transgender	30	71
Total	42	100

The further comments by eleven of these survey participants are illuminating both in regard to their descriptions of these mental health problems or disabilities, and also as to what might cause or exacerbate symptoms:

‘Delayed recovery from Gender Reassignment Surgery’.

‘Depression’.

‘Depression and chronic anxiety’.

‘Have bipolar and epilepsy’.

‘I am not sure if my Bipolar disorder is linked with being trans but all the waiting around for surgeries and how we are treated by the gender clinics can make my bipolar a lot worse’.

‘I have a complex, progressive and incurable auto-immune disease which is significantly more common in intersex people’.

'I have bipolar-spectrum disorder. It is completely separate to my gender identity, but the two often interact negatively'.

'I suffer from depression and anxiety especially in public places due to being verbally and physically abused for being transgendered'.

'I'm tired ... of people's assumptions of the 'validity' of gender, full stop, of being questioned, threatened, interrupted from peeing in public toilets by anxious bangs on (the) door'.

'(I) experienced transphobia from a sibling when first identifying as LGBT and still living at home. Impacted on ability and opportunity for social interactions and the effects are still present today, though I've probably adapted or just don't fully notice some of the social activities I find difficult'.

'OCD (Contamination)/Depression'.

Cross tabulation between current gender role status and the degree to which day to day activities are limited by transgender related problems indicated that, 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 of these said their activities 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 had a male gender identity and had transitioned to a male role four and fourteen years previously, and two had 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.

Two interviewees commented on mental health issues, one from a personal perspective, and one more generally, on possible sources of assistance:

Ciaran: 'I have thought about phoning the Samaritans at times but I'm never brave enough and wouldn't know what to say'.

Sarah: ‘Practitioner/lived-experience/co-facilitation of trans-specific support will hopefully go a long way towards getting some more positive stories out there, and encourage others to seek help before their poor health escalates to the point of severity where interventions are performed, self-harm goes out of control, or a serious attempt at suicide is made - or worse still succeeds’.

The findings by McNeil et al that 70% of respondents felt that, amongst a range of ‘losses’ linked with being trans, they had lost out on family life, relationships and dating, friendships, intimacy, social life, and personal development, are important for highlighting the pervasive nature of the effects of being transgender and consequences for mental health (2012: 89). Stage of transition is also a potential factor in levels of stress, reinforced by the NHS/Glasgow University survey’s findings of ‘major psychological distress before transition’ which contrasts with a noticeable difference in wellbeing following the transition process (Wilson et al, 2005: 28/29). Similarly the S.T.A. survey of 2012 found that 70% of participants were more satisfied with their lives after transitioning (McNeil et al, 2012: 87). This latter figure fits closely with the research figure of five of the twenty one people who had already changed their gender role to match their gender identity, describing their activities as limited ‘a lot’.

It was suggested by one interviewee that a further issue, the consequences of living within a small town/rural community, without the anonymity of a larger city, and with limited access to a transgender support group or to the nearest G.I.C., might place additional stress on a transgender person:

Ciaran: ‘I live in a small town and as you can imagine everyone knows everyone else’s business so it didn’t take long before I was verbally abused for being a "freak" and even assaulted in public more than once. I would like to move away to a place where nobody knows me and I can leave the house without having panic attacks, but my family are here (the ones that haven't disowned me)’ and my angel of a fiancée/her family’.

The notion of such a ‘small town mentality’ within smaller communities was extended to the local mental health services on offer, by another interviewee:

Lucy: ‘The trouble with local services in an area like this is that (they are) staffed by folk who come from the area, which is very regressive for LGBT people. We have a

small population and a resultant small local mental health team who to a great degree reflect the inherent local prejudices’.

Living in a small town or community seems to highlight the nature of the stresses which Mind refer to in regard to LGBT (2014), and which were alluded to in the opening paragraph of this section. The effect of transphobia on mental health has been discussed at some length in the literature review, but the degree to which gender is pervasive in everyday life may also play a part in constantly highlighting a transgender person’s difficulties, particularly if they are unable to pass successfully as their preferred gender, for as Connell notes, ‘ideas about gender-appropriate behaviour are constantly being circulated, not only by legislators, but also by ... parents, teachers, advertisers...’ (2009: 5).

Support with Mental Health Problems and Social Isolation

One potential consequence of being unable to conform to gender norms may be that transgender people withdraw from a wide range of social contacts and become socially isolated. The present research indicated that eleven (41%) of twenty seven respondents would greatly value advice, information and support to help address social isolation linked with being transgender (table thirty).

Table Thirty: The value of advice, information and support to help address social isolation linked with being transgender (Survey Two: n = 29)

Would you value advice, information and support to help you to address social isolation linked with being transgender?	Number of Respondents	Percentage of Respondents
I would value this advice, information and support greatly	11	41
I would value this advice, information and support a little	5	19
I don't know how much I would value this advice, information and support	2	7
I would not value this advice, information and support very much	2	7
I would not value this advice, information and support at all	0	0
Not applicable : I do not need this advice, information and support	5	19
Not applicable : I have not experienced social isolation linked with being transgender	2	7
Total	27	100

A cross tabulation of this question with age indicated that the numbers of those who would value this assistance greatly tended to rise gradually up to the age group 46 to 55, but when those who would value this assistance a little were included, this tended to even out these age difference. Six of twelve respondents currently in a female role and three of ten respondents currently in a male role said that they would value this advice and information greatly. A three way cross tabulation indicated that each of these nine respondents had transitioned to their current roles.

When cross tabulated with biological sex, 58% of biological males (seven of twelve) and 20% of biological females (two of ten) said that they would value this information and support greatly. Including those who would value such support a little brought these numbers up to sixteen transgender individuals (60%), suggesting that social isolation may be a significant contributor to mental health issues associated with being transgender. Just two of twenty nine participants (one biological male, one 'other', in the age ranges 36 to 45 and 46 to 55) said that they had not experienced social isolation linked with being transgender, but only one person indicated that they were currently receiving support to address social isolation from a social or care worker, whilst one respondent was receiving it from another source. Five people indicated that they have received assistance from a social or care worker to address this problem in the past, and one had received it from another source, whilst two survey respondents commented:

'At present I have a support team and my gender specialist to discuss social isolation with. However it is not something I wish to discuss very often'.

'I am involved in providing services to people, including trans people, to reduce social isolation. Indirectly, this is supportive (to) me (too) even though I am not out to most people to whom I provide services'.

Twenty three (85%) participants indicated that they were not currently receiving such support, while twenty people (74%) noted that they had not received such assistance in the past.

In total therefore, 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.

The NHS/Glasgow University survey recognised that the ‘single most important health issue is the lack of appropriate mental health services for transpeople’ (Wilson et al, 2005: 28/29), so it is reassuring to find that, of those respondents to this research who had received support for mental health difficulties linked with being transgender, almost half of those who reported that they had received assistance from a counsellor or psychiatrist rated this as of the highest importance (table thirty one). This suggests a more positive experience for some transgender people with general psychiatrists than others have described (Morton, 2008: 11/18).

Table Thirty One: The importance of sources of advice or support regarding health problems or disability linked with being transgender
(Survey One: n = 47: 20 respondents).

Importance of Sources of Advice and Support Regarding Health Problem or Disability linked with Transgender Condition (1=highest importance, 11=least importance)

Source of Advice or Support	1	2	3	4	5	6	7	8	9	10	11
a.Close Friends	2	7	0	1	1	1	0	0	1	2	4
b.Family Members	5	0	2	2	0	0	3	0	2	0	5
c.Colleagues at Work/Line Manager	1	1	0	1	0	0	0	1	0	2	7
d. Transgender Support Group	5	1	2	0	2	0	0	2	0	0	3
e.General Practitioner	3	1	3	3	0	0	0	0	1	0	3
f.Gender Specialist at G.I.C.	2	1	0	1	3	1	0	1	1	0	4
g.Speech Therapist	1	0	0	2	0	0	0	0	0	0	5
h.Health Visitor or District Nurse	0	0	0	0	0	0	1	0	1	0	7
i.Counsellor or Psychiatrist	8	1	2	0	2	1	0	0	1	0	3
j.Social Worker	1	0	0	0	0	1	0	1	0	1	5
k.Carer/PersonalAssistant/SupportWorker	2	0	0	0	0	0	0	1	0	0	7

(for key to colour coding, please see table sixteen above)

Low respondent numbers (twenty of a possible forty seven) to this question are noticeable when compared with other tables in this series. Nonetheless, counsellors or psychiatrists were rated as of the highest importance by over eight of twenty respondents as a source of advice and support regarding a health problem or disability linked with being transgender, and a further cross tabulation indicates that those respondents in a male role with a male

gender identity rated this support similarly to those in a female role with a female gender identity.

Ratings of support from transgender groups were spread fairly evenly between those who were living in a male gender role, with a male gender identity, and those who were living in a female gender role with a female gender identity.

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 gender identity issues, (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.

Social and care workers received very low ratings of importance, in general.

Support with Long-Term Physical or Mental Ill health, Disability or Problems Related to Old Age

Incidence of Long-Term Physical/Mental Ill Health etc.

The potential importance and extent of long-term conditions and disabilities within transgender people appears quite significant when eighteen (38%) of forty seven respondents said that they had a mental health condition which has lasted or is expected to last at least twelve months (with at least one ‘other’ also suffering from depression) (table thirty two), and fifteen respondents (32%) said that they had a long-term illness, disease or condition. Ten respondents (21%) said that they were suffering from a range of physical conditions. These are all much higher figures than those of the Scottish Household Survey which indicates a national average of 5% who are ‘permanently sick or disabled’ (Scottish Government, 2013, Section 5).

Table Thirty Two: Long-term illnesses, diseases or conditions which have lasted, or are expected to last, at least twelve months (Survey One: n = 47)

Long-term Illness, Disease or Condition	Number of Responses
Deafness or partial hearing loss	2
Blindness or partial sight loss	0
Learning disability (for example, Down's Syndrome)	0
Learning difficulty (for example, Dyslexia)	3
Developmental disorder (for example, Asperger syndrome)	1
Physical disability	4
Mental health condition	18
Long-term illness, disease or condition	15
Problems related to old age	0
Other*	4
Total ('select all that apply') (31 respondents)	47

*Other: ‘depression’, ‘dyspraxia’, ‘chronic pain and excessive scarring’.

Twice as many biological males indicated that they have ‘long-term conditions’ compared to biological females, (although the same percentage (24%) of twenty six biological males and thirteen biological females were in this category). However, nine people in a female gender role but just one person in a male gender role, (and two each in a transgender or ‘other’ gender role), said that they had a long-term illness, while the percentage of biological females with a mental health condition (41%) was rather higher than that of

biological males (24%). Three way cross tabulation indicated that of those with a long-term condition, all of those who were currently in a male or female gender role and had the same gender identity, had transitioned to this role. While there may of course have been an overlap with mental health conditions, the research findings did not indicate what these 'long-term conditions' might have been, and whether they were related to the health inequalities which Greenwood and Gruskin found to affect transgender people, associated with 'high levels of daily stress due to stigma ... discrimination ... and transphobia' which they linked with 'high rates of smoking ... and drinking' (2007: 566/572).

Cross tabulation indicated that 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. Three way cross tabulation indicated that of those with a mental health condition, all of those who were currently in a male or female gender role and who had the same gender identity, had transitioned to this role.

Further cross tabulation indicates that 41% of biological females had mental health conditions, and that they tended to be in a younger age group (16 to 25, where the female to male ratio was 6:1 and where four respondents had mental health problems and six of the nine respondents had either changed gender or were in the process of transition). The 24% of biological males with mental health conditions tended to be in an older age group (46 to 55, where the female to male ratio was 1:9 and where five respondents had mental health conditions and nine of the eleven respondents had either changed gender or were in the process of transition). These findings suggest associations between age, gender and mental health, perhaps linked with imminent, ongoing or recently completed transition, which might usefully be explored further in future research.

Kenagy found that approximately 30% of transgender individuals had attempted suicide (2005:19). The large number of respondents who described themselves as having a mental health condition which had lasted or was expected to last at least twelve months suggests that McNeil's finding of '63% thinking about or attempting suicide ... before they transitioned' (2012: 89) may likely have had relevance to the respondents of this research. It seems that biological females may be more vulnerable at an earlier age than biological males, because of the apparent different ages of transition indicated above, and with the

additional factor of potentially longer term vulnerability to transphobia for biological males. The small numbers of respondents leave these associations rather tenuous, the notion of causality even more so, but if these associations were to be validated, they would fit with the findings of the NHS/Glasgow survey that ‘the vast majority of respondents reported major psychological stress before transition’ (Wilson et al, 2005: 28/29). It must however be stressed that these extrapolations are based on data which formed replies to a question on non-gender-identity-specific mental health issues, (the more directly linked section on mental health and gender identity appears earlier in this chapter).

Support from Family, Friends, Neighbours, Paid Carers

Table thirty three indicates that thirty four (83%) of forty one participants in survey one received no help or support for their long-term physical or mental ill health. Even allowing for the possibility of complete overlap between the eighteen people describing themselves as having a mental health condition and the fifteen people with a long-term illness, disease or condition, noted in table thirty two, at least eleven people (18 - (41 – 34): the number of people with a mental health condition etc. less those people receiving support) with one of these conditions received no support or help at all. The level of need appeared to be at least twice that of the level of support provided, apparently partially confirming the Inclusion Project’s findings that ‘mental health problems are a serious concern but (that there is) no targeted service provision’ (2003: 34).

Table Thirty Three: Help or support given by family members, friends, neighbours or paid carers because of long-term physical/mental ill health/disability or because of problems related to old age (Survey One: n = 47)

Support from family members, friends, neighbours or carers	Number of Respondents	Percentage: Respondents
No	34	82.9
Yes, 1-19 hours a week	3	7.3
Yes, 20-34 hours a week	2	4.9
Yes, 35-49 hours a week	0	0
Yes, 50 or more hours a week	2	4.9
Total	41	100

Several respondents described the nature of the help or support they received:

'I need support to eat, bathe, go in and out of my home, travel, obtain medication, get documents to the post, etc. I cannot do my own housework or shopping. I need help to get to my feet when I fall. Sometimes I need help to dress'.

'My partner or mum comes with me shopping or when I'm out in public and to any appointments'.

'My two sons help me look after house and also have to put up with my mental health problem, sometimes sitting up with me in the night on bad times'.

Of the seven people who were receiving help or support from family members etc., a cross tabulation with home circumstances indicated that four of these were living with their husband/wife/partner.

Support with Long-Term Physical or Mental Ill Health etc.

Table Thirty Four: The importance of sources of advice or support for long-term ill health, disability, or problems related to old age (Survey One: n = 47: 21 respondents)

Importance of Sources of Advice and Support Regarding Physical or Mental Ill Health, Disability, or Old Age (1=highest importance, 11=least importance)

Source of Advice or Support	1	2	3	4	5	6	7	8	9	10	11
a.Close Friends	3	5	3	0	1	0	0	0	0	2	5
b.Family Members	7	1	0	0	1	0	0	0	1	0	7
c.Colleagues at Work/Line Manager	0	1	1	0	1	0	0	0	1	0	10
d. Transgender Support Group	3	0	2	2	1	2	0	1	1	0	3
e.General Practitioner	9	1	1	0	0	2	1	0	0	1	3
f.Gender Specialist at G.I.C.	0	3	0	0	0	2	0	1	1	0	7
g.Speech Therapist	1	0	0	0	1	0	1	0	0	0	8
h.Health Visitor or District Nurse	0	0	0	0	0	0	1	0	1	0	10
i.Counsellor or Psychiatrist	7	3	1	0	1	0	1	1	1	0	3
j.Social Worker	1	0	1	0	0	1	0	1	0	1	7
k.Carer/PersonalAssistant/SupportWorker	1	1	0	1	0	0	0	1	0	0	9

(for key to colour coding, please see table sixteen above)

Once again fewer numbers than usual (twenty one of forty seven) responded to a question about the importance of sources of support summarised in table thirty four above. Results were much more mixed than in some of the responses to earlier questions, which makes for greater caution in generalising.

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.

Perhaps surprisingly, levels of family support with long-term health issues, though relatively low, were similarly rated by those in both a male and female gender role. Social and care workers received very low ratings of importance, in general.

The Effect of Transgender Status on Quality of Support Received

Some transgender respondents appeared to feel that problems with physical or mental health were either viewed through a 'transgender' perspective by their GP, or that their transgender status might affect the treatment or support they might receive.

Table thirty five indicates that while eight participants felt that their transgender status did not affect the quality of advice or support they received for long-term physical or mental ill health or problems related to old age, one felt that this was a factor whilst four participants were unsure about this (see also table thirty seven below). Two of the comments which follow provide insight into concerns about transphobia which some of the participants expressed:

Table Thirty Five: Quality of support for long-term physical or mental ill health or problems related to old age, affected by transgender status (Survey One: n = 47)

Quality of Support Affected by Your Transgender Status?	Number of Respondents
Yes	1
No	8
Not Sure	4
Total	13

Please give details :

‘I would like to bring in an outside carer to make things easier for my partner but I am afraid of being confronted by prejudice in a situation in which I am extremely vulnerable’.

‘Very possibly it was the other way round - my treatment as a gender dysphoric person was affected by my other medical conditions’.

‘Local mental health services by their own admittance know little about transgender issues and try and avoid you’.

One interviewee commented more fully on how being transgender might affect health care:

Luke: ‘I have had illnesses that anyone could get, yet it has been turned into a massive fiasco because I am transgender and find accessing health care very difficult. Someone to help balance out what I should and shouldn't be talking to my doctor about would be helpful, because for the most part I don't, other than to refill prescriptions. And someone to reassure (me) that no, I am not unwell because I am transgender’.

Support Provided by Trans-People to Family, Friends etc.

It is also important to note that, amongst what may seem at times like a plethora of concerns about transgender issues, six respondents said that they provide or have provided up to nineteen hours weekly of unpaid help or support to others (table thirty six)

which included quite general support, end of life care, and support to other transgender people.

Table Thirty Six: Unpaid help or support given to family members, friends, neighbours or others because of their long-term physical or mental ill health, disability or problems related to old age (Survey One: n = 47)

Do you provide unpaid help or support to others?	Number of Respondents	Percentage of Respondents
No	30	83
Yes, 1-19 hours a week	6	17
Yes, 20-34 hours a week	0	0
Yes, 35-49 hours a week	0	0
Yes, 50 or more hours a week	0	0
Total	36	100

Several respondents added explanatory comments:

‘I don't, but I previously cared full time for (a partner) during a decade-long illness’.

‘Not now - looked after Mum till she died’.

‘Phone calls twice a day, shopping, visits twice a week, hospital visits, dealing with their business affairs’

‘One to one support in listening and explaining the Gender Reassignment process, likely obstacles and time scale’.

This final comment suggests that at least some of the unpaid help or support was given to other transgender people. Cross tabulations of age and biological sex with giving unpaid help or support to family members, friends etc. indicated that of the six participants who provided such help, three were in the age group 46 to 55 and the other three were in the age group 56 to 65, and while all were biological male, five were living currently in a female role, and one was living in an ‘other’ role.

Armand Hotimsky (2009) noted that some transsexual children are chosen by their dying parent to care for them at the time of their final illness: Hotimsky suggested that this new role of care giver may mark a rite of passage (for MtF transgender people) from one gender to another, and that experiences of loss might even enable families to reconnect and

reconfigure, as a death may necessitate the opportunity for a full coming out with distant members of the family for the first time.

On the other hand, Kenagy and Hsieh found that FtM transgender people were significantly more likely to revert to a traditional female caring role by seeking social care help with parenting skills, family planning and child care, even though 68% of those who reported needing child care were not parents themselves. They hypothesised that 'perhaps many of the FtM's ... were socialized as female during childhood and learned that parenting and caring for children were part of their primary responsibilities' (2005: 18).

That these carers will in time become cared for, is largely absent from the literature of transgender social care. Even Fullmer's chapter on LGBT ageing (within Morrow and Messinger, 2006) mainly does so within a discussion of issues from a lesbian and gay perspective although it is noted that 'transgender people are often denied the opportunity to be gainfully employed in their youth, and they suffer the financial consequences of that later in life (2006: 293). She bases this on an article by Donovan which also 'chronicles the abuses and neglect within the medical establishment as one attempts to get assistance for psychological and physical ailments ... and ... shows how crucial LGBT organizations and support groups can be to transgender survival' (2001: 19).

The present research did not receive responses from elderly transgender people, but, as well as social care needs linked with the ageing process, three of the issues which are likely to also be of importance to older transgender people include finding empathetic and sensitive carers (see the section on self-directed support in the discussion chapter), an increasing sense of isolation perhaps linked with limited social networks (see Addis et al 2009) and what Lombardi and Davis call 'coming out as a lifetime task' (2006: 359), for the care of the elderly may involve an erosion of privacy, exposing the transitioned older person to wider scrutiny of their transgender status than they may have experienced during most of their adult life, except during periods of illness, hospitalisation or convalescence.

Support Received from Social Care Services etc.

Table thirty seven indicates that 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:

Table Thirty Seven: Advice or support or other input relating to Social Care Services (Survey One n = 47)

Social Care Service Advice or Support Received	Number of Responses
Addiction to alcohol, tobacco or drugs	2
Criminal Justice, including diversion, supervised attendance, community service and/or probation	0
Residential care or nursing care	0
Accommodation issues, including care at home, supported housing and housing support	1
Welfare benefits and homelessness advice	7
Support related to mental illness, physical or learning disability, domestic or societal abuse	11
Support to yourself (including short breaks) for care given by you to others	1
Other*	4
Total (select all that apply) (19 respondents)	26

*Other comments included:

‘CBT to deal with confidence issues of ability at work to do my specific role’.

‘My GP told me ‘there’s no hurry’ (from my ‘breakdown’) ... I was manifesting suicidal, and agitated ... about signing for sickness benefit ... I thought they would hassle me ... and, therefore (my G.P.) gave me space to live’.

‘Sought social work help when at F.E. college due to psychologically unsafe home environment (transphobia from sibling, worsened when drinking alcohol), but was (offered shared) accommodation options that would not have been possible for me, as a trans-person, to make use of’.

A three way cross tabulation indicated that of those receiving social care support, all of those who were currently in a male or female gender role and who had the same gender identity had transitioned to this role. In addition, five people were living in either a transgender role (four) or an ‘other’ role (one). The eleventh respondent did not indicate their current gender status.

Table thirty eight indicates that although nine participants felt that their transgender status did not affect the quality of social care services they received, five felt that this was a factor

(a higher figure than in table thirty five above), whilst a further five participants were unsure about this.

Table Thirty Eight: Quality of social care support affected by gender identity, or gender/transgender status (if applicable) (Survey One: n = 47)

Quality of Social Care Service Affected by Your Gender Identity or Transgender Status?	Number of Respondents	Percentage of Respondents
Yes	5	18
No	9	32
Not Sure	5	18
Not applicable: I am not receiving any of the types of Social Care support within any of the service areas described	9	32
Total	28	100

As nine of the respondents were not receiving social care, these respondents accounted for over half (ten of nineteen) service users, which may illuminate the concerns expressed by several service users about the ability of care and support services to meet the needs of transgender people, leading to, in the case of one survey respondent, an alternative pragmatic solution:

‘Because contact was limited I found it simpler to hide my gender circumstances’

These underlying concerns suggest that for some transgender people at least there is a need for providers of social care to demonstrate their knowledge and experience of transgender concerns and their empathy, awareness and stance on transgender issues if they are to fully gain the trust of transgender service users.

Table Thirty Nine: Sources of care and support at home, to enable more independent living (Survey One: n = 47)

Source of Care And Support at Home	Number of Respondents
Through family and/or friends	6
Through staff employed by a Local Authority Social Work Department	1
Through staff employed by an Independent or Voluntary provider of care and support in the home	3
Through staff employed by yourself through a self-directed support scheme	0
Total	10

Table thirty nine indicates that ten participants received care and support at home, usually provided by family and/or friends or through a private or voluntary provider of care.

A cross tabulation of age with care and support received at home, indicated that of the six people who had care provided for them by family and/or friends, three were young people aged 16 to 25.

Post-Transitional and Societal Issues

Post Gender Identity Clinic Support

The need for support during the period after transition when G.I.C. support is no longer available, was a subject initially raised in the pilot study focus group. Billings and Urban perhaps pre-empt the likelihood of post-transition difficulties when they note Hastings quote (1974: 337) that ‘rarely does such a patient initiate a realistic discussion about the obvious problems that follow surgery: legal, social, economic and emotional’ (1996: 107). It is possible however that in the intervening forty years such apparent naivety has been replaced in the minds of many transgender people with at least some recognition of the possible difficulties which they may encounter: the results from this research indicate that between a third and a half of respondents would value support in, for example, making plans for the future, in undertaking a transition, or in amending documentation. Similarly thirteen of thirty three respondents said that they would greatly value the support of a suitably qualified social worker because they were no longer receiving G.I.C. input, with a further seven saying that they would value such support a little – in total almost two thirds of respondents (table forty). Just two participants said that they would not value this support at all:

Table Forty: The value of advice, information and support if no longer receiving support/advice with transgender issues from a Gender Identity Clinic (Survey One: n = 47)

Would you value the support of a Social Worker on transgender issues if no longer receiving support and advice from G.I.C.?	Number of Respondents	Percentage of Respondents
I would value this support greatly	13	40
I would value this support a little	7	21
I don't know if I would value this support	4	12
I would not value this support very much	2	6
I would not value this support at all	2	6
Not applicable: I am still receiving support and advice with transgender issues from a Gender Identity Clinic	5	15
Total	33	100

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), clearly indicating that the need for support was, for most, no longer centred around transitional issues and the transition period.

Support during transitioning was only relevant to a minority of these respondents (nine of forty seven respondents (19%) to survey one, spread across most age ranges, were currently transitioning and just five of the respondents listed in table forty were currently receiving G.I.C. support), so the high percentages of those who would value additional support in the absence of G.I.C. support appears significant. However, the post-transition needs of transgender people receive scant attention in the literature of social care practice. Mallon (2009), Brown and Rounsley (2003), Brill and Pepper (2008) each mainly include detailed consideration of the issues affecting transition, with little reference to the longer term. Morrow and Messinger include a chapter on transgender health issues by Lombardi and Davis but only towards the end of this chapter is there a brief chapter on 'integration' which includes the suggestion that 'common adjustment challenges in the post-transition period include forming intimate relationships ... self-acceptance as a non-traditional man or woman ... and coping with stigma in society' (2006: 359).

The 'self-acceptance' process, whilst perhaps more evident pre-transition, may be a long-term task for some transgender people, particularly those who do not fully self-identify with or who are not readily perceived as belonging to one of the binary gender categories.

'Coping with stigma' is addressed within several other sections of these research findings chapters, including those relating to social rejection and abuse, social isolation, addressing differences, disagreements or conflicts with family, friends, colleagues and neighbours, and developing a more confident community presence.

The notion of 'intimate relationships' is further explored by Lombardi and Davis within a paragraph on sexual orientation (2006: 358). They note that 'transsexuals span the full range of sexual orientations ... and ... may experience an unexpected change in their sexual orientation during the transition process. They suggest that, as 'sexual orientation depends largely on a stable gender identity (post-transition transsexuals) may need to explore their new sexual orientation and examine the impact it may have on their relationships'. Hines suggests that 'experiences of gender transition may enable an increased freedom of sexual expression, and offer a greater diversity of sexual identification' (2007: 125).

Support with Social Rejection and/or Abuse

The Scottish Transgender Alliance survey of 2007 indicated that transgender people report that they are regularly concerned about harassment through abusive and transphobic behaviours (Morton, 2008). In response to a further question included within survey two, twelve respondents said that they would highly value the advice of a social worker to address the consequences of societal rejection and/or abuse linked with being transgender, with a further four saying that they would value this a little (table forty one). Just two of the twenty seven respondents said that they had not experienced social rejection/abuse linked with being transgender (one aged 36 to 45, and one in the age range 46 to 55).

Table Forty One: The value of advice, information and support to help to address the consequences of social rejection and/or abuse linked with being transgender (Survey Two: n = 29)

Would you value advice, information and support to help you to address rejection/abuse linked with being transgender?	Number of Respondents	Percentage of Respondents
I would value this advice, information and support greatly	12	45
I would value this advice, information and support a little	4	15
I don't know how much I would value this advice, information and support	3	11
I would not value this advice, information and support very much	0	0
I would not value this advice, information and support at all	0	0
Not applicable : I do not need this advice, information and support	6	22
Not applicable : I have not experienced social rejection/abuse linked with being transgender	2	7
Total	27	100

A cross tabulation of this question with age indicated that the numbers of those who would value this assistance greatly tended to rise gradually with age, up to the age group 46 to 55, but when those who would value this assistance a little were included, this evened out these age differences almost completely.

Seven of twelve (58%) of biological males but only two of ten (20%) biological females said that they would value support with social rejection highly, but once again including those

who would value this assistance a little reduced this difference considerably, to eight (66%) and five (50%) respectively.

A further three way cross tabulation indicated that three respondents currently living in a male gender role, seven in a female gender role (each of whom described themselves as having the same gender identity) one in a transgender role, and one in an 'other' role said that they would value such advice greatly. Two further male role respondents and two further 'other' respondents said they would value such support a little. 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 indicated that they were currently receiving such support from a social or care worker while three people indicated that they have received this assistance in the past from a social or care worker.

Twenty six (96%) participants indicated that they were not receiving such support at present, while twenty three people (85%) noted that they have not received such assistance in the past. One person commented:

'I would have valued this greatly, if it had been available to me as a teenager'

One interviewee graphically described rejection and abuse in her home town:

Lucy: '(My home town) in 19xx was not a welcoming place for transsexuals. I was spat at, beaten up, refused service in shops (including M&S) because of my gender change, humiliated in public, had excrement pushed through my letterbox. I soon learned not to ask the police for help; they on one occasion stood by and watched me get beaten. When injured in such cases I soon learnt to avoid the local A&E who were quite judgemental and made it quite plain that if I lived as I did what else could I expect. My GP however was excellent and very supportive ... my present GP is excellent ... she admits she knows very little about the trans scene but always asks sensible questions and asks for references'.

Mitchell and Howarth in their trans-research review reported that 'health and social care issues included isolation' (2009: 62), and the discussion of the research findings above, within the section on mental health and gender identity issues, suggests that social isolation may be a significant contributor to mental ill health for those who are

transgender. Yet almost all (96.3%) of the twenty seven respondents to survey two were not receiving any support for mental health issues. Just one person was currently receiving support from a social/care worker, and three people had received this assistance in the past. Sixteen (59%) of twenty seven respondents in the present research said that they would value advice, information and support to address social isolation either greatly (eleven) or a little (five) (table thirty).

The effects of social isolation may be as pervasive as the effects of transphobia, and the most significant effect of intermittent transphobic incidents may be the increasing reclusion of the transgender person:

Ciaran: 'I would love to be out working again but the anxiety I feel about even leaving the house some days overwhelms me.'

Each of the handbooks on social care to transgender people explores the issue of social isolation in some detail, particularly in relation to youth and adolescents. Davis suggests that 'social isolation may be considered one of the most significant and dangerous aspects of a trans identity ... identification with one's cultural group is a significant component in the development of an individual's self-concept ... (and yet) ... positive trans role models are rare ... when trans people do appear in the media it is often in a pejorative sense ... as sex-workers, freaks, self-mutilators' (2009: 16). Indeed, McNeil et al found that '51% of respondents felt that the way trans people were represented in the media had a negative effect on their emotional wellbeing' (2012: 90).

One interviewee commented on the role of the media in the public perception of transgender people:

Lucy: 'The media, well they take one step forward and then two back. They could be part of the solution but at the same time they are part of the problem. Some papers in particular treat transsexuals as a commodity - I've been door stepped by the national press. Did they want to hear about my politics? – no. My sex life? - yes. A long way to go...'

In a review of 'cross dressing, sex-changing and the press' King explores the range of media reports which may indeed 'influence self-identification and understanding and provide practical information. King suggests press interest is high in

transvestite and transgender matters because they question the natural 'fit' of sex, gender and gender appearance, so that 'the general public may be misled or misinformed but it may also be educated and enlightened'. Such exposure is however 'is a double-edged sword ... (for) ... 'individual transvestites and transsexuals may be damaged by the exposure they receive' (1996b: 133/150).

And indeed transphobic press coverage continues – an article published in the Observer in January 2013, included the description of transsexuals as 'a bunch of bed-wetters in bad wigs' (Burchill, 2013).

Just two months later, in March 2013 a brief report in the Independent, related news of the death of Lucy Meadows, a primary school teacher from Accrington, who had transitioned over the Christmas period before returning to work in January. She had been 'outed' by both the local press and in particular by the Daily Mail, for whom Richard Littlejohn had written an article entitled 'he's not only in the wrong body – he's in the wrong job' (later withdrawn). Ms Meadows had contacted the Press Complaints Commission to seek action to stop press camping outside her house and school. An inquest later confirmed that she had taken her own life (Brown, 2013).

Support with Transgender Linked Relationship Difficulties with Friends

Sarah: 'The real losses I experienced in transition were of friendships either immediately upon discovery of my transitioning, or after a little while without much explanation'.

The importance of friends and friendships is mentioned throughout this thesis, both within the literature review and the research findings, but there is often a sense of duality about the nature of friendship for the transgender person, which is evident for example in the finding that although almost a third (twelve of forty) of respondents rated close friends as of the highest importance as a source of advice regarding 'helping you to come to terms with your gender identity' almost as many (eleven) rated them as of lowest importance (table sixteen). However, the total number of friends rated as in the highest three columns of importance was double the total of those in the lowest three columns. Similarly an analysis of the importance of friendships in support during a transition (table twenty), showed that almost twice as many friends were rated in the three columns of highest

importance as in the three columns of lowest importance. It seems that, if close friendships are in place prior to coming out or transition, (which was not clear from the research findings), rather more of these friendships may survive the difficulties of gender identity conflict and transition than founder.

However, table forty two below indicates that seven (26%) of twenty seven participants said that they would greatly value assistance from a suitably trained and experienced social worker to help them with relationship difficulties with their friends linked with being transgender, with a further five participants saying that they would value this a little. Eight (30%) participants said that they did not need such assistance, whilst two participants said that they have not experienced such difficulties:

Table Forty Two: The value of advice, information and support to help to better understand and/or address differences, disagreements or conflicts with friends, concerning being transgender and/or the consequences of transitioning (Survey Two: n = 29)

Would you value advice, information and support to help you to better understand and/or address differences with friends?	Number of Respondents	Percentage of Respondents
I would value this advice, information and support greatly	7	26
I would value this advice, information and support a little	5	19
I don't know how much I would value this advice, information and support	3	11
I would not value this advice, information and support very much	2	7
I would not value this advice, information and support at all	0	0
Not applicable : I do not need this advice, information and support	8	30
Not applicable : I have not experienced such differences, disagreements or conflicts with friends linked with being transgender, or transitioning	2	7
Total	27	100

A cross tabulation of this question with age indicated that the numbers of those who would value such assistance greatly tended to rise gradually with age, up to the age group 46 to 55, but once again when those who would value this assistance a little were included, this tended to even out these age differences almost completely. 42% (five of twelve) of

biological males but only 10% (one of ten) biological females said that they would value support with difficulties with friends greatly, which might appear to fit with the suggestion of the NHS/Glasgow survey that 'problems with friendships seem to be greater for MtF respondents than FtM participants' (Wilson et al, 2005: 27). However, including those who would value this support a little altered these figures to 50% (six of twelve) and 40% (four of ten) respectively. Further three way cross tabulation with current gender role indicated that two respondents in a male gender role, four in a female role (each of whom described themselves as having the same gender identity as their gender role) and one in a transgender role, said that they would value such support greatly. These numbers increased to five (male role), five (female role), one (transgender) and one 'other' when those who would value such support a little were included.

89% of respondents were currently receiving no support with friendships. Just two of the twenty seven respondents said that they had not experienced such differences or disagreements with friends.

One person indicated that they were currently receiving such support from a social or care worker and one participant indicated that they were receiving this assistance from another source. Four people indicated that they have received this assistance in the past, three from a social or care worker and one from another source.

Twenty four (89%) participants indicated that they were not receiving such support at present and twenty two people (81.5%) noted that they have not received such assistance in the past.

Support with Transgender Linked Relationship Difficulties with Colleagues, Neighbours etc.

The NHS/Glasgow University survey found that 'most respondents had experienced verbal aggression (and) threats (and that) there were also many reports of physical aggression' committed by acquaintances, neighbours and strangers' (Wilson et al, 2005: 27/29). On an everyday level, as Brill and Pepper note in regard to transgender children, 'everyone tends to worry about what the neighbours think' suggesting that 'it is up to you to decide whether to tell them and how much information to share. Gossip will spread regardless, as it does in every neighbourhood, about everyone' (2008: 140/141). Such advice perhaps applies to transgender people of all ages.

Sharing information is a process which requires some consideration: whether a transgender person starts living in the opposite gender on a chosen date, without letting others around them know, or whether they take the time to share this information in advance, may significantly affect how some others respond. As one parent quoted in Brill and Pepper explains:

‘I started with my most trusted and deepest friends. I eventually sent an announcement letter to our neighbours. Most people have been wonderfully supportive. It’s been nearly nine months now, and I have adopted the attitude that if I treat this with shame or embarrassment, I am perpetuating the problem that we have in society’ (2008: 139).

Not all the interviewees in this survey had been so well supported, resulting in gossip spreading, fuelled by information from next of kin:

Ciaran: ‘Maybe if there had been someone my dad could have spoken (with) he wouldn’t have publicly disowned me (...which...) led to more people whispering/pointing, knowing my business and posting horrible things online’.

In relation to workplace colleagues, Brown and Rounsley note that ‘some co-workers are uncomfortable, resistant or even openly hostile ... When transsexuals are excluded from meetings and are no longer invited to join their fellow employees for lunch or for social gatherings, it obviously takes an emotional toll’. But they also include examples of supportive written messages from the colleagues of transgender people at the time of transitioning too and note that one ‘significant, long-lasting effect of transitioning is that transsexuals are often more productive ... because they no longer have to struggle under the ... burden of gender dysphoria’ (2003: 156/158, 163/166). Schilt’s study of transmen provides a fascinating insight into the ‘patriarchal dividend’ which many of her respondents found themselves receiving as men, including ‘more authority, reward and respect in the workplace than they would have received as women, even when they remain in the same job’ (2006: 465). Her later study of transwomen is quoted by Jeffreys who notes that ‘men who transition lose money, through ‘significant losses in hourly earnings’ (Schilt and Wiswall, 2008 : 4, cited in Jeffreys, 2014: 111)

Table forty three below indicates that ten (37%) of twenty seven participants said that they would greatly value assistance from a suitably trained and experienced social worker to

help them with relationship difficulties with their colleagues, neighbours and/or acquaintances, linked with being transgender, with a further four participants saying that they would value this a little. Seven (25.9%) participants said that they did not need such assistance, while three participants said that they have not experienced such difficulties:

Table Forty Three: The value of advice, information and support to better understand and/or address differences, disagreements or conflicts within relationships with colleagues, neighbours and/or acquaintances, concerning being transgender and/or the consequences of transitioning (Survey Two: n = 29)

Would you value advice, information and support to help you to address differences with colleagues, neighbours etc.?	Number of Respondents	Percentage of Respondents
I would value this advice, information and support greatly	10	37
I would value this advice, information and support a little	4	15
I don't know how much I would value this advice, information and support	2	7
I would not value this advice, information and support very much	1	4
I would not value this advice, information and support at all	0	0
Not applicable : I do not need this advice, information and support	7	26
Not applicable : I have not experienced such differences, disagreements or conflicts with colleagues, neighbours or acquaintances, linked with being transgender, or transitioning	3	11
Total	27	100

A cross tabulation of this question with age indicated that the numbers of those who would value this assistance greatly, tended to rise gradually with age up to the age group 46 to 55, but once again when those who would value this assistance a little were included, this tended to even out these age differences almost completely. Similarly, the numbers of biological males (50%: six of twelve) and biological females (20%: two of ten) who would value this information greatly were quite different but including those who would value this assistance a little reduced this difference considerably, increasing the percentages to 58% (seven of twelve biological males) and 50% (five of ten biological females) respectively. A further three way cross tabulation indicated that four respondents currently living in a male gender role (two of whom also described their gender identity as male), five in a female gender role (all of whom described their gender identity as female) and one in a transgender role, said that they would value such advice greatly, whilst two further ‘male

role' respondents and two further 'other' respondents said they would value such support a little.

Two people indicated that they were currently receiving such support from a social or care worker whilst four people indicated that they had received this assistance from a social or care worker in the past, two of whom valued the assistance greatly.

Twenty five (93%) participants indicated that they were not receiving such support at present and twenty three people (85%) said that they have not received such assistance in the past.

Support with Developing a More Confident Community Presence

Transgender people may be at their most vulnerable within the community when they first venture out within their preferred gender role. As Brown and Rounsley explain 'these are the times when they are least likely to pass, as most transsexuals will have just begun taking hormones and ... still exhibit many of the contours and features of their original gender' (2003: 135). G.I.C. support may be limited and whilst some specialist health services (e.g. speech therapy) may assist with aspects of self-presentation, for at least some transgender people, appearing in public for the first time during transition is likely to be a very great step.

However, even for the most practiced transitioned transgender person, particularly those who do not 'pass' easily, going out into the local or wider community may continue to involve 'being read' long after the transition period 'for many transsexuals it is a daily concern' (Brown and Rounsley, 2003: 135). For some this may involve a long-term aim of being increasingly accepted within one of the binary genders, without ambiguity. For others it may lead to a gradual acceptance of, or resignation to, a lifelong transgender status.

Table forty four below indicates that twelve (44%) of twenty seven participants said that they would greatly value assistance from a suitably trained and experienced social worker to help them with developing a more confident community presence, with a further three participants saying that they would value this a little. Eight (30%) participants said that they did not need such assistance:

Table Forty Four: The value of advice, information and support to help to develop a more confident community presence (Survey Two: n = 29)

Would you value advice, information and support to help you to develop a more confident community presence?	Number of Respondents	Percentage of Respondents
I would value this advice, information and support greatly	12	44
I would value this advice, information and support a little	3	11
I don't know how much I would value this advice, information and support	2	7
I would not value this advice, information and support very much	1	4
I would not value this advice, information and support at all	1	4
Not applicable : I do not need this advice, information and support	8	30
Total	27	100

A cross tabulation of this question with age once again indicated that the numbers of those who would value assistance with developing a more confident community presence greatly, tended to rise steadily with age, up to the age group 46 to 55, but when those who would value this assistance a little were included, this tended to even out these age differences. The numbers of biological males (66%: eight of twelve) and biological females (20%: two of ten) who would value this information greatly were quite different. Including those who would value this assistance a little, altered these percentages to 66% and 40% respectively (the ratio of biological males to biological females was 4:3 for this survey). A further three way cross tabulation indicated that three respondents currently living in a male gender role (two of whom also described their gender identity as male), six in a female gender role (all of whom described their gender identity as female), two in a transgender role, and one in an 'other' role, said that they would value such advice greatly, whilst two further male role respondents and one further 'other' respondent said they would value such support a little.

In some cases this lack of a confident community presence appeared to be severely debilitating, but just one person indicated that they were currently receiving such support from a social or care worker, one participant indicated that they were also receiving this assistance at present but from another source, and two people indicated that they have received this assistance from a social or care worker in the past.

Twenty five (93%) participants indicated that they were not receiving such support at present and the same number, twenty five (93%), noted that they have not received such assistance in the past.

Interviewee comments ranged from their individual community presence to the status of transgender people in society:

Amy: 'I do not like be perceived as a transsexual by society. I did not go through the slow processes of transitioning to become a transsexual ... the only issue I think of (that a social worker) could help me with is having loving relationships with males. I must confess that I am frightened about a relationship in case they get violent with me if I tell them that I'm a transwoman. Also being rejected would hurt me'.

Ciaran: 'I would love to be out working again but the anxiety I feel about even leaving the house some days overwhelms me and I sometimes worry about the future children we don't yet have, finding out about me and getting teased. As I have said before I would like to move away and start somewhere fresh but for various reasons this is not a viable option ... Being able to discuss our future with regards to starting a family would be very helpful. I had the choice of freezing eggs but a combination of being keen to start the hormones and the invasive nature of the procedure made me decline the offer which I'm not quite sure if I regret or not'.

The notion of community presence has been highlighted by Browne et al (2010), who question 'geography's presumption of man/woman and male/female' (2010: 573). However, Jeffrey's argument against what she perceives as the intrusion of MtF transgender people into women's spaces (including not just social events but toilets, hospital wards and prisons) suggests that transitioning may present unforeseen difficulties, and limited scope for integration and the resolution of gender related conflicts at the present time (2014: 163/182). It is not difficult to comprehend the anxiety expressed by some transgender people when they venture out into the local or wider community, given the degree to which the effects of transphobia have been documented (see, for example, Whittle (2000), Hill and Willoughby (2005), Bockting et al (2006), Whittle, et al (2007), Stryker and Whittle (2006), Bromley et al (2007), Greenwood and Gruskin (2007), Meyer (2007), Morton (2008), Mitchell and Howarth (2009), Turner et al (2009), Kennedy and Hellen (2010), Roch et al (2010), and McNeil et al (2012).

Billings and Urban (quite astonishingly, in view of evidence to the contrary of the success of many transitions, to the satisfaction of most individuals (see the follow up studies in Appendix Six)) argue that the anxieties and difficulties that many transgender people experience in seeking to be a part of the local or wider community suggest (1996: 114) 'that Meyer and Hoopes were correct when they wrote that,

'in a thousand subtle ways the reassignee has the bitter experience that he (sic) is not – and never will be – a real girl, but is, at best a convincing simulated female. Such an adjustment cannot compensate for the tragedy of having lost all chance to be male, and of having in the final analysis, no way to be really female (1974: 450)'.

Such a perspective on 'tragedy', of 'having lost all chance to be male', and what it means to be 'really female' simply does not fit with much of the evidence from this research, which supports the viewpoint that transgender people almost without exception do not relate or feel a sense of belonging to the gender role which corresponds with their biological sex, because of gender dysphoria. Nonetheless the research findings reflect many of the difficulties and disappointments which transgender people encounter in understanding themselves as individuals and in undertaking a fraught and complex personal journey of transition. Despite the complexities of finding a valued niche within an, at times at least, antipathetic and sometimes downright hostile world, there is very little evidence of serious regret at decisions taken, or of major disappointment with the outcomes of a life which few would wish to emulate (for further discussion of Follow Up Studies see also Appendix Six).

That being accepted, and feeling part of a community, part of a family, or part of a relationship may be continually evolving for some transgender people whose sense of ambiguity does not easily fit within the binary, is neatly summarised within the following quote, which perhaps aptly bring these four chapters of research findings to an apt conclusion:

Abigail: 'I should also say that living as a female is very important to me, and very liberating too, and has healed the appalling feeling I used to have that I didn't somehow really belong to the human race. Recently my daughter had some wonderful news to give me. She said: "Dad, you're going to be a grandma!" which kind of sums up, very beautifully, how I would like my family to feel about it all. And they mostly do'.

Chapter Summary: Key Findings

In this chapter the research findings relating to transgender linked mental health problems, support with long-term disabilities, and post transitional issues have been reviewed.

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 a mental health problem or disability linked with being transgender. Counsellors or psychiatrists were rated as of the highest importance by over a third of these respondents (eight of twenty) as a source of advice and support for this.

Eighteen of forty seven (37%) of 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.

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.

Twelve of twenty seven respondents to survey two said that they would value support from a social or care worker greatly (seven) or a little (five) to address differences or disagreements with friends.

Fourteen of twenty seven respondents to survey two said that they would value support greatly (ten) or a little (four) to address transgender related differences /disagreements with neighbours, colleagues etc.

Fifteen of twenty seven respondents to survey two said that they would value support greatly (twelve) or a little (three) to establish a more confident community presence.

A more detailed summary of the research findings covered in this chapter is included within Appendix Seven.

Chapter Seven: Discussion

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Introduction

In this chapter some of the most important research findings which were laid out within the four previous chapters are highlighted within the context of key issues arising from the three research questions which underpin the research.

Whilst almost all of the research findings have already been explored within the previous chapters, some additional quotes from interviewees are included within this discussion chapter where they highlight and develop themes raised within the main body of the research (six annotated interviews and linked survey responses can be found at Appendix Five).

The chapter begins by re-considering the design and methodology of the research, in the light of its implication, setting the scene for the discussion which follows. This is followed by a section which explores how the research findings shed light on the concepts of sex and gender discussed within the literature review.

Each of the main sections of this discussion chapter explores the research findings within the context of each of the three research questions. They each include a discussion of potential future social care service development and additional support to transgender people highlighted by the research, to fill gaps in service provision, thereby completing the process of answering each of the research questions.

The chapter ends with a proposal, based around the concept of such support, for the 'socializing' of transgender.

Review of the Design and Methodology of the Research

The methodology chapter laid out the process by which the research questions developed, as well as the ontology and epistemology which underpinned the subsequent mixed methods research. While the description of the development of the research process may appear to indicate a seeming inevitability about the way it evolved, this is really only fully apparent in retrospect. Several decisions were made during the research process itself which at the time were far from simple. For example, the decision to omit focus groups required careful analysis and reconsideration of the most effective methods for undertaking the research, following the experience of the pilot study, in order to best answer the research questions, particularly in the light of Gibbs' comment that 'focus groups can help to explore or generate hypothesis ... and develop questions or concepts for questionnaires' (1997: 2). Retention of focus groups may have provided a series of exploratory discussions which might also have resulted in a range of ideas for future social care services, but the preferred alternative of individual online asynchronous interviews resulted in a level of personal sharing of ideas and experiences which, I believe, form one of the major strengths of this research.

Similarly the decision to implement a second questionnaire for transgender people had to be carefully thought through, balancing the additional work that this would bring to a necessarily time limited research period, with the implications for writing and distributing an additional questionnaire, and collating, analyzing and considering the data within a synthesis of the results from the other two questionnaires, and the nineteen interviews. Omitting this second questionnaire to transgender people would have streamlined the research process and allowed for data to be reported on much earlier, but would have resulted in the loss of important factual information about the different numbers of transgender people who were using, had used, or would like to use social care advice and support, and who valued such support, across a range of issues. This data was not clarified within the first questionnaire partially because of, in hindsight, mistakenly combining these aspects within single questions, in an attempt to reduce the survey length, and because some of the themes were not apparent until after the analysis of the data from the first questionnaire responses and the interviews.

Limitations in statutory and voluntary responses have inevitably meant that an extensive overview was not possible of dedicated/specialist services that were made available to or received by transgender people across Scotland, resulting in more of a patchwork of knowledge, ideas and experiences than might have been possible if as complete a picture of those services that are available at present had been sought, but this would almost certainly have meant the pragmatic omission of the research into transgender people's own experiences of such services.

The mailing list of the voluntary organisation, the Scottish Transgender Alliance, formed the sampling frame for the Scottish transgender population, through which individuals self-selected to participate in the research. The transgender research participants themselves consisted in the main of transitioning 'migrators', with only a small number of 'oscillators' and 'transcenders' taking part, and with no apparent representatives of Ekins and Kings' (2006) 'negator' category. It is difficult to conceive of how these minorities within a minority might have been better represented within the sampling system adopted. It seems unlikely that the most obvious alternative sampling frame, of seeking participation from transgender people who were currently attending Gender Identity Clinics in Scotland, or who had used these in the past, would have improved these minorities' involvement. Nonetheless the number of participants who identified with non-binary identities was evidence of the importance of transcending and gender-queer categories to some participants.

Attribute data for the respondents to surveys one and two indicate a wide span of ages (table ten), home circumstances (table eleven), employment status (table twelve), gender identities (table thirteen) and gender descriptors (table fourteen), suggesting a broad range of participants, although the ideas and comments of young and elderly transgender people and their support services are missing from the research. Their participation would have provided valuable insights and knowledge into the experiences of two age groups at different polarities in their transgender experience. In retrospect, positive action to ensure that services to young transgender people were contacted directly, rather than relying on the Scottish Transgender Alliance's mailing list, might have led to more extensive service and user perspectives. However, it is difficult to see how the involvement of older transgender people could have been facilitated without perhaps reconsidering the use of

internet surveys, for, as the most recent Scottish Household Survey has since indicated, internet usage declines 'as respondents get older' (Scottish Government, 2013: Section 9).

It was noted in the outline of the structure of the first two surveys that each of the questions which were included were carefully worded to avoid misunderstanding. For example, the questions on biological sex and gender identity included an explanatory phrase to indicate as clearly as possible what was being sought:

How would you describe your biological sex? (usually this corresponds to the sex that you were assigned at birth)

How would you describe your gender identity? (the internal sense of which gender you belong to)

These questions appeared to work well, allowing, for example, for those individuals who felt that they did not fit within a binary category of sex and gender, (perhaps, as one participant suggested, because they felt that their use of hormones had altered aspects of their biological sex). An additional question on the sex allocated on a respondent's original birth certificate may perhaps have clarified original biological sex somewhat.

Similarly the questions on original/current gender role contained an explanatory clause:

How would you describe your original/current gender role in everyday life? (gender related behaviour including the clothing which you wear/wore for the majority of the time in public)

The research findings on this were discussed within chapter four. There are several anomalies in these results which suggest that some respondents displayed contrary original gendered behaviour and appearance to the biological sex which they indicated earlier. As there is an absence of research data suggesting that transgender people are likely to be brought up in an opposite gender role to their biological sex, it seems more likely that respondents have shown more flexibility than might have been anticipated in their responses to questions about their biological sex and gender roles (see the annotated interview with 'Luke' in Appendix Five), or that some misunderstanding of the questions has contributed to the results. Indeed descriptions of subsequent transitions suggest that original gender role and biological sex almost certainly coincided in most if not all of these cases.

It is also clear in retrospect that two questions from the first transgender survey (relating to relatives who received advice or support about transition, and sources of care and support at home) would have been more appropriately designed if they had allowed respondents to 'select all that apply' rather than restricting responses to just one category only (see tables twenty two and thirty nine). In each case the number of respondents to whom the question was relevant was very low, but a more open question and answer system would have led to greater confidence in the results obtained.

Several questions in each questionnaire asked respondents to indicate what they believed other people would think about a particular issue: for example, table twenty four (from survey two) indicates respondents' opinions on the value of advice etc. to partners or other family members, while table thirty eight (from survey one) indicates whether respondents' thought that their transgender status affected the quality of social care support they received. To some extent such questions might rely on hypothesizing, for example by the respondent of their family members' likely response to support (or even perhaps on hearsay about the quality of care others receive, to compare with that which they themselves receive). The questions were included, however, because the questionnaires were not designed for family members etc. or social/care workers to complete. De Vaus indicates that such 'belief questions' focus on 'establishing what people think is true rather than on the accuracy of their beliefs' (2002: 95). Separate questionnaires, or even separate sections of these surveys, aimed directly at family members etc., or social/care workers may have been likely to provide more accurate data, but this was unfortunately beyond the scope of this research, so that this data, while useful, must be treated with a little caution.

One further example of how each of the questionnaires might have been improved links to some of the terminology used throughout, which, while consistently employed, may not have meant the same thing to different respondents. For example, each of the questions concerning the value of potential support services (see tables sixteen, twenty, twenty three, twenty six, thirty one, and thirty four) clustered the terms 'psychiatrist' and 'counsellor' within the same grouping, despite their likely different roles in mental health support. In the former case a role might be anticipated primarily diagnosing and treating a mental health condition (in this case perhaps linked with gender dysphoria), whereas in the latter case the role might be more likely to involve assisting someone to reflect on their life and experiences as a transgender person, pre-, during, and/or post- transition, by exploring

the person's feelings and emotions relating to these experiences. Separating these two roles in each of these tables may well have provided clearer information on the relative importance of each of these quite different support roles.

Similarly, the term 'social care' to transgender people was used throughout all three questionnaires. In the mind of the researcher, this term covers a range of care provision to further the well-being of transgender individuals, groups or the transgender community by advocacy or through the formal input of the staff of an organization, perhaps associated with a formally assessed need, or through the informal support of staff or users of a statutory or voluntary agency, a relative, neighbour, colleague or friend. Some of the responses noted in the research findings suggest that a consistently broad understanding of such a flexible model of social care may not have been held by all participants.

The process of data analysis for this research was discussed within the four separate sections of the methodology chapter relating to each of the questionnaires and the nineteen interviews, as well as within the section on grounded theory in that chapter too. Those sections indicated the way in which information from the first transgender questionnaire and from the transgender interviews informed the second transgender questionnaire content. In addition, it was noted that the juxtaposition of data from each of the surveys with extracts from the interview responses was an essential part of the data analysis process and the synthesis of the data, and this process continued throughout the planning and the writing of the four research findings chapters, together with appropriate reference to publications which have direct relevance to these findings.

This discussion chapter follows the example of the research findings chapters by including, where appropriate, further reference to additional research which sheds light both on the research findings themselves, and also on some of the gaps in these findings. Research publications and handbooks on social work practice with transgender people have provided some ideas and suggestions for the proposals for potential future service development and additional support to transgender people which are included within this chapter.

The discussion chapter continues by next reconsidering the concepts of sex and gender which were explored in depth within the literature review, in the light of comments by participants to the research about their own sense of their sex and gender, often within a transitional context.

Reflections on the Concepts of Sex, Gender and Transgender

In this section of the discussion chapter, concepts of sex, gender and transgender which have been highlighted by respondents to the questionnaires and interviews, will be discussed in relation to some of the theoretical material which was explored within the literature review. Some of the comments from survey respondents and interviewees showed a thoughtful and perceptive awareness of the complexities of sex and gender, and, what it means to be transgender. In some cases these comments, (which are included in full within the research findings chapters four, five and six, but are paraphrased within the current discussion) reinforced or extended perceptions of sex, gender and transgender outlined within the literature review.

As noted earlier in the thesis, Connell suggests the need to study gender by moving 'across conventional boundaries between academic disciplines' ... 'from psychology and sociology to political science, cultural studies, education and history' (2009: xiv). However, as the aims and objectives of the research have been mainly considered in sociological terms within the methodology of this thesis, an understanding of gender and, as importantly, of transgender and transgender experience too, is mainly considered within this section from the perspective of sociological theory.

Some research participants nonetheless 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).

Whittle and Turner's explanation of the UK Gender Recognition Act 2004 that 'a transsexual 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' (2007) concurs with this notion of sex change alongside gender change, but, from the experiences of some research participants, even after transition, the legal basis and the self-perception of one's biological sex may not be ratified in the views of others. Visibility may still be a feature of a transgender person's life after the transition process is completed (Whittle, 2000). This may result in an extension of the state of transsexuality noted by one interviewee, Sarah, who explained that she viewed 'transsexual' as a process that she went through, rather than as an identity.

Such visibility may result in the 'transsexual phase' becoming a long-term or even permanent condition, perhaps replacing a sense of personal isolation prior to transition, with one of societal alienation, outwith the binary, afterwards. One interviewee, Amy, was disappointed when she was not viewed as a woman, making it clear that she did not undertake transitioning to be seen as a transsexual. In this situation, the notion of West and Zimmerman's distinction between 'sex' and 'sex category', the latter being based on 'the *presumption* that essential criteria exist and would or should be there if looked for' (1987: 132, *italic original*), appears to work to the transgender person's disadvantage: it seems that some may still be viewed as essentially belonging to their original biological sex, perhaps for the rest of their lives (particularly so perhaps, in the case of some MtF transgender people: Whittle, 2000, 49/50).

However, some indicators of biological sex (including secondary sexual characteristics) may be transformed to a greater or lesser degree for MtF and FtM transgender people and hormonal changes 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 (see Appendix Three), 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 FtM persons. 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 gender dysphoria that many transgender people feel very early in their lives (Whittle 2000: 19, though see also Connell, 2010) 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.

That the dilemma of gender dysphoria in children cannot be readily explained within performativity 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). As was noted in the literature review, although the separation of gender role and identity is no longer widely recognised within much of the gender theory discussed within the literature review, it has been retained within the thesis as it appears to underpin the early experience, motivation for reassignment and subsequent transition of many transgender individuals, including participants to the present research. The maintenance of an initial gender role – individually nuanced perhaps, but apparently concordant with the multiplicity of behaviours which may be construed as 'appropriate' 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 are 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.

Reinforcing research by Cohen-Kettenis and van Goozen (1997), Smith et al (2001 and 2005), and Wallien and Cohen-Kettenis (2008), 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 readily supported by the 20% of responses from 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 responses preferring options including bi-gender, a-gender, and poly-gender (table fourteen), over the 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 (9 and 4 respectively) and those who chose the 'other' category (5 in survey one and 8 in survey two), preferring terms such as 'third gender', 'intergender or gender queer', 'gender fluid', 'polygender' 'queer or transgender' on 'a continuum' or 'somewhere in between' (table thirteen) to describe their gender identity. Similar identification with the notion of their current gender role being transgender was indicated by participants of surveys one and two (7 and 3 respectively), or as 'other' (3 and 4 respectively).

It is not clear to what degree such identification with transgender and 'other' gender identities and roles extend into observable behaviours which break the boundaries of conformity to gender power, status and inequality. Nonetheless these findings reflect other research findings, reflected in Cohen-Kettenis and Pfäfflin's observations, from the study of Bockting from 2008, in which 'the more classical binary view of transgenderism', reflected in responses such as 'female to male' and 'male to female', was extended to include additional descriptives such as 'in-between and beyond', 'shemale' bigender/two spirit', 'third gender', 'genderless' etc. Such category choices appear to refute Jeffreys claim that 'transsexualism opposes feminism by maintaining and reinforcing false and constructed notions of correct femininity and masculinity' (1997: 57), at least for some transgender people.

It should also be noted that the research suggests that gender identity issues are not the prerogative of transsexual people, for one of the two respondents to survey one who explained that they were 'happy to spend some time in the opposite gender role but I don't

want to do this permanently' indicated that they 'valued/would value/would have valued' advice regarding gender identity issues and being transgender. The notion of a continuum between transvestism and transsexuality, suggesting a possible range of life-style options for transgender people (Jeffreys, 2014: 81), was not however supported by the research, for almost all participants indicated that they had either transitioned, or were intending to undertake such a transition, although the possibility of a continuum of transgender self-perception (within and between binary genders) is of course supported by the above figures on self-perception of gender identity and gender role from the current research.

As noted in the literature review, understanding of the cultural determination of gendered behaviours reflects a scrutiny which has sought to clarify the importance of incorporating a reflexive, re-active model of social learning within a range of learning processes. Such social learning appears to take place throughout childhood (and, as implied by de Beauvoir, throughout adulthood too (1949, reprint 1997: 295), Richardson suggests such social learning includes 'observation, imitation, modelling, differential reinforcement (and) agencies of socialization (for example parents, teachers, peers, the media)', so that children learn 'the social meanings, values, norms and expectations associated with 'being a girl' or 'being a boy'' (2008: 9).

That the consequent complexities of transitioning after childhood and adolescence have been negotiated 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 little apparent consideration for the social implications of such a journey. This has been 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.

That such social assimilation often fails, is evident, for example, from the findings of the Scottish Transgender Alliance survey of seventy one transgender people in Scotland in 2007, which found 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). This survey is more fully discussed within the literature review, but the rejection of

transgender people is well exemplified within the present research findings. 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, and sometimes at the expense of other family relationships perhaps: 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 etc. 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.

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 gender identity, 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 have resulted in trading the deeply distressing personal dilemma of gender dysphoria for a similarly distressing, but more publicly evident conflict which centres around their gendered behaviour and appearance.

Perhaps one of the most striking outcomes of this research is the degree to which some participants have shown 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 transitional period, but the data included in the research findings chapters (see for example table fourteen) indicate a much greater flexibility of self-perception within transgender identities.

It is the flexibility of these category choices which informs one of the conclusions to this thesis. 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 a number of research respondents too, leading to the proposed inclusion 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).

The Provision of Dedicated and Generic Social Care Services

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?

Transgender Needs and Unmet Needs

Two of the key research findings relating to dedicated/specialist services were that of the limited provision or commissioning of such services by statutory organisations, and of their limited awareness of local voluntary sector transgender service provision and of local transgender service need. Compensation for these deficits came from rather more extensive voluntary sector provision and awareness, though this was largely dependent upon poorly funded groups of volunteers, who, as with their statutory sector counterparts, had access to limited training, service guidelines or policy statements.

At this initial stage the notion of ‘assessed and/or perceived needs of transgender individuals’ may be subsumed within a ‘self-perceived’ need equivalent to Forder’s ‘felt’ need (1974: 64/65), and perhaps for some transgender people it is this sense of self-perceived difference which leads to them making contact with their peers within a transgender support group, possibly initially online or by telephone, and subsequently in person, whilst moving from a sense of ‘perceived’ to ‘expressed’ need. However, not everyone is able to do this, because of the limited availability of local support groups, highlighted by half of the voluntary respondents and three of the statutory sector respondents. For those who are able to make these links, 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. Transgender support groups were rated as the most highly valued source of support regarding gender identity and transition issues by over a third of respondents, though mainly by those in a male role and with a male gender identity.

It is perhaps only if a transgender person seeks support via a statutory agency that the notion of 'assessed' need becomes more formal and procedural, and this may be one of the contributory factors to the success of voluntary sector support: it does not require the sharing of any information other than a name (which may itself be adopted to reflect a transitional gender state or for anonymity). Initial online contact may ensure a still greater degree of anonymity, for it includes the additional precautionary measure of preventing visual recognition, offering a level of safety that is one of the key features of Maslow's alternative hierarchy of need (1943). That telephone support was identified as one of the more necessary additional services perhaps reinforces 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.

Underpinning Attitudes to Transgender

Despite the importance of limitations in dedicated service provision noted in the above section, inadequacies in the accessibility of generic services were of equal concern, partly because of the apparent very limited awareness of current transgender usage of such services (but see below: 'self-directed support', paragraph one, and also Whittle's comments on confidentiality, 2005). The apparent inadequacy of equality impact assessments to reflect service provider awareness of, detailing 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. The cited rationale of 'chicken and egg' which perhaps lacks credibility as the main reason for not developing dedicated transgender services, also perhaps lacks credibility for inadequacies in the preparation of generic services where, as one example of good initiative indicated, increased awareness of transgender need was shown to be successful when targeted at staff working at 'points of access'.

Additional, subtler, concerns were also highlighted within the following extracts from an interview with a statutory sector staff member involved in service development. She presented a valuable perspective on how transgender people might be viewed by service providers and other service users, particularly in 'single sex' services, and how this might impact on access to such services. The interviewee initially sought to identify some of the factors which might affect service accessibility:

Alana: 'I became aware of the needs of transgender people for social care services through a range of learning opportunities, in particular relating to gender based violence ... It was clear ... that the traditional model of service provision for domestic abuse/rape & sexual assault posed challenges and barriers to transgender people ... associated with service philosophy, service accessibility, practitioner knowledge, understanding and attitude, and a range of cultural/community barriers.

There are many factors at play which could deny access for transgender women and men to specialist services. These include:

- 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.
- a lack of understanding about the needs of transgender people, for example ... it has been known that refuge providers would not offer safe refuge to a transgender woman, because she may still prove a risk to other women in refuge, as ultimately she is still a "man".
- an inability to "think" differently (where) responses are based very much on "myth" and a skewed view of any risks associated with supporting transgender women'.

What was particularly valuable here was the honesty with which this 'professional non-trans' person shared her perspective of how others within her organisation might regard transgender people, for example, because of the perception of both gender and sex as immutable. Many people who have not had cause to question an anomaly between their body and their identity may have little reason to doubt or to question a binary gendered and binary sexed society, but in this case it became clear that such underpinning values

may have wide reaching consequences for policy and practice. The interviewee went on to suggest that the binary nature of service provision may itself be problematical:

Alana: (there is a) 'fundamental flaw in a whole host of policy development, academic and professional development/training around gender (that) is hardly acknowledged ... the binary view of gender is more related to an "ease" by which services can ... be developed ... according to male/female aspects of gender'.

The interviewee further developed her argument when she subsequently raised the concept of 'core values'. Briefly, the interviewee explained that, in relation to protecting other clients of domestic abuse/sexual violence services:

Alana: '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 lay out these ideas in some detail:

Alana: 'My perceptions of challenges and barriers posed for transgender people accessing specialist domestic abuse/sexual violence services are related to service models/philosophy. 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.'

The absence of detailed data about such 'core values' of transgender people both pre- and post-transition has been noted within the literature review. It was also noted that information is missing about the degree to which transition reflects an expression of previous (or newly developed) personal interests, activities, hobbies and leisure activities, as well as alterations in the composition of social networks and the nature and extent of personal relationships and friendships.

In an apparently honest example of the dilemmas which face those who seek to come to terms with how transgender people can fit within a bi-gendered social system, she also admitted that, while:

Alana: 'there will be some services within the feminist model of support who fully embrace any women who present for support ... I am unclear as to how services may support transgender men who are "survivors of domestic abuse" as a woman. I feel there may be a "philosophical clash" at play.'

Ross, interviewed by Namaste, suggests that such a clash or contradiction may be readily found within transgender lives and discourses, when she notes 'the insistence of ... FtMs who are years post transition, on being included in women's spaces based on their 'history' as women'. Ross explores the concept of 'core values' in relation to FtM transgender people who 'were 'born' women, 'oppressed' as women, and experienced 'sexism' as women' ... and therefore have emotional, social, political and historical connections to that world, hence claiming their right to remain part of the women's community and to be included in women-only spaces'. But Ross suggests little sympathy or empathy for such a view, suggesting that 'through such a stance, FTM activists are violating the key principles for which transsexual people (MTFs and FtMs) have fought since the early 1960's' ... current FtM politics are taking us, conceptually and politically 40 years behind' (Namaste: 2011: 126/7).

It seems then that the power of the binary may be both a major restraining factor in the development of an acceptance of a spectrum of transgender identities, and more specifically, that attempts, even within transgender communities, to recognise the importance of early experiences relating to assimilation of core values may meet with considerable resistance. As Ross argues: 'we struggled hard so that our sex and gender, our identities and lives ... wouldn't be determined by the sex and gender we were assigned at birth, but by the sex and gender (that) feel genuine and appropriate for us. That ... has been the heart and spirit of our fight for transsexual rights' (Namaste: 2011: 126/7).

It is possible that other service providers may share the views of fixed gender and sex that are described above, hindering some transgender people's access to other 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 care staffs' knowledge of transgender identities increases through targeted training and experience.

However, the oft quoted descriptions of a transsexual as 'a woman in a man's body' or 'a man in a woman's body', perhaps reassure neither professionals or lay people alike about the seemingly underlying conundrum that gender is more complex than one's sense of gender identity, or one's relationship with one's biological sex. Connell notes that 'transsexual women reach for one metaphor after another to describe their experience', suggesting that 'no metaphor is adequate' (2012: 867) and indeed some of the comments from respondents to this research indicate that self-perception, before, during or after transition, is far less straightforward than the notion of a 'woman in a man's body' might suggest. It might be welcomed therefore, if social care providers with a background in seeking to understand the individual within a holistic model of care, endeavour to understand the complex concepts underlying the notion of transgender: transgender may also be about how one sees oneself in relation to binary gender identities and roles, how one portrays and presents oneself within and between masculine or feminine norms, whether and if one is viewed by others as male or female, and indeed, as Alana postulated, how one's gender history as a child, adolescent or adult has affected both the attitudes and the underpinning 'core values' which are held by each individual.

The views expressed by some research participants suggest that such a comprehensive appreciation of their individualised gender status may be welcomed by a transgender person if it leads to a greater understanding of their personal needs, and, by taking into account a more nuanced understanding of their gender status, to the provision of a service that might better meet these needs. However it must be stressed that those transgender people who make the change to live permanently in their preferred gender role, and who obtain a gender recognition certificate, have all the legal rights of this gender and sex, without unwarranted, intrusive questioning into their gender status and gender identity.

Transgender Erasure

The apparent lack of awareness of the needs of transgender people within the present research into generic services appears to reflect Namaste's observation that: 'if we actually do empirical research on some of the matters most pressing for transsexuals ... we discover

that (they) are quite literally shut out and excluded from the institutional world' (2011: 3). Mitchell and Howarth also noted that 'there were ... problems with access to health and social care ... gender reassignment pathways were criticised for a 'one size fits all approach. Those with more complex or ambiguous gender identities ... may be denied treatment' (2009: 62). Bauer et al suggest, in recognising that 'trans people represent one of the most marginalised groups in our society' that in relation to health services 'care providers lack of preparation for working with trans patients stems in part from inaccurate current estimates of the size of trans populations'. The absence of knowledge about transgender populations and transgender need evidenced in 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). Appendix Two indicates that it is possible to estimate the numbers of transsexual individuals who might be present in each Scottish Council Area (table forty five), 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.

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:

Self-Directed Support

For almost thirty years the devolution of the provision of social care from statutory authorities to the private and voluntary sectors has meant that for some social care services, for example care at home and residential care, a service user is now more likely to receive a service which is not directly provided (but which may still be funded) by their local authority. This may partially explain the absence of clarity from statutory survey respondents about the approximate numbers of transgender adults or children/young people who were currently being supported across a wide range of generic social care services. For, unlike within dedicated/specialist transgender services, there is little need for a service user to declare themselves as transgender to a funding authority, regardless of their financial circumstances, in order to access a generic service. It may be that the service user, if they choose, may prefer to make their transgender status known to the service provider only, perhaps at the point of entry to the service.

Self-directed support might offer a different approach to personalized support to transgender people, though funding for this can only be provided through a statutory authority after initial, detailed financial and needs assessments. The website for this national strategy of care explains that 'self-directed support (SDS) allows people to choose how their support is provided to them by giving them as much ongoing control as they want over the individual budget spent on their support. SDS is the support a person purchases or arranges to meet agreed health and social care outcomes'. At the present time SDS offers a number of options for obtaining support, including the provision of a service user's individual budget as a direct payment which is then used to purchase services 'from a service provider such as a voluntary organisation or care agency, or by employing personal assistants, or a combination of both' (SDS Scotland, 2013).

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 example, 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.

Service Development/Potential Additional Support

The above discussions have largely explored care services which the research findings indicate are 'requested, made available to or received by transgender people in Scotland', with additional discussions on the concepts of transgender needs, underpinning attitudes, erasure and self-directed support. In this section, a number of suggestions are made for service developments which might better meet these needs. Whilst it is not possible to indicate local priorities for support to transgender people within individual areas of Scotland, the main issues arising from the discussion of dedicated/specialist services give some indication of the types of service development which might be usefully considered:

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 perhaps 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 on 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 social 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 to not only 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.

Finally, 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. Staff working with transgender people need to 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).

Transgender Identity and Transitional Issues

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?

Self-Perceptions

The research findings have evidenced instances where a sense of self-perceived difference has led to transgender people making contact with their peers, within local groups or online, or to seeking more formal sources of support. This self-perception of difference is consistent across much transgender writing. Warnke, for example, in her exploration of 'transsexuality and contextual identities', quotes from a memoir by Boylan (2003, italic original) 'the awareness that I was in the wrong body, living the wrong life was never out of my conscious mind – *never*' and from Thompson (1998): 'my body didn't exist in the way it was born: for me it only existed in my inner identity as a male' (2009: 28). These quotes fit well with some of the quotes from within the current research, for example, one interviewee, Amy explained that she had known that something was not right with her body since the age of seven.

Perhaps the strongest common factor is the certainty of the self-perception, apparent from each of these four quotes, that something fundamental to being human, one's sex, gender role and sense of gender identity, did not match, although even this was not a view with which everyone concurred: 'I'm the same sex I always was – female. Effectively my body doesn't produce enough oestrogen itself and that had developmental consequences for me' (*Sarah*).

Other participants in the current research expressed lesser certainty. One, Andrew, stated simply that he always knew he was different and another, Abigail, explained that she had never had a female or male identity and that she 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 was still 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. Moran and Sharpe explain that 'it is necessary ... to recognise the many differences between transgender people ... along the axes of race, ethnicity, class, age and sexuality as well as ... between transgender women and transgender men and the different meanings the term *transgender* has, including its relationship to surgery, for different people' (2001: 281). Hines concludes that 'transgender communities represent a diverse constituency and, rather than articulating a common experience, transgender narratives suggest a range of competing discourses' (2007: 187).

Such narrative diversity may perhaps itself have contributed to some incoherence in the wider understanding of transgender issues, leading to increased marginalization of transgender individuals. Within the respondents to survey one, for example, of the twenty five participants to survey one who described themselves as biological males, thirteen described their gender identity and current gender role as female, while the remainder described their gender identity or gender role in combinations of male, female, transgender and 'other' (the full list is included within appendix seven). Similarly, just eight of the thirteen participants to survey one who described themselves as biological females 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 full list is included within appendix seven).

For some older transgender people the self-discovery of the nature of being transgender was slow and tortuous: one of the pilot study participants, Agnes, commented on the lack of knowledge and sympathy amongst medical staff forty years ago. Understanding may take many years: one interviewee, Andrew, explained that he did not understand his gender dysphoria until he was thirty nine, although the journey may be shorter nowadays perhaps because, as one respondent, Suzie, suggested, of greater awareness through the internet. Over a third of respondents to survey two said that they would greatly value advice, information and support from a suitably trained and experienced social worker on gender identity/transgender issues. Eight of these had however already transitioned to an opposite gender role, suggesting that transition may not always bring immediate resolution

to concerns about gender identity or being transgender. Incidentally, one of two respondents in survey one who explained that they were 'happy to spend some time in the opposite gender role but I don't want to do this permanently', indicated that 'they valued/would value/would have valued' advice: it seems that gender identity/transgender issues are not simply the prerogative of transsexual migrants.

Despite the apparently wide range of starting points and journeys, for many people (85%) in the current research, resolution of their conflict had involved, or they indicated that it will involve, changing their gender role to match their gender identity, with many seeking surgery via a gender identity clinic (G.I.C.) to make their body's appearance as close to the sex of their gender identity as they are able. Morris explains that 'patients with gender disorders do not want therapy ... they want surgery' (2007: 91) and one respondent concurred that 'I am still writing to the G.I.C. and trying to get seen, and I will certainly take any help when offered, mostly I feel because the specialist is the 'gatekeeper' to physical progression, certainly surgery, for those with no finance' (Kay).

It thus becomes necessary to ask the question: what is so important about the body that it becomes the focus of resolution for so many transgender people?

Embodiment and Transgender

Howson highlights the importance of the body when she states that 'despite the considerable evidence that suggests variability within the bodies of men or women ... and also points to overlap and similarity between the bodies of men and women, the body is used ... to categorise people into either/or social groups (male/female) that are constituted through and overlaid by social practice and cultural assumptions'. Having outlined the development of the sex/gender dichotomy (and recognised that such a 'distinction is now viewed as problematic and unstable'), she goes on to describe how 'the body has been subsequently viewed as reduced to sex, defined in turn as a neutral platform for the inscription of gender identity' (2005: 55, 57).

That such a 'problematic' distinction is increasingly questioned was discussed within the literature review of this thesis, but it seems that for many transgender people, changing one's body to 'match' the sex normally associated with one's gender identity becomes a primary objective in the resolution of their gender dysphoria. Davidmann notes that 'medical interest in transsexuality developed upon the principle that genital surgery is

fundamental to transsexual identities' (2010: 188) and Ekins and King explain that 'genital surgery often indicate(s) for gender migrants that their journey is over' (2006: 49). A FtM respondent to this research indicated some of the rationale behind surgery when he explained that 'I hope that once my bottom surgery is complete I will feel more comfortable in my own skin' (*Ciaran*). One MtF respondent's main concern was not about genital surgery per se, but was about what to do and when to effect a gender transition: 'my problem is knowing in what order to do what, on a limited budget ... should hormones take priority over voice coaching/electrolysis etc.?' (*Kay*). Another FtM respondent noted the importance of surgery when he explained that 'when I first got my consultation for chest surgery I was told I would probably have to wait about two years ... I was completely devastated' (*Luke*).

Surgery and/or hormones may offer the gateway or 'hoops' through which entry to a preferred gendered body is gained, but the limitations of surgery might be easier to assimilate by those who perceive themselves as transgender rather than by those whose self-perception is as 'a man (or woman) trapped in a woman's (or man's) body'. In the case of FtM surgery, the limited success of penis construction means that such an acceptance of the likely outcomes of compromised post-surgery embodiment may be essential if 'genital surgery, rather than bringing their body closer to the 'norm' in fact makes bodies even more complex and visibly different (serving) to further stigmatise and marginalise these individuals' (Witten and Whittle, 2004: 516). Conversely, for MtF migrants, the development of male facial and bodily features, including a male voice, during puberty and early adulthood may lead to persistent doubt in others about one's gender status, both in person and on the telephone, post-transition.

Connell explains that 'most (transsexuals) are aware of the limits of bodily change in transition and know the results will not be normative' (2012: 873). However the expectation that transitioning transsexuals will re-form their bodies to reflect the 'natural' male or female body may be difficult to resist, not least because of continuous exposure to 'perfectly' formed male and female bodies within media advertising. A first step at an individual level might be to acknowledge, as did one of the survey respondents within the current research that 'at birth my biological sex was female but I have subsequently undergone gender reassignment ... so I do not consider it accurate any more to say my biological sex is simply female (although I also recognise it is not fully male either)'.

By acknowledging compromise within one's sex status, perhaps it might be possible to compromise the need to conform to embodied binary standards too, for as Davidmann suggests: 'contrary to the popular belief that a desire for genital surgery is an essential criteria of a transsexual identity, the focus of transsexual experiences does not always reside with the genitals' (and may present as) 'a counter-narrative to the notion of 'being born in the wrong body''. However, she cautions that, while 'some transsexual people are creating what could be construed as new configurations of sex and gender, the link between transsexual well-being and the broader social domain is more significant than is generally acknowledged' (2010: 189). Once again, given the nature of the complex issues which need to be worked through and if possible resolved and reconciled, a little over a third of respondents (ten) to survey two said that they would greatly value advice, information and support from a suitably trained and experienced social worker in making plans for the future, including perhaps a gender transition. Surprisingly perhaps, seven of these ten people were already living in an opposite gender role to their biological sex, suggesting that either transitional difficulties were still an issue, or that plans for the longer term future remained uncertain. Ten people also said they would greatly value support during a gender role transition or the real life test, to provide, for example, 'emotional support so as not to feel isolated', or for 'trustworthy information or useful contacts in the transition process'. Six of these respondents had already made a transition to an opposite gender role, highlighting perhaps the complexities of the transitional process and the slow process before its 'completion' (if indeed, expanding on de Beauvoir's notion of 'becoming' in womanhood (1949, reprint 1997: 295), transition can ever be said to be completed).

Age is also an issue in regard to transition status, for those with a female biological sex and currently in a male role outnumbered those with a male biological sex and a current female role within the age group 16 to 25 by 5:1, while being equal in ratio for the age group 26 to 35 (1:1), and outnumbered in the age groups 36 to 45 (by 2:3), 46 to 55 (by 1:8) and 56 to 65 (by 0:3).

One additional aspect of embodiment needs to be considered here: the notion of sickness or disability. Rates of 'long-term sick or disabled' (table twelve) were high: thirteen (24%) of the forty seven participants in survey one, compared to a Scottish national average of 4% who are described as 'permanently sick or disabled'. The causation of such long-term sickness is difficult to clarify: seven of the twenty three people were living alone and 20% of

biological males and 27% of biological females were classified in this way, and there appeared to be little correlation between gender role or transition status. Cross tabulation of separate data (table thirty two) indicated that of those with mental health conditions five of those with a female gender identity, and four of those with a male gender identity had however already transitioned to a role matching their gender identity. The value of counsellors and psychiatrists in assisting those with long-term sickness or disability was indicated by over a third of respondents rating them as of the highest importance.

Gender Norms and Stigma

Whittle's comment has been noted that 'in reality, despite all that medical technology can achieve, the majority of trans women cannot and will never 'pass' (and) similarly for trans men, although 'passing' might appear at first glance easily achieved, the limitations of gender reassignment mean that they will never be able to form a sexual relationship without having to disclose their past' (2000: 49/50). This presents a stark prognosis for the likelihood of 'success' at conformity to appearances and roles for both transitioned biological male and female transgender people. Such non-conformity, whether during a real-life test, transition, or post-transition period, can result in a heavy price being paid by any migrator who is 'read' and who fails to pass successfully. Goffman suggests, in a broader discussion of the relationship between stigma and the 'discrediting' of social groupings, that there may be 'no open recognition to what is discrediting' (1968: 57). If it is for example, not 'politically correct' to criticize a member of a minority group openly about their status, it may perhaps be more socially acceptable and therefore likely, that criticism might be tangential or substituted for the discrediting factor, about other aspects of a person's behavior, appearance etc. However, the intensity of negative responses which some research respondents experienced was still profoundly disturbing: 'I was spat at, beaten up, refused service in shops ... because of my gender change, humiliated in public, had excrement pushed through my letterbox' (*Lucy*).

Twelve respondents (of twenty seven) to survey two said that they would highly value the advice of a social worker to address the consequences of societal rejection and/or abuse linked with being transgender, with a further four saying that they would value this a little. Ten of these twelve were currently living in the same gender role as their gender identity. That such rejection and abuse may have mental health consequences is suggested by the finding that, 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' because of a mental health problem or disability linked with being transgender.

Davidmann appears to at least partially confirm the concerns which stem from Whittle's (2000) comments on the visibility of transgender people of a decade earlier that 'despite the important social changes and shifts in theoretical perspectives that have taken place since the 1990's, everyday life for the transsexual person who openly transgresses the binary sex and gender borders remains highly problematic' (2010: 189).

Self-Esteem and Status

'In what way does the person herself (sic) persist through the sex/gender transition? She persists insofar as her way of being, after transition, is desired and actively sought by her previous self' (Overall, 2009: 20). The process of transition may not however be as straightforward as this statement suggests. From the feedback of some transsexual individuals within the present research, a post-transition 'way of being' appears to be sometimes a very different experience from that visualized or sought after: 'I do not like be perceived as a transsexual by society. I did not go through the slow processes of transitioning to become a transsexual' (Amy). The stigma and abuse from strangers which is alluded to within the previous section may have a significant erosive effect on an individual's mental health and self-esteem. That a transgender person's family, friends and even their GP may be unsympathetic may also be a significant contributory factor to lowered self-esteem (Whittle et al 2007).

Maslow's (1943) hierarchy includes reference to 'esteem' which for many transgender people may involve the achievement of a state of resolution of their gender dysphoria even if this is not always reflected in others' perceptions of them, or the respect they receive from others. This seems to become more important, the closer the relationship: that support via the family might help to counterbalance external stressors is suggested by Ryan et al who note that family acceptance predicts greater self-esteem, social support and general status (2010: 205). Greatly varying family responses to coming out as transgender or transitioning, and inadequacies in support to family members are discussed further in the final section of this chapter.

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,

including 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 (but are less dissimilar once transgender and 'other' categories are included), and figures for unemployment (five: 9%) are fairly comparable with the national average of 7%. It is the figure for long-term sick and disabled (thirteen of forty seven, 24%, discussed above) which raises the most concern about employment status for quite a high percentage of transgender people in this Scottish sample.

Lastly, legal status is an important stage (and, for some, an anticipated end-point) for transitioning individuals. Transgender support groups were rated as of the highest importance by eighteen of thirty three respondents as a source of advice regarding 'helping you to change your documentation'. However, 44% (twelve of twenty seven) of respondents to survey two said that they would greatly value advice, information and support to help change documentation, and it is suggested that focused support might best be developed within the adept assistance already offered by transgender support groups on this issue.

Despite statements from some participants of their desire to have their birth certificate changed to better reflect their identity concern was expressed by one respondent, Abigail, about having to live as a woman, with a gender recognition certificate, and a female birth certificate, knowing it is a lie. Other countries, (for example Australia which has recently adopted the option for passport coding of gender 'x' as well as M or F, Germany, which now offers the 'x' option for those of indeterminate gender at birth, and India which has most recently adopted a 'third gender' option for transgender people too (BBC news online, 2014) are beginning to offer the possibility of a more widely accepted legal status for transgender and intersex individuals. Not all of these developments have been welcomed (see, for example, Jeffrey's concerns about the Australian Sex Discrimination Act Amendment 2013, (2014: 152/3) but it is proposed that in time a true transgender option should be available to such individuals in Scotland, and for those who do not feel the need for, or who do not opt for transition, in line with the recent WPATH observation that 'choices of identity limited to Male or Female may be inadequate to reflect all gender identities' (Green, 2015)

Service Development/Potential Additional Support

Research question two addresses 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 might 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 social 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 social 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 high proportion of transgender people.

While Lev's model is clearly aimed at migratory transsexual people, it is suggested that 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 the intense and emotionally complex process of transition. 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 social worker, prior to, during or post-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 if their view of this role falls within one of the bi-gender 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. However, the choice of some transgender people to live non binary conforming lives may challenge support services which base their support on the notion of living within the binary, whilst further stretching the mental resources of these transgender people for whom role models are likely to be very limited.

It has already been noted that while coping with 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' (*Kay*). Given the lead role that transgender support groups in Scotland have played to date in supporting individuals in changing documentation (table twenty five), 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 lead to this too becoming an option in the future for Scottish people who do not feel at ease with the labels male or female as a descriptor of their gender or biological sex.

If future research can 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, then this may strengthen an argument for potential targeted social care support to the pre-transition or transitioning MtF or FtM transgender person during these difficult months and years, even if G.I.C.'s, GP's, psychiatrists and counselors might continue to provide the main sources of support for transgender related mental health issues themselves.

A need for post-transition support is, however, also indicated by the current research. The possible inclusion of an individually assigned social/care worker within a G.I.C. based support team during and following a gender transition might also be usefully explored, 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, with a tendency for those who transitioned to a female role to rate transgender groups as less valuable than those who transitioned to a male role).

It is also not difficult to visualize a role for a trained and experienced social worker in supporting a transgender person on wider issues, particularly in the absence of other support systems, by developing pro-active strategies to cope with the lack of understanding in others, or with the discrimination, harassment, bullying and other forms of transphobia described by research participants. Regular discussions with a social worker may also help a transgender person to gradually address any 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.

Without more detail of the difficulties which affected the eighteen respondents who said that they had a mental health condition which had lasted or was expected to last at least twelve months, and the fifteen respondents who said that they had a long-term illness, disease or condition, it is difficult to be clear about additional appropriate social care support. However, these were very high numbers when compared with the S.H.S. (Scottish Government, 2013) figures for permanent disabilities. Because of this, although this series of questions attempted to separate transgender related difficulties from these 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.

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 (bearing in mind concerns raised in the first of these three discussion sections about access to generic services).

The potential for addressing the difficulties of social isolation, which may affect pre- and post- transition individuals as well as those in the process of transitioning, has been highlighted by these research findings. As discussed further below, within the sections on societal rejection and abuse and on developing a community presence, a further potential role for the social worker may be to facilitate regular 'safe' trips for the transgender person into the community through personalized volunteer support.

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. Ageing too brings its own complications to the social care of transgender people; it might be hypothesised that assistance from a social or 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)).

Relationships with Family, Friends, Neighbours and Within the Wider Community

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 research findings discussed in this section are mainly linked by the notion that, together they comprise some of the key social care issues facing many transgender people after transition has been completed.

Family Relationships

The importance of family acceptance or rejection of a family member's transgender identity has been noted by several participants in this research, particularly within the 'individual experiences' included within the section on transition and support to families in chapter five above, and has also been alluded to within the earlier section of this chapter relating to self-esteem. Landen et al indicate that if 'the patient either lacks family or close friends, or that the relatives take a negative attitude towards sex reassignment', this was the most important core factor which predicted regret of reassignment (which was present in 3.8% of a sample of 218 post transition transsexuals: 1998: 284).

Participants in the current research described greatly varying levels of support from within their families, with difficulties for partners, family divisions, rejection by close family members, and estrangement from family relationships - 'you're no son of mine!' (*Sarah*). Transgender people with a male gender identity and role were more likely to have found the support and advice of their family valuable with gender identity and transition issues, than those with a female gender identity and role, several of whom rated the support of family members in the three lowest categories. It is particularly concerning that thirty of forty three respondents' family members received no advice or support about their transition, with limited evidence of support to respondents' spouses, partners and children (survey one), reinforcing Lev's suggestion that 'the clinical philosophy of most gender specialists has been to view family members as extraneous to the process of evaluation and treatment' (2006: 263).

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 and the same number said this about the need for support to understand/address family differences and disagreements re transgender issues: Brown and Rounsley note that 'coming out to family members is usually much more difficult for transsexuals than coming out at work ... there are few losses greater than that of the family bond' (2003: 167).

Friendships and Other Relationships

The importance of close friends noted by Landen et al (1998: 284), seems to assume that there are indeed close friendships in place prior to transition. Agnes, the subject of Garfinkel's seminal study, notes that 'I didn't have friends because I didn't react normally under any kind of a relationship like that ... how could I have pals?' (1967: 70), suggesting that at least some transsexual people may live a socially inhibited or isolated life *prior* to transition. Whilst it was unclear from the research findings just how many transgender respondents were without close friendships, it appeared that rather more than half of respondents had such friendships which were a source of support with the difficulties of gender identity conflict and transition (table twenty), though transgender people in a male role, with a male gender identity were more likely to have found the support and advice of their friends valuable with gender identity and transition issues than those in a female role with a female gender identity, several of whom rated the support of friends in the lowest categories. Twelve of twenty seven respondents to survey two said that they would value support from a social or care worker greatly (seven) or a little (five) to address differences/disagreements with friends, with a tendency for those in a female role, with a female gender identity, to say they would value this support more than those in a male role with a male gender identity.

The NHS/Glasgow University Survey found that 'many respondents had lost all their pre-transition friends (and that) problems with friendships seem to be greater for MtF respondents than FtM participants' (Wilson et al 2005: 27), and Hines found that 'many participants stressed the significance of their friendships with other transgender people' drawing parallels with Weeks et al's (2001) observation that 'for lesbians and gay men, friendship networks are crucial providers of care' (2007: 40/41, 156).

Fourteen of twenty seven respondents to survey two said that they would value support greatly (ten) or a little (four) to address transgender related differences /disagreements with neighbours, colleagues etc. Once again there was a tendency for those in a female role, with a female gender identity, to say they would value this support more than those in a male role with a male gender identity.

These more distant relationships with transgender people are little mentioned within the research literature, and indeed were not highlighted in interviews or surveys by research respondents, but just three of twenty seven respondents to survey two said that they had not experienced transgender related differences/disagreements with neighbours, colleagues etc.

Exclusion and Isolation

As far back as the pilot group for the research, a sense of post-transition isolation was raised by a number of focus group participants, as G.I.C. involvement reduced, compensated by mutual support at regular group meetings, but lacking individualised professional advice. 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 with the spread of periods in the transitioned role varying from 1, 1.5, 3, 4 (3). 6, 8, 14, 20 and 24 years, indicating that the need for support was mainly no longer centred around the immediate transition period.

As noted within the first section of this chapter, the need for additional transgender support groups indicated by half of the voluntary sector respondents and three of those from the statutory sector, highlights the possibility of an isolated lifestyle, lacking suitable support, for many transgender people in Scotland. Sixteen (60%) of twenty seven respondents said that they would value advice, information and support to help address social isolation linked with being transgender either greatly (eleven) or a little (five), evidencing the notion of a widespread sense of isolation linked with limited social networks (Addis et al 2009). Once again there was a tendency for those in a female role, with a female gender identity, to say they would value this support more than those in a male role with a male gender identity.

Reinforcing individual statistics on post G.I.C support, isolation, social rejection, abuse, and relationship difficulties was the finding that fifteen of twenty seven respondents to survey two said that they would value support greatly (twelve) or a little (three) to establish a more confident community presence with a clear tendency for those in a female role, with a female gender identity, to say they would value this support more than those in a male role with a male gender identity.

What form might such a presence take? For many, it might involve presenting an appearance and lifestyle as indistinguishable for as much of the time as possible from the wide range of available options within the binary norms. As one of Hines' interviewees explains: 'some trans women do disappear into the woodwork and don't want to be identified as trans anymore' (2007: 77). Namaste puts this in perspective when she writes that 'transsexuality is about individuals who change our physical bodies because we want to move through the world on all levels in a sex and gender other than the one assigned to us at birth. 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).

For some though, the complexities of life pre-transition don't go away, post-transition: 'I'm not a man - about that much I'm very clear, and I've come to the conclusion that I'm not a woman either, at least not according to a lot of people's rules on this sort of thing. The trouble is, we're living in a world that insists we be one or the other' (Bornstein, 1994: 8). Thus the pragmatics of gender difference suggest that establishing a community presence will involve building up confidence and self-esteem in a gender role within which most people have had a lifetime to find their own individual niche, or for those transenders who live outwith the binary divide, developing the confidence to personalise stereotypical or identifiable behaviours from either side of the binary in a novel or unusual, rule-breaking mix.

Bolin quotes a 'middle-aged postoperative transsexual' who argues that 'transsexual people must learn to come out. The closet for them is as real as it is for gay men and lesbians. But transsexualism has two closets ... that's where people go after their transitions to deny their past and their transsexualism ... in the past there was little choice but to go into the closet ... for public identity as a transsexual person meant media attention, ridicule, loss of employment and employability, and even physical danger. As times have changed, it has

become possible to have a public identity as a transsexual and still have a reasonably normal life' (1996: 483).

Service Development/Potential Additional Support

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 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 social 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. It may also be necessary for a transgender person to further readjust to the notion of this identity if acceptance by others of this transition to the opposite binary gender role (at family, friend, colleague, neighbour, and community levels) proves only partially forthcoming. This model may also be of value to social workers working with the families of other transgender people than those who are transsexual.

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 will likely 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 also important to clarify the needs of children of a transsexual parent 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 with their transgender parent have been inadequately researched to date. 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 social 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 which form the basis of this thesis. 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, for whom, as noted within the research findings, there is limited local support, while G.I.C. support is not available 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 work to support 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 social 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 (summarized in Appendix Six) 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).

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. In addition, there is no 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 of the prescription of androgens or estrogens.

As has been noted within the research findings, 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 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.

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 is likely to form part of this exploration of intimacy, given the potential for change in sexual orientation that gender role transition appears to bring to the transitioned individual, although this is also

likely to be affected by the degree to which the person is accepted in their transitioned gender role.

A social 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 social worker may be able to take with a transgender person who is having problems with their colleagues or neighbours over their 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.

The role of the social 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 social 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 transsexual 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 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 worker 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 social 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 regular 'safe' trips for the transgender person into the community.

The social worker role might be mainly to link the transgender person and 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, but, reflecting the notions of performativity explored within the literature review chapter, it may aid the consolidation of some transgender people's sense of their gender identity – or at least their success in masculine or feminine patterns of behavior - too. It may be possible that funding for an ally/volunteer's expenses may be undertaken through the self-directed support scheme as outlined in the first of these discussion sections.

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.

The Socializing of Transgender

Hird, in her article on a 'Sociology of Transsexualism', offers 'a typology of theories of transsexualism that pivots on the understandings of sex and gender as either objects of 'reality' or performative effects of social interaction ... it is the possibility of transcending sex and gender altogether that offers, from a sociological perspective, the most interesting possibilities' (2002: 591). As noted in the literature review to this thesis, 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 Jan 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 discussed in this thesis has indeed shown that some respondents have been willing to, or have needed to explore fundamentally their concept 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 thesis has explored the potential role of social workers and social carers, within statutory and voluntary, 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 the four key areas of transgender support groups, G.I.C. support, counsellors and psychiatrists, and family and friends (for full summaries of social care concerns see Appendix Four, and for summaries of the research findings into sources of support see either the source chapters or Appendix Seven).

Transgender support 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 role and gender identity than those with a female role/gender identity, and 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 group support was 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 role/gender identity to value G.I.C. support more highly than those with a male role/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 role and gender identity, rather than by those with a male role/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 in a male gender role and with a male gender identity, than by those with a female gender role/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 in a male gender role and with a male gender identity than by those in a female gender role and with a female gender identity.

Around a half of respondents said that they would value social work assistance, either greatly or a little, 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. A summary of responses has been collated for convenience within table forty six. 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 (Appendix Four). 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 current 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 appears to be clearly a 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, perhaps reflect a continuing emphasis on the medical aspects of transgender. By this process the effects of gender dysphoria have become categorised as an illness that is then, to a greater or lesser extent, 'cured' by surgical interventions, 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 transgender people, has subsequently led some to question the primary role of medicalization in providing a resolution for gender dysphoria. Namaste, too, suggests 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. 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 (see Appendix Six) 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 therefore, 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).

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 cardio-vascular 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 these same 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 wide 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 proposed that a combination of social care support and advocacy on behalf of transgender people, aiming 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 migrants, but it is proposed that care services could supplement medical support through seeking the establishment of a transgender legal status alongside a greater understanding and acceptance of transgender people, through social care assistance to individual transgender people during the socialization phase of transition and beyond, and 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 chapter. As one interviewee within the current research 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'.

Summary and Conclusion

The thesis began with an overview of literature relating to the research, exploring notions of gender and transgender roles and identities, within and outwith the binary, alongside discussion of the nature of biological sex. A distinction between oscillating, migrating, and transcending transgender categories was felt to be particularly useful, while recognizing that issues for transgender children and young people, and also for older transgender people, may be rather different than those of adult transsexual migrators, about whom much of the research literature is centred. That the decisions which transgender people face in seeking a gender role which reflects a more appropriate expression of their sense of gender identity may then evoke rejection within intimate and wider circles of family, friends and acquaintances, led to a consideration of underpinning attitudes of transphobia.

It was proposed that as most of the research literature reflects medical and health issues rather than social care issues, which may be of equal relevance, this provided a logical basis for the research undertaken. The research highlighted a range of social care issues which are not addressed within the current medical model of transition. These issues link with follow-up research indicating concerns about the social isolation of transitioned individuals, particularly those who are older, MtF, and were formerly in heterosexual relationships.

Three research questions were proposed, to be explored within a mixed methods research strategy consisting of three online surveys and nineteen online, asynchronous semi-structured interviews with commissioners/service providers, and with transgender people themselves, following a short pilot study. Few younger or older people took part in the research, which, because of those who chose to participate, mainly reflected the issues facing adult transsexual migrators far more than those of oscillators or transenders. Data analysis was influenced by grounded theory in the development of themes and sub-themes which structured the research findings.

Proposals have been put forward concerning the need for greater liaison between the statutory and voluntary sectors to improve existing services, to clarify additional needs, and to develop and implement new services for transgender people and their families across Scotland. In addition a greater awareness is needed of the barriers which transgender people face in accessing generic social care services, the ignorance and uncertainty that

they may experience with regards to their gender status and gender related needs, by both support staff and other service users, and inadequacies within guidance and policy statements, equality assessments, staff training and funding.

The findings of the research surveys and interviews with transgender people led to a series of proposals for improving social care service delivery to meet identified needs in response to the range of issues identified through the three research questions. These may need to supplement formal and informal support systems provided by the statutory and voluntary sectors, including transgender support groups, G.I.C. input, psychiatrists and counsellors, GPs, social care staff and families and friends, according to local and personal circumstances.

The possibility of social care support to transsexual people in their exploration of gender and transgender issues led to the suggestion of additional social care support prior to/during and/or consequent to transition. Some of the research findings suggest that the timing of such interventions may differ for FtM and MtF transsexual people, as their appeared to be a correlation between age, biological sex, gender identity and gender role transition at earlier and later points in the lifespan for these groups respectively. Social care models for assisting transsexual people to work through issues relating to their gender and transgender status may have a value for other transgender people too.

It was recognized that a range of additional potential support roles might be taken by social care services in supporting transgender people who live within and outwith the binary via additional group support, telephone support and assistance with documentation including G.R.C. applications. A significant gap in social care support to families of transgender individuals was noted, as was an additional role in supporting those transgender people experiencing difficulties with friends, colleagues or neighbours. The particular support needs of partners and children of transsexual individuals were also noted, together with those of young people and the elderly. It was also suggested that social care services might be able to support transgender people with the consequences of social isolation and social rejection, and in developing a more confident community presence, perhaps through facilitating supportive relationships with 'allies'.

In conclusion, it has been proposed that a re-balancing of the historical systematic 'medicalization' of transgender might be achieved through a complimentary 'socializing' of

transgender, through advocacy work seeking legal status and greater understanding and acceptance of transgender people, and through the provision of the wider range of additional social care support, to transgender individuals and their families, suggested by the research findings. This may be particularly necessary during the complex socialization phase of transition, if the acceptance and assimilation of transgender people of all ages, gender identities and gender presentations is to be facilitated within wider society.

Appendix One: Legislative Perspectives

Since 1990 there have been three key legislative regulations which have sought to protect the rights of transgender people in the United Kingdom or Scotland.

'The Sex Discrimination (Gender Reassignment) Regulations (UK Government, 1999), amending the Sex Discrimination Act (UK Government, 1975), sought to protect employees and those in vocational training from trans-phobic discrimination. These regulations significantly improved the job security of transgender people in Britain, although the initial 1998 consultation paper was described by Press for Change as 'a downright offensive document, embodying the belief, for instance, that trans-people should justifiably be kept away from children, and mandating discrimination (which would be intolerable against a lesbian or gay man) in professions involving body contact' (Press for Change, 1998)'. These regulations were amended and enhanced in 2008, to include goods and services and harassment (United Kingdom Government, 2008).

'The Gender Recognition Act and Equal Treatment Directive (UK Government, 2004) made clearer the rights of transgender people, and laid out the process for gender recognition certification', and in the process eroded the boundary between sex and gender, established as far back as 'Stoller's work in the 60's' (1968, cited in Whittle and Turner, 2007: 12). Whittle (2005) also noted at the time of the Act's introduction that it imposes 'new responsibilities to maintain client confidentiality ... (which could) ... cause problems for workers seeking advice from their managers and co-providers. It makes it a crime, with a fine of up to £5000, for any individual who has obtained the information in an official capacity to disclose that a person has a gender recognition certificate or to do anything that would make such a disclosure. This means that it will no longer be possible to identify a particular client, except with their express permission, as to do so will incur criminal liability'.

Tirohl draws attention to the 'rights of cross – dressers in the UK' and notes that although transsexual people at work 'enjoy protection through a European Directive transposed into the Sex Discrimination Act 1975, 1986, the more recent Gender Recognition Act (UK Government, 2004) and UK case law ... cross dressers conversely can expect little legal protection through statutory provision, and are adversely affected by the outcomes of case

law on dress codes at work' (2007: 277). In addition Tirohl notes that cross dressing 'men are left generally in a less favourable position than women with regard to their dress'. He concludes: 'the Gender Recognition Act is silent on the issue of cross-dressers. For the courts these persons living on the boundaries of gender identity are the most perplexing and consequently have fewer legal rights because if we don't know who they are, how can we define and protect them – assuming that we wanted to?' (2007: 286).

'The Offences (Aggravation by Prejudice) (Scotland) Act (Scottish Government, 2009) has made transphobic harassment a criminal offence'. Two years prior to the Offences Act, the Scottish Transgender Alliance found that 62% of respondents reported harassment from strangers, mostly in 'the form of verbal abuse' (Morton, 2008: 11). It is hoped that the implementation of the Offences Act will affect the degree of transphobic harassment reported in the future.

From a broader perspective, Whittle et al note in their transgender Eurostudy, that 'very few countries had fully embraced the range of transgender protections available in Europe. Some have made very little progress, leaving their trans citizens in fear for their safety, unable to work due to discrimination, and facing great difficulties in obtaining access to gender reassignment services ... no country is by any means perfect. The UK does better than most states but this must partly be due to the volume of cases brought by trans people in the UK' (2008: 8).

With particular regard to the subject of this research, it is also important to note existing legislation in Scotland regarding the monitoring of Health and Social Care services:

Firstly, the Regulation of Care (Scotland) Act 2001, (Scottish Government 2001), set out a requirement for National Care Standards applicable to care services, which would, together with the Scottish Social Services Council's codes of practice, be applicable to all care services in Scotland, with slight amendments for procedures for fostering and adoption services. These National Care Standards (Scottish Government, 2002) were implemented and monitored by the Scottish Commission for the Regulation of Care (S.C.R.C.).

However, the S.C.R.C. was superseded by Social Care and Social Work Improvement Scotland (S.C.S.W.I.S.) from April 1st 2011 (renamed as the Care Inspectorate, 2014), which was created under the Public Services Reform (Scotland) Act 2010 (Scottish Government,

2010b). The S.C.S.W.I.S. was set up to inspect, regulate and support improvement of social care and social work services across Scotland but while the regulations will be different and activities like registration, inspection, and complaints enforcement will be dealt with according to the law as set out in the new Act, the National Care Standards which apply to all regulated services will remain in place (Scottish Government, 2002).

Similarly, NHS Quality Improvement Scotland, (whose role was in providing guidance on clinical practice, including setting standards, and supporting implementation and improvement of services, and assessing the performance of the NHS and reporting findings) was taken over by Healthcare Improvement Scotland (2014), also under the 2010 Public Services Reform (Scotland) Act (Scottish Government, 2010b). Healthcare Improvement Scotland has also taken over the regulation of independent healthcare services, previously carried by the Care Commission.

Most recently, public bodies in Scotland also have new responsibilities to engage and consult with LGBT people. The new general Public Sector Equality Duty is part of the Equality Duty in the Equality Act of 2010, which replaced the three existing duties for race, disability and gender (Scottish Government, 2012b). This new duty also extends to age, religion and belief, sexual orientation, gender reassignment and pregnancy and maternity leave. It came into force in April 2011 and the Scottish specific duties followed in 2012. The public duty 'on sexual orientation and gender identity with a focus on transgender issues' was recommended within the Scottish Government response 'Challenging Prejudice', the recommendations of the LGBT Hearts and Minds Agenda Group which focused primarily on the 'attitudes of the general public towards LGBT people, but also included attitudes of LGBT people towards ourselves' (Scottish Government, 2008: 11/14).

Lastly, it should be noted that the potential implications of legislation relating to Children and Young People in Scotland and to Adults with Incapacity are discussed within the ethics section of the methodology chapter of this thesis.

Appendix Two: Estimated Scottish Transsexual Population by Council Area

A comment by one of the statutory sector survey respondents, within the research reported in this thesis, 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'.

What evidence is there that the population of Scotland contains 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, and using the population of Scotland of 5,254,800 at June 2011 (General Register Office 2012a) it is possible to calculate the numbers of transsexual individuals who might be present in each Scottish Council Area (table forty five).

These figures suggest that the estimates of very small numbers of transsexual people living in some Council areas do 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 of the support from transgender groups and/or gender identity clinics.

It is of course not known how many of the estimated 429 to 1,051 individuals across Scotland maintain secrecy about their gender dysphoria, nor is it known how many other transgender people there are in Scotland who are not transsexual.

Table Forty Five: Estimated Scottish Transsexual Population 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
TOTAL SCOTLAND	5,254,800	429	1051

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

Appendix Three: Reassignment Surgeries and the Scottish Protocol

The following information regarding transgender surgical procedures was obtained through discussions with a G.I.C. consultant to transgender patients, prior to the formal commencement of the PhD research process, and from Barrett (2007: 201/244 (MtF) and 227/246 (FtM)).

Genital surgery, or vaginoplasty is available for MtF transsexuals. There is an equivalent phalloplasty, available for FtM transsexuals, but the former procedure is rather more common than the latter. FtM genital surgery is much more costly, because of its complexity. In addition the creation of a phallus with limited functionality is less likely to be successful than the creation of a vagina. The creation of a phallus requires skin to be taken from either the forearm or from the abdominal wall or thigh, which can result in scarring and disfigurement. For some FtM transsexuals the ability to stand and urinate and to have some sexual functioning through the phallus, may be important enough to balance these concerns.

For most FtM transsexuals, the primary surgery which is sought is bilateral mastectomy. Breast removal can be obtained on the NHS, aiding both physical and psychological development for FtM migrators. Further major surgery options for FtM transsexuals may involve hysterectomy, oophorectomy, and salpingectomy (removal of the womb and cervix, and bilateral removal of the ovaries and fallopian tubes).

The genital surgical procedure for MtF transsexuals is rather more straightforward. Initial amputation of the penis and testicles, leads to the penile skin being used to create a new vagina. Part of the glans is also retained to create a clitoris and the final part of the procedure involves the fashioning of the labia from the scrotal skin. This is now a well-established procedure with excellent cosmetic and functional results, both urinary and sexual. Intercourse and/or masturbation usually result in orgasm.

The Scottish Gender Reassignment Protocol

The Scottish Gender Reassignment Protocol (Scottish Government, 2012a) was circulated in July 2012, following extensive collaboration between 'clinicians, members of the transgender community, representatives from the Scottish Government ... and a lay person with an interest in transgender issues', and incorporated 'recommendations from the

seventh edition of the World Professional Association for Transgender Care (W.P.A.T.H.) Standards of Care' (2011).

The protocol identifies the main steps in the reassignment process from (self) referral to a gender identity clinic, first assessment and provisional diagnosis of transsexualism/gender dysphoria, discussion of treatment possibilities, preoperative twelve months lived experience, second assessment and confirmation of diagnosis, identification of individual treatment plan including surgical options, access to surgery/surgeries, and follow up appointments. There are some recommendations for timescale, for example concerning the twelve month period of the 'lived experience', and the need for a follow up appointment within six months of surgery, though there are no guidelines for length of time from referral to first appointment, for the period between subsequent appointments, or for post transition health care. The 'Mapping Project' found that 'long waiting lists for assessments, specialist appointments and surgery continue to be a significant problem' (across England) (Combs et al 2008: 3/24), and the Edinburgh based Engender report 'Women thinking trans issues' found that 61% of forty nine respondents indicated that their personal well-being had been affected by waiting times – many respondents reported episodes of anxiety and depression at this time, including incidents of self-harming and attempted suicide' (Burrows et al, 2011: 15).

Common options for MtF and FtM transsexuals are identified within the protocol, including hormone therapy, speech therapy and psychotherapy, whilst separate options such as facial hair removal and mastectomy are also noted. Appendices to the protocol include detailed explanations of these common and separate options with details of the main surgical treatments on offer though it is noted that 'not all patients will undergo genital surgery' (Scottish Government, 2012a: 5). Some procedures not exclusive to gender reassignment such as breast augmentation, facial feminisation surgery and lipoplasty/body contouring are also included. Although these are not available through the gender reassignment programme, it is noted that they may be made available within the Adult Exceptional Aesthetic Referral Protocol.

Treatment criteria for hormone therapy are listed, together with guidelines for hormone management for both transwomen and transmen. Criteria for surgical procedures are also listed, 'adapted from the W.P.A.T.H. Standard of Care, 7th version' (2011: 13).

An appendix to the protocol covers services for children and young people, indicating that those 'who are sixteen and seventeen years of age are entitled to consent to their own treatment and follow the standard adult protocol', whilst, as per Gillick, 'children who are under sixteen years old can consent to their own treatment if it is thought that they have enough intelligence, competence and understanding to fully appreciate what is involved in their treatment' (Scottish Government, 2012a: 16).

However, because 'at present specialist gender identity development services for children and young people under sixteen are not available in Scotland' referral via a GP or via a gender identity clinic is required, to the Tavistock Centre in London. A link to the Tavistock Centre's website is provided in the protocol. No guidelines are included in the Scottish Protocol regarding treatment options for children and young people, including for example puberty delay, which might be suitable and/or made available to Scottish young people, nor the timescales under which these might be expected to be made available (for example relating to the onset of puberty and adolescence).

Unfortunately the Mapping Project of Gender Identity Services in England (Combs et al 2008) does not address services to transgender children and young people either, and so does not provide a yardstick against which the Scottish Protocol can be measured or compared.

**Appendix Four: Summary, Cross Tabulation and Significance Testing
for the Value of all Sources of Advice, Information and Support from a
Social Worker, Across all Categories**

Table Forty Six : The Value of All Sources of Advice, Information and Support (Survey One: n = 47: table 40 data only) (Survey Two: n = 29: all other tables)

I would value the advice, information and support from a social worker ...	I would value this advice greatly	I would value this advice a little	I/they* do not need this advice	I have not experienced ...
... regarding gender identity and being transgender (table 17)	10/28 (36%)	3/28 (11%)	11/28 (39%)	n/a
... regarding making plans for the future (table 19)	10/27 (37%)	3/27 (11%)	10/27 (37%)	n/a
... during a gender role transition (table 21)	10/27 (37%)	4/27 (15%)	10/27 (37%)	n/a
... to help partners/children/ other family members* to better understand transgender/ transitioning (table 24)	10/27 (37%)	2/27 (7%)	7/27 (26%)	n/a
... to understand/address family differences, disagreements, conflicts (table 25)	10/27 (37%)	4/27 (15%)	9/27 (33%)	1/27
... to help to change documentation (table 27)	12/27 (44%)	2/27 (7%)	10/27 (37%)	n/a
... to apply for a gender recognition certificate (table 28)	15/27 (55%)	1/27 (4%)	8/27 (30%)	n/a
... to help address social isolation (table 30)	11/27 (41%)	5/27 (19%)	5/27 (19%)	2/27 (7%)
... if no longer receiving support from gender identity clinic (G.I.C.) (table 40)	13/33 (39%)	7/33 (21%)	5/33 (15%)	n/a
... to help address social rejection/abuse (table 41)	12/27 (44%)	4/27 (15%)	6/27 (22%)	2/27 (7%)
... to understand/address differences etc. with friends (table 42)	7/27 (26%)	5/27 (19%)	8/27 (30%)	2/27 (7%)
... to understand/address differences etc. with colleagues, neighbours etc. (table 43)	10/27 (37%)	4/27 (15%)	7/27 (26%)	3/27 (11%)
... to help to develop a more confident community presence (table 44)	12/27 (44%)	3/27 (11%)	8/27 (30%)	n/a

Table forty six summarises responses across all advice categories, information and support explored within this research, indicating that around a half of respondents said that they would value social work assistance, either greatly or a little, with addressing concerns and difficulties across a wide range of transgender related issues as noted throughout the research findings chapters and the discussion chapter.

Cross Tabulation of Advice Categories Which Were Valued ‘Greatly’

Table Forty Seven: Cross Tabulation of Advice Categories Valued ‘Greatly’

Question/Table Reference Number

I would value advice greatly re ...	7/ 17	10/ 19	13/ 21	16/ 24	19/ 25	22/ 27	25/ 28	28/ 30	31/ 41	34/ 42	37/ 43	40/ 44	Av/ % *
... gender identity/transgender (Q.7, table 17)	10	8	9	6	7	9	10	8	8	6	8	9	8 /80
... making plans for the future (Q.10, table 19)	8	10	9	6	7	9	10	8	8	7	8	9	8.1 /81
... a gender role transition (Q.13, table 21)	9	9	10	7	8	9	10	8	9	7	9	9	8.5 /85
... to help family members (Q.16, table 24)	6	6	7	10	9	7	9	6	8	5	8	6	7 /70
... to address conflicts : family (Q.19, table 25)	7	7	8	9	10	8	9	7	9	5	8	7	7.6 /76
... to change documentation (Q.22, table 27)	9	9	9	7	8	12	12	9	9	7	8	10	8.8 /73
... to apply for a G.R.C. (Q.25, table 28)	10	10	10	9	9	12	15	9	10	7	9	10	9.5 /64
... to address social isolation (Q.28, table 30)	8	8	8	6	7	9	9	11	9	6	7	11	8 /73
... to address social rejection (Q.31, table 41)	8	8	9	8	9	9	10	9	12	6	8	9	8.5 /70
... to address conflicts : friends (Q.34, table 42)	6	7	7	5	5	7	7	6	6	7	7	7	6.4 /91
... to address conflicts: colleagues (Q.37, table 43)	8	8	9	8	8	8	9	7	8	7	10	8	8 /80
... to develop community presence (Q.40, table 44)	9	9	9	6	7	10	10	11	9	7	8	12	8.6 /72
Average/Percentage respondents 'greatly valuing' additional advice*	8 /80	8.1 /81	8.5 /85	7 /70	7.6 /76	8.8 /73	9.5 /64	8 /73	8.5 /70	6.4 /91	8 /80	8.8 /72	8.1 /76

Survey Two: total n = 29. The n in each box in the table = number of participants who said that they would ‘greatly’ value both sets of support indicated in each column/row combination

Table forty seven looks at the outcome of cross tabulating respondents who valued advice from each of the categories 'greatly' whilst table forty eight (see below) adds to these respondents those who said that they would additionally value advice from each of the categories 'a little'.

Cross tabulations undertaken between responses to each of the twelve advice categories indicate:

- Between 64% and 91% of respondents who said that they would greatly value advice on one issue, said that they would also value advice on other issues listed, suggesting quite high to very high levels of correlation between these issues.
- 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.
- Some closely related advice issues appear to correlate highly. For example all twelve of those who said that they would greatly value assistance with changing their documentation (Q.22) said that they would also value assistance with applying for a G.R.C. (Q.25). (Conversely of the fifteen people who would value assistance with applying for a G.R.C. (Q.25), twelve said that they would also value assistance with changing their documentation (Q.22) suggesting that this aspect of need had perhaps already been addressed by three participants).
- Similar apparent high correlations are indicated by the nine of ten people who would greatly value assistance with making plans for the future (Q.10) and the nine people who said that they would greatly value assistance with a gender role transition, although these may not be exactly the same nine individuals of course (Q.13).

A similar apparent high correlation can be discerned between the nine people who would greatly value assistance with helping family members to understand about their being transgender (Q.16) and the nine people who would greatly value assistance with addressing disagreements or family conflicts about their being transgender (Q.19).

Similarly, all eleven respondents who said that they would greatly value assistance with dealing with social isolation (Q.28) also said that they would greatly value assistance with developing their community presence (Q.40).

(all these figures are highlighted in red in table forty seven).

- Some issues that do not appear to be necessarily closely related in terms of their topic, nonetheless still appear to correlate very highly. For example all ten people who said that they would greatly value advice with understanding their gender identity (Q.7), with making plans for the future (Q.10) and with undertaking a gender role transition (Q.13), also said that they would greatly value advice with applying for a G.R.C. (Q.25).

Similarly, nine of the ten respondents to Q.7, Q.10 and Q.13, said that they would also greatly value advice with changing documentation (Q.22), and with developing a community presence (Q.40), although once again, the same nine individuals may not be represented within each correlation.

Apparent high correlation between quite different topics for advice are also indicated by the finding that of the ten people who said that they would value advice and support with a gender transition (Q.13) nine of these said that they would also value advice and support with addressing social rejection (Q.31), to address conflicts with colleagues (Q.37) and to develop a more confident community presence (Q.40). Once again, the same nine of ten individuals may not have responded to Q.31, Q.37 and Q.40.

(all these figures are highlighted in blue in table forty seven)

- Many other slightly less strong correlations are also apparent within table forty seven.

For example, three quarters (nine of twelve) of those who said that they would greatly value assistance with changing documentation (Q.22), also said that they would greatly value assistance with addressing social isolation (Q.28) and social rejection (Q.31).

Similarly, eight of the ten people who said that they would greatly value advice regarding their gender identity (Q.7), making plans for the future (Q.10), and a gender role transition

(Q.13) also constituted eight of the eleven individuals who said that they would greatly value advice and support to address social isolation (Q.28), although once again, these may not be the same eight individuals within Q.7, Q.10 and Q.13 (all these figures are highlighted in green in table forty seven).

Cross Tabulation of Advice Categories Which Were Valued 'Greatly' or 'A Little'

Table Forty Eight: Cross Tabulation of Advice Categories Valued 'Greatly' or 'A Little'

Question / Table Cross Reference Number

I would value advice ... greatly or a little ... regarding ...	7/ 17	10/ 19	13/ 21	16/ 24	19/ 25	22/ 27	25/ 28	28/ 30	31/ 41	34/ 42	37/ 43	40/ 44	Av/ %*
... gender identity/transgender (Q.7, table 17)	13	10	11	7	9	11	12	11	11	8	11	12	10.3 79%
... making plans for the future (Q.10, table 19)	10	13	11	8	8	11	13	10	10	9	10	11	10.1 78%
... a gender role transition (Q.13, table 21)	10	12	14	9	9	12	14	10	11	9	11	11	10.7 77%
... to help family members (Q.16, table 24)	8	8	8	12	11	9	11	8	10	7	10	8	8.9 74%
... to address conflicts : family (Q.19, table 25)	10	9	9	11	14	10	11	10	12	7	11	10	10 71%
... to change documentation (Q.22, table 27)	9	10	10	8	9	14	14	11	10	8	10	11	10 71%
... to apply for a G.R.C. (Q.25, table 28)	10	10	10	10	10	13	16	10	10	7	10	10	10 63%
... to address social isolation (Q.28, table 30)	10	10	11	8	9	12	13	16	12	9	11	14	10.8 68%
... to address social rejection (Q.31, table 41)	11	11	9	9	11	12	13	13	16	9	12	13	11.2 70%
... to address conflicts : friends (Q.34, table 42)	10	11	11	8	8	11	12	11	11	12	12	12	10.6 89%
... to address conflicts: colleagues (Q.37, table 43)	11	11	11	9	10	11	12	11	12	10	14	12	10.9 78%
... to develop community presence (Q.40, table 44)	11	11	12	7	8	12	13	14	12	10	10	15	10.9 72%
Average/Percentage respondents valuing advice greatly or a little*	10 77%	10.3 79%	10.3 73%	8.5 71%	9.3 66%	11.3 81%	12.5 78%	10.8 68%	11 69%	8.5 70%	10.7 76%	11.3 75%	10.4 74% 10.4 74%

Survey Two: total n = 29. The n in each box in the table = number of participants who said that they would value 'greatly' or 'a little' both sets of support shown in each column/row combination

Cross tabulations undertaken between responses to each of the twelve advice categories but including those who would value advice etc 'a little' as well as 'greatly', indicate many similarities with the correlations described in table forty seven above and affirm the

likelihood of high levels of correlation between individual areas of need for advice. Differences between the two tables suggest that these are minimal, and that adding those respondents who would value advice 'a little' to those who would value advice 'greatly' confirms the earlier correlations rather than extending them to additional areas of need or greater levels of correlation across advice categories.

- Between 66% and 81% of respondents who said that they would value greatly or a little advice on one issue, said that they would also similarly value advice on other issues listed, suggesting quite high to very high levels of correlation between these issues.
- An average of 74% of respondents who said that they would value greatly or a little advice on one issue, said that they would also value other advice on other issues.
- Some closely related issues appear to correlate highly. For example, all fourteen of those who said that they would value assistance with changing their documentation (Q.22) said that they would also value assistance with applying for a G.R.C. (Q.25). Conversely, of the sixteen people who would value assistance with applying for a G.R.C. (Q.25), thirteen said that they would also value assistance with changing their documentation (Q.22).

Similar apparent high correlations are indicated by the thirteen people who would value assistance with making plans for the future (Q.10), of whom eleven would also value advice regarding a gender role transition, and fourteen people who said that they would value assistance with a gender role transition, twelve of whom would also value advice regarding making plans for the future (Q.13).

A similar apparent high correlation can be discerned between the finding that eleven of twelve people who would value assistance with helping family members to understand about their being transgender (Q.16) would also value assistance with addressing family conflicts (Q.19), and that eleven of the fourteen people who would value assistance with addressing disagreements or family conflicts about their being transgender (Q.19) would also value assistance with helping family members to understand about their being transgender. These eleven respondents may not be the same individuals for both Q.19 and Q.16 of course.

Similarly, twelve of the sixteen respondents who said that they would value assistance with dealing with social isolation (Q.28) also said that they would value assistance with dealing with social rejection (Q.31), whilst thirteen of the sixteen who said that they would value advice with dealing with social rejection, also said that they would value such support with dealing with social isolation.

(all these figures are highlighted in red in table forty eight).

- As with table forty seven, some advice issues that do not appear to be necessarily closely related in terms of their topic, nonetheless still appear to correlate very highly. For example eleven of the thirteen people who said that they would value advice with understanding their gender identity or transgender status (Q.7) eleven respondents also said that they would value advice with addressing social rejection (Q.31), addressing conflicts with colleagues (Q.37) and with developing a community presence (Q.40) suggesting that issues of gender identity and transgender status still remained to be addressed after transition for at least some of these individuals. Once again, these eleven respondents may not be the same individuals for Q.7. Q.31, Q.37 and Q.40 of course.

Apparent high correlation between quite different topics of advice are also apparent from the finding that of the thirteen people who said that they would value advice and support with making plans for the future (Q.10) eleven of these said that they would also value advice and support with addressing social rejection (Q.31), eleven said that they would value advice to address conflicts with friends (Q.34) and with colleagues (Q.37) and to develop a more confident community presence (Q.40). Once again, although there will be significant overlap, not all these eleven respondents may necessarily be the same individuals for Q.31, Q.37 and Q.40.

(all these figures are highlighted in blue in table forty seven)

- Many other slightly less strong correlations are also apparent within table forty eight.

For example, three quarters (twelve of sixteen) of those who said that they would value assistance and social rejection (Q.31), also said that they would value advice and assistance to address social isolation (Q.28) and conflicts with colleagues etc. (Q.37).

Similarly, thirteen of the sixteen people who said that they would value advice regarding applying for a G.R.C. (Q.25), also said that they would value advice on making plans for the future (Q.10), and said that they would value advice and support to address social isolation (Q.28) and social rejection (Q.31). Once again, same thirteen individuals of the sixteen respondents to Q.25, may not be responding to each of these additional questions.

(all these figures are highlighted in green in table forty eight)

Significance Testing for Correlation

By carrying out the cross tabulations described above, between the twelve advice categories in the follow up questionnaire to transgender people, the data for each advice category has been sorted into tables showing how many people would value 'greatly' (table forty seven) or 'greatly or a little' (table forty eight) each of the advice categories, cross tabulated against each of the other advice categories.

The cross tabulations indicate that there appear to be quite strong correlations between apparently related items (e.g. questions 10 and 13) and apparently unrelated items (e.g. questions 7 and 40), although some items appear to have notably lower levels of correlation (e.g. questions 16 and 40).

In addition the cross tabulations indicate that the distribution of values in each of the cross tabulations relating to sources of advice and support is 'two tailed' – i.e. there is an accumulation of responses at the opposite corner of each SPSS cross tabulation table, representing those who 'do not need this advice, information and support' which counterbalances those who would value such advice information and support 'greatly or a little'.

Further analysis has been undertaken using Yules Q, which is appropriate for two ordinal variables, using the cross tabulated results from the values 1 ('greatly') and 2 ('a little'). Because of the nature of this statistic, not all the cross tabulated results for the questions are meaningful; the low numbers of respondents mean that the cells b, c, or d may have a value of 0, which undermines the validity of the result.

However, where all the values of cells a, b, c and d are equal or greater to 1, the value of Yules Q as a correlation coefficient is clear:

For example, the numbers of cross tabulated respondents to questions 28 and 31 are collated below within a two by two table, indicating a strong association.

Table Forty Nine: Data for calculation of Yules Q for Questions 28 and 31

	Q.28 'I would value advice greatly or a little to address social isolation ...		
Q.31 'I would value advice greatly or a little to address social rejection and/or abuse...	...greatly'	... a little'	
'greatly'	a = 9	b = 1	10
'a little'	c = 2	d = 2	4
Total	11	3	

Yules Q = $ad - bc / ad + bc$

Yules Q = $18 - 2 / 18 + 2 = 16 / 20 = 0.8$

(0.8 is rated as a 'strong' relationship by Rowntree's classification of coefficient strengths)

A similar high correlation is apparent even for seemingly unrelated questions, for example when considering the data relating to questions 7 and 31:

Table Fifty: Data for calculation of Yules Q for Questions 7 and 31

	Q.7 'I would value advice greatly or a little to assist with understanding gender identity and being transgender ...		
Q.31 'I would value advice greatly or a little to help address social rejection and/or abuse greatly'	... a little'	
'greatly'	a = 8	b = 1	9
'a little'	c = 1	d = 2	3
Total	9	3	

Yules Q = $ad - bc / ad + bc$

Yules Q = $16 - 1 / 16 + 1 = 15 / 17 = 0.88$

(0.88 is rated as a 'very strong' relationship by Rowntree's classification of coefficient strengths)

Lastly, even some of those questions which appear rather less correlated within table forty eight, still score moderately, or strongly for correlation using Yule's Q:

Table Fifty One: Data for calculation of Yules Q for Questions 16 and 34

	Q.16 ' I would value advice greatly or a little to help family members better understand my being transgender or my transitioning ...		
Q.34 ' I would value advice greatly or a little to help address conflicts with friends greatly'	... a little'	
'greatly'	a = 5	b = 1	6
'a little'	c = 2	d = 1	3
Total	7	2	

$$\text{Yules Q} = \frac{ad - bc}{ad + bc}$$

$$\text{Yules Q} = \frac{5 - 2}{5 + 2} = \frac{3}{7} = 0.43$$

(0.43 is rated as a 'moderate' relationship by Rowntree's classification of coefficient strengths)

Table Fifty Two: Data for calculation of Yules Q for Questions 10 and 28

	Q.10 ' I would value advice greatly or a little regarding making plans for the future including perhaps a gender role transition ...		
Q.28 ' I would value advice greatly or a little to help address social isolation greatly'	... a little'	
'greatly'	a = 8	b = 1	9
'a little'	c = 1	d = 1	2
Total	9	2	

$$\text{Yules Q} = \frac{ad - bc}{ad + bc}$$

$$\text{Yules Q} = \frac{8 - 1}{8 + 1} = \frac{7}{9} = 0.77$$

(0.77 is rated as a 'strong' relationship by Rowntree's classification of coefficient strengths)

In summary, it seems that for all the cross tabulations between the twelve advice categories in the follow up questionnaire to transgender people, there are moderate, strong or very strong correlations, although, because of low respondent numbers resulting in 0 scores in some cells, not all correlations can be demonstrated within a test of significance.

Appendix Five

Case Studies: Six Transgender Interviewees

The case studies which are included within this appendix offer a redacted overview of six of the interviewees' responses to a selection of survey and interview questions, mainly in relation to their gender dysphoria, transition and social care support to themselves and/or their families. The interview responses have been edited to provide as much anonymity as possible by, for example, erasing or limiting information on personal health matters, dates and locations.

Each case study begins with a short summary of key attribute information from the interviewee's responses to the first survey, followed by an exposition of some of their edited interview comments. These usually correspond to a chronological approach to the interviewees' life history, and are interspersed with generally brief, linking comments.

Case Study: Kay

Key Issues Relating to Research Findings:

- Absence of support during waiting period prior to appointments with G.I.C.
- Strong support from friends and colleagues
- Pragmatic advice needed regarding 'road map' of transition
- Absence of support to parents to understand transgender
- Absence of support to partner (and rejection by partner's family)
- Documentation changes onerous and time consuming

Kay was in the age group 26 to 35 and had transitioned to live as a woman prior to the first survey and the interview. She was living with her partner, and described her employment status as 'employee', 'self-employed freelance' and 'student'. Her education had taken her to S.C.E. Higher level.

She identified her biological sex as male, and described her gender identity as female, identifying with the gender descriptive 'female' too. She had not undertaken a 'real life experience' as part of her gender reassignment process, and had not applied for a gender recognition certificate.

Kay explained initially that, despite transitioning a year earlier, she had not yet had any support from the G.I.C. service to transgender people in Scotland.

'I am still waiting to see the specialist at the G.I.C. I had my first semi appointment in October 2xxx when, due to the impossibility of getting any reliable help or information I decided to try and pay for my first session privately, simply to try and orientate myself in what is happening and get some good advice. As soon as I explained that I did not have the money to do further sessions privately she terminated the session early and placed me on the NHS waiting list. I was charged for half a session and informed that if I would be willing to see a trainee then my waiting time might be a matter of weeks instead of months. I agreed to this readily. I have heard nothing back from the G.I.C. in 7 months now'.

'I have also got in touch by email and letter simply asking for advice with my transition such as where to go for voice therapy or laser treatment and have never even had my communication acknowledged'.

She also noted how support from a social worker or care worker could have been valuable during this difficult period because of the absence of reliable information:

‘An experienced social worker or care worker during this waiting period could have provided advice at least, and even just the emotional support so as not to feel isolated. Simply having access to reliable information is valuable and a support worker who could recommend providers and trustworthy information, or useful contacts, in the transition process. This would be greatly appreciated as the internet is dubious at best for this’.

I am still writing to the G.I.C. and trying to get seen, and I will certainly take any help when offered, mostly I feel because the specialist is the 'gatekeeper' to physical progression, certainly surgery, for those with no finance. I am considering self-medicating hormones at some point this year if I don't hear from the G.I.C., and again, gaining reliable, impartial and trust worthy advice is the hardest part. I was unimpressed with my laser treatment (I've had ten sessions now) and I am beginning electrolysis this month to finish the job, but this journey seems to have all been through self-research and experimentation’.

Kay went on to explain how her friends and colleagues had supported her in the last year, the difficulties which she had faced with explaining her feelings to her parents, particularly in trying to describe what being transgender means, and the additional support which may have been of assistance to her, had it been available:

‘Both my work and friends have been wonderful. They are not knowledgeable on transgender at all, and so can't help in that respect, but the support, encouragement and warmth has been desperately critical, especially from work. I feel much sympathy for folk without this support’.

‘I guess your question brings me back to the role of a support or social worker. I don't really know what my priorities should be, in a pragmatic sense. I feel very stable in my gender identity and have no battles there. I know where I want to go and my life feels happy so I don't really need counselling as such. My problem is knowing in what order to do what, on a limited budget... should hormones take priority over voice- coaching or electrolysis etc? Pragmatic advice is what I am most lacking. I guess my answer is that when the G.I.C. do finally deign to see me,

my priority would be to make a sensible road map of what needs to happen instead of my low budget DIY transition attempts at present’.

‘The biggest battle with my family was in explaining what transgender is, and means: the difference between cross dressing, transvestites, androgyne and transsexual. Attempting to convince them that I am not a pervert in any way, that dressing as female is not a sexual thing at all for me, that it is identity and internal make up, not kink. This was a steep battle, particularly as my mum is a very strong Christian. A support worker could have taken some of this basic explaining work off me, particularly because I was the subject issue... my mum in particular was desperate to talk with a medical authority, and would not, and still does not, really believe I am serious. In many ways my explanation and interpretation of the transsexual landscape was treated with caution because I was trying to describe it in relation to myself and so was biased, whereas had an impartial, knowledgeable, external party explained it they would have been trusted instantly. Googling transsexual usually just brings up a frightening amount of porn and all the wrong notions. My mum went to her doctor who, fortunately, explained he was not a specialist and couldn’t say much about it. (My parents) latched on to the notion that I was being looked after by G.I.C. and I have not really explained the lack of support to them’ (Kay’s parents live some distance away from her).

Kay’s partner had clearly been supportive, but, as Kay recognised, also needed support of her own:

‘I was married when I came out, and my wife listened to what I had to say, but again, would have greatly appreciated an external source of knowledgeable discussion about the basic facts of transgender. It was very emotional at first, and she (spent time) by herself ... to think. On her return she was very keen to engage in what was happening with me and she made a remarkable effort to research and (to) understand what transgender is. I know she also got frustrated by the lack of useful external information beyond porn and dating sites. She has been my main source of strength and friendship since.

‘Her family have been completely unaccepting, and no amount of support workers would ever help that! We share a flat together but have decided we are going to

separate at some point due to her basically wanting children with a man. It's an impossible relationship to describe, but very loving. I think support workers for spouses are often overlooked. We have both used the (a web-site) enormously they have a forum section for spouses and partners and in the early days I know my wife found it helpful to chat with other spouses of trans-people'.

When asked about the potential role of family therapy or counselling, Kay was clearly willing to explore the option. She explained her reservations and some of the doubt she felt about whether this was appropriate to her situation:

'I must admit that I have no previous experience and scant knowledge of how family liaison/family therapy works. Whether it would have been suitable in my case or not I am unsure but certainly there is a role for it for transitioning people and their loved ones. One of my reservations about therapy and counselling is that it potentially makes an issue where there need not be one (although) I think family session work would be an invaluable option to present to families and individuals transitioning, and that there is serious scope for it benefiting people. I remain unsure if I would consider it in my case, and feel I personally would avoid it unless my family felt it was needed'.

As with so many respondents, changing documentation had proved somewhat onerous, though Kay had found a way through the complexities, without as yet tackling an application for a G.R.C.

'The documentation side has certainly been one of the more time consuming areas of personal research and bureaucratic embroilment. Again, there has been absolutely no help or advice from G.I.C., but fortunately the practical side is something relatively easily researched on the net. Changing the DVLA and tax office were much simpler than I thought and as soon as I called up the tax office they were wonderful with it from the start ... changing name by deed poll was also quite straightforward. The banks were a bit of a fight, as were all the utility companies'.

'Again, it is about knowing what to do, in what order, which is hard for an individual to fathom, even with research. Individually each organisation usually explains how

to change your identity with them, but it is only through trial and error that one realises when you can't change one I.D. without changing another one first'.

'I do sometimes wonder why on earth something ... can't be done for people transitioning regarding documentation: as soon as an individual makes contact with the G.I.C., 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. Without being too facetious or simplistic a 'you are here' arrow on a map of legal and document change might be useful. This could be done by the G.I.C., social or support workers or indeed almost any organisation. It need not even require a person but a known, vetted and recommended area of chatroom/forum/guidance online etc. One can find bits and bobs in various websites but I have yet to come across a cohesive whole document/online format'.

'I think, regarding the question of social work helping individuals understanding documentation change, that it hinges on where we draw the boundaries of what social work entails. Certainly if one organisation somewhere took on the charge of direction it would be useful: whether this is G.I.C., social work or an LGBT website seems moot'.

'As regards my gender certificate I am still mildly in the dark but feel it is such a long way off I don't need to think about it too much. I have not even been seen by the G.I.C. yet. I have been living full time as a woman (legally and documented) ... and I think that fills one criteria. The tax office has some good links to what needs to be done for the certificate'.

Case Study: Andrew

Key Issues Relating to Research Findings:

- Initial comprehension of own transgender status came in mid-life
- Advice re 'why I was feeling different' would have been valued earlier
- Pragmatic advice regarding options available would have been valued greatly
- Very supportive family – but no advice or support available to them
- Very supportive partner – but no advice or support available to her
- Documentation advice missing or contradictory

Andrew was in the age group 36 to 45 and had transitioned to live as a man prior to the first survey and the interview. He was living with his partner, and was self-employed/looking after the home. He had studied to a higher education level.

He identified his biological sex as female, and described his gender identity as male, identifying with the gender descriptives 'male', 'transgender' and 'trans-man, trans-male, transgender male, transsexual male, FtM (or similar)'. He had undertaken a 'real life experience' as part of his gender reassignment process, but had not applied for a gender recognition certificate.

Andrew described the quite sudden recognition, in mid-life, that he was transgender:

'I did not understand that I was transgender until I was thirty nine years old. I always knew I was different but it was only when I saw a documentary of a transgender female to male person on TV that it became clear to me what was different about me and my feelings and I immediately started to look for help'.

Andrew sought professional help very early in the process of self-understanding:

'I first sought the help of a privately paid psychologist to help me be sure that I wanted to change gender. If there had been a trained social worker I could have talked to I would have done so. I simply wanted to make sure I was on the right path and that the feelings I had about my body were genuine'.

He also explained why a trained social worker would have been helpful, and went on to explain that such an input earlier in his life might have made a significant difference, perhaps leading to an earlier transition, or at least to a referral to alternative sources of support:

'A trained social worker would have been able to explore those areas with me. It was hugely confusing which steps I needed to take in which order. A trained social worker with knowledge about local possibilities would have been a massive help'.

'If the service of a trained social worker would have been available at an earlier time of my life I may have contacted them to explore why I was feeling different and possibly would have transitioned a lot earlier in my life. Even if a trained social worker would have been unable to offer direct support, it would have been possible for them to refer (me) to another professional'.

Despite a lack of input to Andrew's wider family, they proved very supportive to him. He simply and eloquently describes their response to his transition:

'My family did not receive any support. I do have a very supportive family and my parents both understood that I needed to transition. They, and my sister, said that I had always been a bit awkward and that it all made sense now. My grandmother and great aunt (both in their eighties!) also accepted quickly that I needed to transition'.

Similarly, Andrew's partner also received no advice, but proved very supportive to him. He also recognised the need to be there for her, too:

'My partner ... who watched the TV program with me, also did not receive any support. She had many questions, some of which I could not answer. It was also difficult to be so wrapped up in my own transition and having to support my partner at the same time (who had the same sort of problem, having to come to terms with me transitioning and supporting me at the same time)'.

Andrew described how the nature of his relationship with his partner became a subject of discussion amongst other people, as well as between themselves, whilst the absence of a disinterested party to talk to was keenly felt by both himself and his partner:

'My partner identified as lesbian and was suddenly confronted with members of the public telling her she was heterosexual. Being a social worker herself I am sure she would have very much appreciated somebody to talk to who was not involved in my transition. There is very little support, even online, for partners and families.

A social worker could have simply been available for a chat when things got difficult. We are both independent and strong people but knowing that there is somebody who can listen to your thoughts, who is not your partner, can be very helpful’.

The complexities of changing documentation at transition were again highlighted as problematic:

‘When I considered changing my documentation I first asked my GP but he had no help to offer. I then researched the topic online and found several contradicting sources. Eventually I changed my name through an online service and then changed my driving license so that I could use that as proof of ID when changing all my other documentation’.

‘I did not tick a box for either female or male as I was going to ask when handing in the form which box I legally need to tick. On handing over the form at the DVLA the woman quickly glanced at me and ticked "male". I left it at that, which means I now have a driving license with a male marker although I have not legally changed gender’.

Andrew explained how the absence of a gender recognition certificate affects him, four years after transitioning:

‘I have often come across the question over the past four years, since I changed my name and title, which gender box to tick. Recently I had a discussion with a social worker when I completed a Disclosure form and was unsure which gender to tick. The social worker was at a loss as to what box I should tick but we agreed on "male" in the end as we both thought that the form was likely to be returned if the title, name and gender did not match. It would have been most helpful to have a trained social worker guide me through my name and documentation change and clarify the legal side of things’.

However, the situation should be resolved, at last, for as Andrew explained:

‘As I (have) finally had my chest reconstruction surgery ... I will now apply for my gender certificate to legally change my gender to male’.

Case Study: Amy

Key Issues Relating to Research Findings:

- Initial feelings of gender dysphoria at age seven
- Mixed reactions from family – acceptance by parents, rejection by others
- ‘Derogatory’ name calling by members of the public
- Very much values new female birth certificate
- Still sometimes perceived as transsexual, after transition
- Would value relationships advice
- Provides support to other transgender people about transitioning

Amy was in the age group 46 to 55 and had transitioned to live as a woman prior to the first survey and the interview. Her survey responses suggest that she was brought up as a girl, but her interview responses do not repeat this highly unusual assertion: as she has clearly undertaken a gender role transition, it is therefore assumed that she may have misinterpreted the survey question about original gender role. She was living at her parents’ home, and was currently unemployed and stated that ‘because the DWP has determined that I have a mental disorder, I am on long-term Incapacity Benefit because of gender incongruence’. Her education had taken her to HNC/HND/Level 4.

She identified her biological sex as male, and described her gender identity as female, identifying with the gender descriptives ‘female’ and ‘trans-woman, trans-female, transgender female, transsexual female, MtF (or similar)’. She had undertaken a ‘real life experience’ as part of her gender reassignment process, and had applied for and received a gender recognition certificate.

Amy explained her childhood conflict with gender dysphoria, so common amongst transgender people’s memories of their childhood, very succinctly and simply:

‘I have known from (the) early age of 7 years old that ... something was not right with the way my body looked. Why was it not the same as my sister’s body? I ... had to endure feelings of suicide ... before seeking help through my GP ... to explain my feelings that I am a female in a male body’.

She noted that, while her mother and father have been supportive, other members of her immediate family have been quite rejecting:

'I tried to explain to my brother five years ago and he just swore at me. He and his family do not acknowledge my existence; his son turns his head away from me ... He wanted my mother to tell me to leave ... home because I would be an embarrassment to him and his family by association ... however my mother and father said 'no' to him and have supported me'.

'Some family members cannot accept that my gender is female and do not acknowledge me as female. They do not talk to me and have stopped celebrating my birthdays'.

Amy also experienced rejection from members of the public too:

'I was being called names like 'he/she', 'tranny' and 'gay, and other derogatory words'

Amy refers to her transition surgery as 'gender confirmation surgery' rather than 'reassignment surgery' a subtle change in emphasis which is less commonly found in the literature, but is likely to feel appropriate to other transgender people too.

She was able to have a 'brow shave and rhinoplasty twice on the NHS' but was 'dissatisfied with the results'. In addition she explained that she was 'still not happy with (her) voice even after some speech therapy'. She expressed concerns that her voice 'still gives me away as being male bodied'.

Amy found the process of changing her legal name complicated but found that changing her name by Statutory Declaration made subsequent changes easier. She expressed real satisfaction with receiving a new birth certificate (through the Gender Reassignment Certificate system), which she believes will lead to her being treated as a woman within a range of public spaces:

'My new birth certificate has helped to confirm my gender identity legally as female for all purposes which will help in so many ways such as marriage, passport application and if I use the female changing facilities of sports and leisure centres, employment where it (is) sex specific, and health services such as being placed in a female ward in hospitals and treatments (such as) breast screening ... I (have) had practical experience already (when I was) admitted to ... hospital ... for six days ... I was placed in with other female patients and treated as such. Overall I am very

happy with obtaining my birth certificate as female as it is important that my legal rights are protected’.

Nonetheless, she found that difficulties of passing had affected the degree to which she is seen and accepted as a woman. She also expressed concerns that her background may affect her future relationships:

‘How difficult it is to be seen as the gender we transition to, especially as I am a late transition in my 50's! Years of testosterone hormone poisoning in my body has given me unwanted masculine features which are upsetting for me to try living with. I do not like be perceived as a transsexual by society. I did not go through the slow processes of transitioning to become a transsexual ... the only issue I think of (that a social worker) could help me with is having loving relationships with males. I must confess that I am frightened about a relationship in case they get violent with me if I tell them that I'm a transwoman. Also being rejected would hurt me’.

Amy had retained contacts with her local transgender group, after transition, to assist and advise those in a similar situation:

‘I still attend my gender support group meeting ... to help others in their transition as I can answer any questions about gender reassignment surgery’.

Case Study: Luke

Key Issues Relating to Research Findings:

- Male clothes, friends and interests as a child
- Six monthly appointments at G.I.C. insufficient without interim support
- No support available to mother, sister and father
- Rejection by uncle and aunt
- Changing documentation problematical
- Problems with NHS using the wrong name or gendered title
- Concern that physical and mental health issues now linked to being transgender

Luke was in the age group 16 to 25 and had transitioned to live as a man prior to the first survey and the interview. He was living in his parents' home, and was currently an employee. His education had taken him to S.C.E. Higher level.

Luke described his biological sex as female, and his gender identity as male, identifying with the gender descriptive 'male'. He had undertaken a 'real life experience' as part of his gender reassignment process, and had applied for and received a gender recognition certificate. His survey responses suggest that he was brought up as a boy, but his interview responses expand on and explain this highly unusual assertion.

Luke began by explaining in more detail the circumstances of his childhood:

'As a child I only ever held a male gender role, but was still considered female, but was in male clothes and having all male friends and interests. At age 16 I made the conscious effort to have my name changed and only ever be referred to as a male. And at 16 I started to get treatment for my gender dysphoria'.

He explained about the limited support he had received about the process of gender transition:

'I have attended a gender clinic. However an appointment roughly every six months at times hasn't been sufficient. I have always felt there should be some form of more regular interaction between these appointments to help me to cope a little better. For example when I first got my consultation for chest surgery I was told I would probably have to wait about two years to have the surgery done. I was completely devastated and (it) would have been beneficial to have some support

during this (period), other than just my mum because you can't really explain properly how you're feeling to her, particularly because my mum normally starts crying when I get upset over this because she is my mum. So, not to upset her, I bottle up a lot of feelings that are only released twice a year'.

Luke commented further on the contrast between the way his mother and his close and extended family had responded to his transition:

'My mum in particular found my transition very hard and she would have liked to talk to someone about this - particularly the rejection from her brother and his wife. They now ignore me at family gatherings etc. and she finds this very hard. Mum also felt that family help would have also been good so my brother, sister and dad could have talked about what they were feeling. Although it was only me transitioning everyone had their own thoughts and feelings on the matter'.

Changing documentation was also problematical:

'Because I had no help, I ended up filling out the paperwork three or four times over, which made what should (have) been a quick and simple process very hard. For some things like the bank it was straightforward, (whilst changing my) passport ... wasn't. I know of a lot of trans people who have not a clue how to get them. I only figured it out by googling it, which as always brought up completely useless information as well as helpful - I just had to figure out which was which'.

Luke had particular concerns about support from within the NHS:

'What I have found since I started my transition is that every time I am unwell my GP is under the impression it's because I take testosterone. It would have been helpful just to talk about this. I have also had numerous run-ins with certain departments of the NHS ... with some refusing to call me Luke, or being called Miss Luke'.

Links between illness and being transgender were not however only made because of his hormone therapy, leading to a number of areas where support would have been appreciated:

'I have had illnesses that anyone could get, yet it has been turned into a massive fiasco because I am transgender and find accessing health care very difficult. Someone to help balance out what I should and shouldn't be talking to my GP about would be helpful because for the most part I don't, other than to refill prescriptions. And someone to reassure (me) that no, I am not unwell because I am transgender. I have found private health care is far more understanding, and I use my insurance now for most specialist care. A recent illness affected my sleep, and led to a lot of discomfort. Help dealing with my work's attitude would have been helpful. I don't think it helped that the conclusion was that my nerves were over-active because I'm a transgender person. A lot of that got linked to a mental health issue I do not have. So again, (I would have appreciated) someone to reassure me that I am not losing my mind throughout all these scenarios which could happen to anyone but are somehow made more difficult because I am trans'.

Case Study: Ciaran

Key Issues Relating to Research Findings:

- Would have valued support to help come to terms with being transgender, with family's response, and with abuse in public
- Online experiences poor, including sexually motivated responses
- Good support from mother and siblings, fiancée, fiancée's family, and friends, but not from father
- No family members received support, but they supported each other
- Penis construction surgery is on offer, after weight loss
- Verbal and physical abuse in public
- Suffers with panic attacks

Ciaran was in the age group 16 to 25 and had transitioned to live as a man prior to the first survey and the interview. He was living with his partner, and was currently long-term sick and disabled. His education had taken him to Standard Grade level.

Ciaran identified his biological sex as female, and described his gender identity as male, identifying with the gender descriptives 'male', 'transgender' and 'trans-man, FtM etc.'. One of his survey responses had suggested that he was brought up as a boy, but his interview responses supported the notion that he lived as a girl (for example, having a lesbian relationship) until his early twenties when he transitioned. He had undertaken a 'real life experience' as part of his gender reassignment process, and had also applied for and received a gender recognition certificate.

Ciaran had noted in his survey responses that he would have valued the assistance of a social or care worker a little, 'to help you to understand and come to terms with your gender identity'. When asked how such assistance might have been helpful and what sort of issues he would have wanted to explore, he explained that:

'It would have been good to have somebody to help me deal with my family's reaction and the abuse I received in public. The only information I could find about trans was online and I started looking into it when I was (in my late teens) but I was confused about the limited information there was and too scared to discuss it with anyone until I was (in my early twenties) and even then it was coaxed out of me by

a CPN I was seeing for my depression. I would have liked to been able to speak to someone further into their transition but after a few bad experiences online seeking fellow trans-people I'd now rather get on with things the best I can'.

He described his rather unhappy experiences of seeking information online, in helpful detail:

'I tried a couple of the websites printed on leaflets from the (G.I.C.) but the chat option was never open, so I tried some searches which didn't turn up much in common with what I was looking for. I set up a profile (on two websites) explaining that I was the only trans in my small minded town and was looking to have general chat with others at any stage of their transition. I contacted a few people but the only replies I got were of a sexual nature ... one man was sending me messages of encouragement explaining his brother used to be his sister and they were originally from my town etc. so we exchanged emails and he suggested meeting up. I wish I hadn't agreed and I was stupid/naive enough to not tell anyone I'd even been online looking for someone to talk to. Since I started my transformation ... I have still never met another transman or transwoman'.

Later, he was able to access further, though limited, support from the CPN mentioned above, and from the G.I.C., as well as from his GP, family and friends:

'I was seeing a CPN for a few years but was discharged over a year ago, she is very good at her job and she gets in touch now and again to see how I'm getting on but I don't feel I can talk to her about things like I used to. Other than that the support I've received has been from family and a small but brilliant group of friends (even after the majority of them tried to talk me out of my plans)'. My friends got most of their information online (or picked my brain) so maybe some informative reading materials would have helped them too.

'At the G.I.C for the first few appointments it was all questions. I understand why they have to do that but once I started on the testosterone I was told I had to be seen every 6 months to "check in" and while I appreciate the doctors are busy, they are very tricky to get hold of especially when operation dates/times are changed at the last minute. It's also not ideal that my nearest G.I.C involves a 200 mile round trip and I have to travel to London for operations'.

'My GP eventually wrote a referral to G.I.C and wrote a report so I could obtain my G.R.C. and tells me I'm "looking good" on the odd occasions I see her but that's been the most of her involvement so far. I have thought about phoning the Samaritans at times but I'm never brave enough and wouldn't know what to say. I did get in touch with the nearest LGBT group offering to volunteer on the phone lines to hopefully gain some more knowledge and possibly help others, but after they sent me an application form which I returned, I never heard anything back'.

When asked about the support that his family had received, Ciaran explained:

'None of my family received support in the professional sense but they supported each other at times. I think my mum and my aunt ... would have benefited the most from additional support as they did struggle a bit to accept my decision, my aunt spent many hours trying to persuade me it was "just a phase and I would regret it" but once she realised how serious I was she vowed to support me no matter what. If they had support they could have discussed how to deal with nosy people quizzing them to voice their disapproving comments and maybe help them understand how I was feeling mentally as I wasn't very good at vocalising my thoughts/feelings'.

'My mum is a very intelligent, strong woman and while we had a few ups and downs when I first spoke to her of my plans, she always fiercely defended me publicly as did my aunt and my cousin. However I have ... other aunts and ... cousins that I no longer have contact with ... I think my brother and ... sister would have benefited from support as they were old enough to understand but didn't know what to do/say when word got around their schools which made me feel awful and ashamed. 'I know my mum struggled with the "loss" of a daughter and potential grandchildren and my ... sister was also quite upset, but once they came to realise I was the same person inside and much happier they found it easier to move forward from those feelings. My ... sisters actually coped the best looking back on it now; they just accepted my new name and whenever anyone would slip up with my name they would be the first to correct them which always put a smile on my face'.

Ciaran went on to explain at some length how his relationship with his father had suffered, and how this had led to gossip within the town, which was clearly very distressing:

‘Maybe if there had been someone my dad could have spoken (with) he wouldn't have publicly disowned me and proceeded to tell anyone and everyone he meets that know me only (by my male name) that I was in fact a "girl" and my real name was (original female name), which not only put the person in an awkward position but led to more people whispering/pointing, knowing my business and posting horrible things online’.

‘I think any form of family support/therapy from an appropriately trained person would be extremely valuable, especially when younger family members are involved. As for my father I'd like to think if the support had been available a few years ago, things might have been different but I'm so hurt and angry (for separate reasons too) I'd find it difficult to forgive him if he suddenly had a change of heart/lobotomy’.

‘He has often told my mum (when she's trying to explain things to him) that in his heart I'll always be his daughter, which explains why, when I gave him the last birthday card signed in my new name, he told me to "pack it in, it's not funny anymore”’.

‘I actually bumped into him in Tesco just before Christmas. I was with my fiancée and my ... sister ... and he was with his new partner. A whole series of emotions washed over me and I wanted to run out of the shop but my sister swore to punch him in the face if he was horrible to me, so feeling encouraged by her (empty) threat we carried on shopping. The first time they passed we got a nod and when we next ended up in the same aisle I doubled back on myself until he shouted a comment about me running away, which made me see red and walk down to meet him to try and show he wasn't getting the better of me and tried to mentally prepare for confrontation (which I prefer to avoid). However when we got closer he asked how I was doing, I introduced myself to his partner who shook my hand and replied "I know, I've seen the pictures" then my dad chatted away as if we were old friends. He touched the stubble on my chin and told me I was looking good which of course left me feeling like I was in some sort of very vivid/weird dream’.

'I think he was surprised as I looked a lot like him before my transition and when he spoke to my mum ... he said it was like looking in a mirror at a younger him. He tried to make chit chat with my sister and although she was polite and civil in her responses, her main concern was standing as close as possible to me. Then before we went our separate ways he gave me a hug and told me he loves me. My mind went into overdrive and I'm glad I had people with me otherwise I would never have believed it had happened'.

'However a few days later he was in my friend's work and as I'd told her about the Tesco encounter she mentioned she had been round for a visit but my dad refused to talk about me unless she called me by my old name (in a busy shop). She didn't want to tell me but eventually did so. Not only did I have a few restless/sleepless days thinking about building bridges with him but I had a few more trying to get my head around his actions. Approximately a week later I was in Tesco again with my fiancée and sister and he was there with his partner but he made the mistake of telling me to "cheer up". I won't bore you with the details but I finally stood up for myself and when he argued about my real name I pulled out my driver's licence to prove my legal name, and told him to do what he wants with his life but at least have the common courtesy to call me by my chosen name regardless of who he is speaking to. We have never spoken/bumped into each other since and I still hear of him telling people my business so I think even if the support was to be made available to him now he wouldn't accept it'.

'I live in a small town and as you can imagine everyone knows everyone else's business so it didn't take long before I was verbally abused for being a "freak" and even assaulted in public more than once. I would like to move away to a place where nobody knows me and I can leave the house without having panic attacks but my family are here (the ones that haven't disowned me) and my angel of a fiancée/her family'.

This relationship with his fiancée was clearly of very great importance, having begun originally prior to his transition:

'I met my fiancée when we were (in our teens) and we're now (in our twenties). She just accepted it and carried on loving me for me but I think additional support

or information booklets instead of the confusing information online would have made things easier for her too. Her family weren't too happy when we were in a lesbian relationship mainly due to the small town gossip and they're quite private people so when we split up ... they were delighted to say the least, which I understand because I wasn't a very good girlfriend all of the time. So when we got back together we kept it from her parents until I proposed after a year and my fiancée was terrified going home to break the news so I waited in the car and when her dad appeared my legs turned to jelly but I got out and walked over and he shook my hand, made me promise to look after his daughter then gave me a hug. I think it was more because they had bumped into us, didn't recognise me and later asked her who was the guy she was with. So to the outside world we look like a "normal" couple. They're keen to keep the rest of her large family in the dark about my past which suits me fine; they have had a few people trying to quiz them but they tell them to mind their own business and remind them that their daughter is happy. Since our engagement I am always invited to family functions, we pop in once a week to the in-laws for a cuppy, or stay for tea and they come over to our flat for cakes and a catch up. However I think they would have benefited with some reading material to better understand my position'.

Ciaran was able to explain his feelings in some detail too, linked with surgery and being overweight – and about the future too:

'Some days I wake up feeling miserable to be honest. When I try and look ahead, all I see is the weight I have to lose before I can begin my bottom surgery for which the funding has been in place for approximately seven months. Of course I have a good incentive for losing the weight but a common side effect of the Sustanon injections is weight gain and the main side effect of my anti-depressants is an increased appetite, plus I'm a "comfort eater". I need to lose approximately ... before the surgeon will allow me to proceed with my surgery, which I understand is for health reasons etc. but it's been very hard and the doctor at the G.I.C giving me a hard time about my weight doesn't help'.

'I would love to be out working again but the anxiety I feel about even leaving the house some days overwhelms me and I sometimes worry about the future children we don't yet have finding out about me and getting teased. As I have said before I

would like to move away and start somewhere fresh but for various reasons this is not a viable option’.

‘I hope that once my bottom surgery is complete I will feel more comfortable in my own skin and get back to my proud, stubborn, hard-working self. I know "a penis does not a man make" but I'd feel more confident in my argument/defence when people try and tell me I'm not a guy.

‘Being able to discuss our future with regards to starting a family would be very helpful. I had the choice of freezing eggs but a combination of being keen to start the hormones and the invasive nature of the procedure made me decline the offer, which I'm not quite sure if I regret or not’.

Ciaran ended our correspondence with a brief but optimistic series of comments:

‘Social Work support for transgendered people, in my humble opinion, can only have a very positive outcome. From our few email exchanges I feel better within myself and for the first time in years I'm starting to feel proud again of everything I have achieved so far. Compared to the things I had to do to get my top surgery (endless letters to my local MP, and my local NHS) losing a few more pounds seems much more manageable’.

Case Study: Abigail

Key Issues Relating to Research Findings:

- Initial awareness of gender dysphoria as a child
- Gradual awareness of belonging to 'third gender'
- Married, with children; supportive family
- Initially came out as bi-gendered, then as transgender
- Real life test very difficult without much support
- Changing documentation difficult
- Values new birth certificate – but 'it is a lie'

Abigail was in the age group 56 to 65 and had transitioned to live as a woman prior to the first survey and the interview. She was living alone, and was self-employed. Her education had taken her to degree or postgraduate level.

She described her biological sex as male, and her gender identity as 'third gender', identifying with the gender descriptives 'female' and 'transgender'. She had undertaken a 'real life experience' as part of her gender reassignment process, and had applied for and received a gender recognition certificate.

Abigail described her early experiences as a transgender child, with great honesty, summarising the intense confusion and unhappiness that is apparent in so many transgender narratives of childhood:

'Initially I had no understanding of my gender at all. All I knew was that when I looked in the mirror, I didn't really recognise the boy I saw there. I didn't understand this at all, and it frightened me. At the same time I knew that there was no-one I could talk to about this ... after a couple of years I found myself having to admit to myself that I would be much happier being a girl. This frightened me even more and filled me with unbearable shame. This was in the mid-sixties, way before the time trans-people had any visibility at all ... all I could do was try to be "normal". This meant trying to split off my feminine self from me and do all I (could) to suppress her. This was a terrible time. I lost myself. One way of understanding my life since then is as a long attempt to recover my identity as a human being'.

She went on to describe her adult life as a period of apparent relative stability, but with a growing awareness of her sense of belonging to a 'third gender':

'I was lucky to meet a woman whom I could love and who loved me and who was the first human being I could tell the truth about myself to. This was in 19xx, soon after we met'.

'My sense of being 'third gender' evolved. Crucial was the fact that I came across an account of the Two Spirit people of the Native Americans in about 19xx. The discovery that people like me did exist in other cultures where we (were) accepted and allowed to live freely was incredibly important, as was the experience of bringing up our children, which we shared, and being able to connect imaginatively with my female identity in my work'.

Abigail explains that she did not 'come out' until mid-life, (like many MtF transgender people):

'By 2xxx ... I came out to my family and friends as a 'bi-gendered person' but as time passed it became inescapably clear that I needed to abandon my male identity to discover who I was'.

Transition presented difficulties however, not least because of a shortage of support to both Abigail and her family:

'I suppose the point was that at the time, apart from the rather infrequent appointments with the gender specialist, there was no support of any kind available at all but I managed to find support from other sources - from the simple straightforward acceptance of the lady who was doing my facial hair removal; from my very special and amazing dance class. Prior to my first appointment with the gender clinic - a huge concern was to find support for my family as well as for me. Because this so profoundly affected them (not really social work, this: more to do with relationship counselling)'.

In response to a further question, asking if Abigail managed to find support for her family, she explained:

'No. We had to deal with it ourselves. And we did'.

She explained the complexities of the real life test, from a largely practical perspective:

'I began the process called "the real life test" - in which you are supposed to start living full time as a woman. This has the hugest implications in every aspect of your life, again, without support. Anything, absolutely anything, would have been welcome'.

'Late on in the process, the LGBT health centre began a group to help people in transition, run by a trans-woman psychologist. This was so helpful. In social work terms, there is a huge host of practical things - changing NHS card, NI number, passport, bank accounts - the list is endless, and I still haven't got to the bottom of it all (insurance policies are a particular nightmare) where social work guidance would be invaluable'.

'I feel I blundered through, and continue to blunder through, a hugely complex process with all kinds of practical implications I am almost completely ignorant of!'

Finally Abigail explained, with remarkable pragmatism, how she viewed her change of gender role within a binary system as someone with a 'third gender':

'Recently my daughter had some wonderful news to give me. She said: "Dad, you're going to be a grandma!" which kind of sums up, very beautifully, how I would like my family to feel about it all. And they mostly do'.

'While I was dressing in a neutral kind of way, and as I started to go out dressed as a woman, people would frequently point, laugh out loud, and make very cruel remarks. Almost immediately after I had surgery ... this almost completely stopped. Somehow I seemed to stop being perceived as a 'third gender' person and, at least to the casual glance, became accepted as a female'.

'There is a real dilemma here: I am actually very proud of being a trans-woman and do not wish to "go stealth" or conceal this. Nonetheless, for my own safety it is generally very important my trans identity remains unperceived. Because my transition had to be quite a public affair, everyone I work with knows perfectly well I am trans. As to other interactions - shop assistants, waiters, bar staff etc. it is of no importance to me whether people perceive me as trans'.

'The crucial thing is to be treated with consideration and respect'.

'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'.

Appendix Six: Follow Up Studies

Life After Transition: Adult Transsexuals

This section considers the findings of a number of studies which have sought to review the outcomes of gender reassignment of transgender people, post-transition, with a view to identifying factors which may affect outcome, which may be relevant to this research. It will mainly consider the social and personal developmental aspects of transition.

The study by Pfäfflin and Junge was one of the most extensive reviews in the literature, for it considered thirty years of follow up studies in the English and German language, (covering the period of the widespread emergence of sex reassignment surgery (SRS)), consisting of almost eighty papers and reviews 'of approximately two thousand persons who have undergone sex reassignment surgery' (1998: 1). Many of these reviews are at a period of approximately two to three years after surgery, but 'fourteen publications about women and nine about men, and two that do not differentiate by gender reported a follow up period of at least five years since 'the surgery'' (1998: 27), which is an important balance to what might otherwise be viewed as a review of the 'honeymoon period' after transition.

The main outcome of the Pfäfflin and Junge review is that 'gender reassigning treatments are effective. Positive ... desired ... effects overweigh continuously ... negative or non-desired effects (although) the results with (FtM people) are, on average somewhat more favourable than those with (MtF people)' (1998: 39). Subjective satisfaction results mainly range within a spectrum of 71% to 87% for MtF people, and from 89% to 97% for FtM people, with the converse factor of dissatisfaction ranging from 8% to 13% (MtF) and 3% to 10% (FtM) (1998: 39/40).

Pfäfflin and Junge identified seven factors 'that contribute to the effect and effectiveness to treatment of gender reassignment' (1998:42). These were: continuous contact with a treatment centre (or research programme), living in the other gender role, hormone treatment, counselling, or other psychiatric/psychotherapeutic treatment, surgery, quality of surgery, and legal recognition of the new gender name and sex. They noted that MtF patients were more likely to suffer social isolation, while FtM patients were more able to maintain stable and satisfactory partnerships (1998: 44). Pfäfflin and Junge also noted that 'dependency on social welfare (was) predominant amongst (MtF patients)' (1998: 54/55).

Pfäfflin and Junge identified two studies which supported the conclusion that 'the probability of "regrets" with heterosexual (MtFs) is larger than with homosexual (MtFs) as well as (FtMs)' although 'the figures were small and the classification ... problematic' (1998: 55). The age of the patient was found to indicate contradictory results in relation to prognosis; this is a factor which other reviewers have also considered. De Cuypere et al reviewed thirty five MtF and twenty seven FtM transsexuals who had undergone SRS between 1986 and 2001 in Ghent. They indicated that while 'the subjects proclaimed an overall positive change in their family and social life (and) none of them showed regrets about the SRS ... a homosexual orientation, a younger age when applying for SRS and an attractive physical appearance were positive prognostic factors' (2006: 126/127).

The issue of sexual orientation was also addressed by Johansson et al who indicated that 'there was ... a significant difference between the sexes regarding their sexual orientation. Twelve of the MtFs (48%) preferred a female partner compared to only one among the FtMs (6%) who had a preference for a male partner' (2009: 6). Lobato et al were also able to conclude that, (from a follow up study of eighteen MtF and one FtM post-transition patients in Brazil) 'the overall impact of sex-reassignment surgery on this cohort of patients was positive' (2006: 711). In addition they noted that 'sexual experience was considered to have improved by 83.3% of the patients, and became more frequent for 64.7% ... the number of patients with a partner increased from 52.6% to 73.3%' (2006: 711).

Corresponding with the corresponding conclusions of Pfäfflin and Junge, De Cuypere et al, Lobato et al, and Johansson et al, a further study of one hundred and forty one Dutch transsexuals (thirty six FtM people and one hundred and five MtF people) by Kuiper and Cohen-Kettenis, concluded that 'there is no reason to doubt the therapeutic effect of sex reassignment surgery' (1988: 439). They also note that ninety two persons (65.2%) indicated that they felt happy or very happy, thirty three (23.4%) were moderately happy, while sixteen (11.3%) described themselves as unhappy or very unhappy.

When Kuiper and Cohen-Kettenis scrutinised these results and analysed what patients meant by happiness, they reported 'feeling more free, experiencing more inner calm, being relieved and glad that desire and reality had become one (with) positive references to the SRS. However, one factor in particular was related to 'experienced happiness': 'having a steady partner'. Conversely 'feeling unhappy usually correlated with a sense of loneliness'.

Kuiper and Cohen-Kettenis conclude from this that the 'absence or termination of a steady relationship is of decisive significance in this respect for many persons' (1988: 445).

Kuiper and Cohen-Kettenis also further explored the notion of regret that Pfäfflin and Junge had identified, clarifying this by asking if patients 'ever have doubts about your sense of being a man (or woman)?' One hundred and thirty six of the hundred and forty one patients 'reported no or hardly any doubts about their own gender identity': only one FtM person and three MtF people felt occasional doubts. (1988: 448). However, although the majority of respondents were satisfied with their 'own behaviour as a man (FtM) or a woman (MtF)', eight MtF people felt either dissatisfied (seven) or very dissatisfied (one) with this aspect of their identity.

It might be anticipated that this outcome may perhaps be partially explained by responses to the question 'how well do you in your opinion pass as a member of the newly assumed gender?' 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). They explain that 'most of the problems reported ... can be divided into two categories: (i) physical problems like a too low-pitched voice ... no penis' etc. and 'problems in overt management of their transsexual background in relation to a new partner, colleagues, or parents-in-law' (1988: 446/7). Lobato et al had noted that, post SRS, family relationships improved in only 26% of cases, 'whereas 73.7% of the patients did not report a difference' (2006: 711). These detailed findings are of particular relevance to the present research, where the need for support in relationships with relatives, friends, colleagues and neighbours is carefully considered.

In addition, and again of particular relevance to the present research, Kuiper and Cohen-Kettenis note that 'lack of understanding and discrimination are mentioned by six FtMs (of thirty six) and seventeen MtFs (of one hundred and five)' and that 'strikingly, the FtMs mention only *lack of understanding*, whereas the MtFs emphasize *discrimination*' (1988: 447, italics added).

Kuiper and Cohen-Kettenis found that 'one of the FtM's attempted suicide, about two years after starting treatment (and that) fifteen of the MtF's attempted suicide, mostly within two to five years of starting therapy. Ten were motivated in their attempt by psychosocial

problems and the associated feelings of loneliness and depression'. They also note that three MtF people (but no FtM) have committed suicide in the last ten years (1988: 451).

Lastly, and supplementing Pfäfflin and Junge's seven factors noted above 'that contribute to the effect and effectiveness to treatment of gender reassignment', Kuiper and Cohen-Kettenis found a positive correlation between subjective well-being, and ten variables in the study: 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).

It is in their conclusion that Kuiper and Cohen-Kettenis are particularly explicit in their support of 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. Such life situations appear to be the most important factor in the majority of cases of attempted suicide. The fact that one in seven MtF's (and one in thirty six FtMs) tried to commit suicide after treatment started is considered a critical signal' (1988: 455).

Similarly, over twenty years later, 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 overall mortality, death from cardio-vascular disease and suicide, suicide attempts, and psychiatric hospitalisations in sex-reassigned transsexual individuals compared to a healthy control population'. They commented that 'even though surgery and hormonal therapy alleviates gender dysphoria, it is apparently not sufficient to remedy the high rates of morbidity and mortality found among transsexual persons. Improved care for the transsexual group after the sex reassignment should therefore be considered' (2011: 7). As with the findings of Kuiper and Cohen-Kettenis, this

is compelling evidence that social care is likely to be needed alongside medical care to address social factors which may be likely to underlie post-transition difficulties.

Life After Transition: Adolescent Transsexuals

This second section of discussion of follow up studies looks at the specific circumstances of young and adolescent transgender people. It is anticipated that their experience is likely to be significantly different from that of older individuals, particularly prior to, during and immediately following puberty and its linked developmental changes, not least because they may have less options, and less control than their adult counterparts for support with, and resolution of, their gender dysphoria. In the case of Scottish transgender young people the situation is further complicated by the recognition within the Scottish Gender Reassignment Protocol that 'at present specialist gender identity development services for children and young people under sixteen are not available in Scotland'. A referral for support is required, via a GP or gender identity clinic to the Tavistock Centre in London.

Cohen-Kettenis and van Goozen note that 'strong feelings of belonging to the opposite sex and corresponding behavioural manifestations have been reported as beginning as early as two to three years of age (Zucker and Green, 1992)', but that 'prospective studies show that most children with gender identity disorders will not grow up to be transsexuals' (Green, 1987; Zuger, 1984). They add that 'the chance of making the wrong diagnosis and the consequent risk of post-operative regret is felt to be higher in adolescents' and that 'adolescents in many countries are still legally dependent on the consent of their parents when deciding on medical treatment' (1997: 263).

In a study of seventy seven children with gender dysphoria, Wallien and Cohen-Kettenis 'found that 27% of our total group of gender-dysphoric children was still gender dysphoric in adolescence'. They found that 20% of boys were still gender dysphoric, whereas the percentage of girls was much higher than the 12% found in earlier studies (Drummond et al 2008), for '50% of the gender-dysphoric girls seemed to have persistent gender dysphoria' (2008: 1420). They noted that 'in response to our question at what point in time the desisting participants noticed that their cross-gender preferences and feelings had decreased or disappeared, most answered that the change took place upon entry into secondary school ... closely related to the development of the physical markers of maleness and femaleness' (2008: 1422).

Cohen-Kettenis and van Goozen also highlight a number of factors in support of early intervention, particularly to the few individuals who show 'an extreme pattern of cross-

gender identification from their earliest years' for whom 'knowing that they will have to await treatment for many years engenders feelings of hopelessness and slows down their social, psychological and intellectual development'. Puberty itself provides a particular motivator to act early, for Cohen-Kettenis and van Goozen highlight, within a study by Ross and Need (1989), an association between 'post-operative psychopathology' and 'factors that made it difficult for post-operative transsexuals to pass as their new gender' such as a deep voice or the development of breasts. Lastly they suggest that 'unfavourable post-operative outcome seems to be related to a later rather than an early start of the SRS procedure' (1997: 264).

Smith et al explain that for 'those carefully selected patients who are referred for hormone treatment, hormone therapy between the ages of 16 and 18 (is) in two phases: first hormones with reversible effects (for MtFs, anti-androgens to block further masculinization of the body; for FtMs, progestins to suppress menstruation), second, estrogens to feminize the MtFs and androgens to masculinize the FtMs' (2001: 472).

It is important to note that in addition to the absence of G.I.C. support and treatment within Scotland to transgender young people, no guidelines are included in the Scottish Protocol regarding treatment options for children and young people nor indeed diagnostic procedures which might be followed. In addition, there is no 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 of the prescription of androgens or estrogens.

In a follow up study of twenty two patients, (fifteen FtM and seven MtF), one to five years after surgery, Cohen-Kettenis and Goozen found that 'SRS has resolved the patients' gender identity problem and enabled them to live in the new gender role in quite an inconspicuous way. Socially and psychologically these adolescents do not seem to function very differently from non-transsexual peers, perhaps with the exception of a greater reluctance among those in the FtM group to get involved in short-term or incidental sexual encounters' (1997: 269).

Such positive outcomes are however qualified: 'relief of gender dysphoria, however, does not necessarily mean relief of unhappiness in general ... in some cases ... certain non-

transsexualism-related problems had disappeared, such as shyness or bad school grades. But in other cases such changes had not occurred, or the new situation had created new problems such as (in the majority of the FtMs) living as a man without a penis (which) may cause practical problems' such as group showering after sports activities and frustration 'at the impossibility of having "real sex" with one's girl-friend' (1997: 269/270). Smith et al suggest that early treatment may avoid not only the 'irreversible physical changes (especially a low voice and beard growth in MtFs) which may create lifelong traces of the biological sex' but that it may also avoid 'delay or arrest in areas that are particularly important during adolescence (e.g. peer relationships, romantic involvements, or academic achievement' (2001: 473).

A direct comparison by Cohen-Kettenis and van Goozen with the adult study mentioned above (Kuiper and Cohen-Kettenis, 1988) suggests that 'compared with the adult group the 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' (1997: 270). Cohen-Kettenis and van Goozen suggest that 'part of the adolescents' better functioning might be due to the fact that they pass more easily in the desired gender role, because of their convincing appearance (for example in relation to MtF's, the 'early anti-androgen treatment apparently had acted in a timely way to block the facial hair growth and the lowering of the voice (1997: 270). They also suggest that 'those patients selected for early treatment (under the age of 18) not only are among the best functioning applicants but probably they also belong to the sub-type of ... individuals who are, before SRS, sexually attracted to same-sex partners'. Finally, they note, 'most of the transsexuals in our study were FtMs' (1997: 270).

Smith et al, conducted a study of 'outcomes and predictors' for sex reassignment (of three hundred and twenty five adolescent and adult applicants, of whom one hundred and eighty eight completed the process). Using the Utrecht Gender Dysphoria Scale, they confirmed that, 'for the 162 adults (who) were used to evaluate treatment' ... 'gender dysphoria had decreased to such a degree that it had disappeared ... and that, one to four years after surgery, SR (sex reassignment) appeared therapeutic and beneficial (and) the vast majority expressed no regrets about their SR' (2005: 89, 96). They also noted that 'FtMs showed better results (linked with) more convincing gender role behavior and looks' but that 'contrasting most of the more favourable FtM findings are the greater reported satisfaction

of the MtFs with surgical results' (2005: 97). The finding that 'one (adult) MtF expressed deep regrets. She indicated that professional guidance regarding adverse consequences (i.e. intolerance of society, family and her own children) would have made the transition more endurable' (2005: 97), a statement that perhaps has particular pertinence to this thesis.

Smith et al's review of predictors for a successful outcome of SR indicated that 'clinicians assessed applicants to be eligible for hormone treatment when they were more gender dysphoric, psychologically more stable, and when the physical appearance better matched the new gender role'. Unfavourable physical appearance was also taken account when deciding upon referral as 'an unfavourable physical appearance could be a risk factor for post-operative regret'. MtFs, those who showed more psychopathology (psychological instability), and, counter-intuitively, those who showed more GID symptoms in childhood, yet less gender dysphoria at application, were 'more at risk for dropping out of treatment' (Smith et al. 2005: 87/98).

Smith et al also looked at the subtypes of homosexual and non-homosexual transgender people, noting that 'only non-homosexuals reported some regrets during ... and after SR which they all related to a lack of acceptance and support from others'. They also observed that 'because the onset age and age at application have been found to be earlier in homosexuals, it is likely that non-homosexuals encounter more problems in life before applying for SR'. The 'normality' of their post-surgical relationships is also felt to be significant: 'post-surgically, 'homosexuals' will have opposite gender partners, thus forming heterosexual couples. This is still socially more acceptable'. Smith et al conclude that 'non-homosexuals should be able to receive additional guidance in coping with adverse consequences (of SR) such as a more troubled psychological functioning, or a more critical environment' (2005: 97), which again has particular pertinence to this thesis.

Wallien and Cohen-Kettenis found that 'with regard to sexual orientation almost all (those with persistent gender dysphoria) seemed to be attracted to someone of the same biological sex at follow-up', whereas in those whose gender dysphoria reduced during childhood, 'this was found for only about half of the participants'. They conclude that 'compared with sexual orientation rates from a Dutch normative study, both our boys and girls were far more likely to have a bisexual or homosexual sexual orientation. Childhood gender dysphoria thus seems to be associated with a high rate of later same-sex or bisexual

sexual orientation' although they add the qualifier that 'research on the sexual identity development of lesbian, gay and bisexual youths has shown that the sexual orientation, especially for bisexual youths, may change over time' (2008: 1421).

It appears from this brief review of the literature of studies of gender dysphoria and sex reassignment in children and young people, that there are a number of complicating factors which make a firm diagnosis of transsexuality more difficult than with their adult counterparts. Similarly, the implementation of a suitable treatment program, even with clarity of diagnosis, is complicated by the urgency that pubertal changes bring to the lives of adolescents, with profound implications for their future ability to live successfully in an opposite gender role, particularly for MtF young people. The absence of specialist G.I.C. support in Scotland suggests that transgender children and young people, and their parents and families, are likely to struggle to find suitable support locally. A local source of assistance, including consideration of the predictors, outcomes, hormonal and surgical interventions which may be appropriate, are likely to be of very valuable assistance to them during this difficult time. Such a role is likely to be best taken by a specialist gender identity team, rather than by generic social or care workers, but the need for such workers to be aware of these issues, to provide initial or ongoing support if this is sought from them, seems apparent.

Appendix Seven: Summaries of Main Research Findings

Chapter Three: Survey Three

Summary of Key Research Findings: Dedicated/Specialist Services

The key research finding within this section was of limited local dedicated/specialist services either provided or commissioned by statutory services, and also their more limited awareness of local voluntary sector transgender services. Linked with this, and perhaps underpinning the low provision/commissioning rates, was a limited statutory awareness of additional local transgender service need.

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.

Most support, even from within the voluntary sector sample, was provided to transgender adults; there was only a little evidence of similar local support to transgender children/young people or their parents, for whom G.I.C. provision is only available in London. Other family members, including partners and/or children of transgender adults also appeared to receive limited local support.

Two other important findings within this section were that telephone support appeared to be a potentially valuable additional dedicated/specialist service and that voluntary sector funding varied from self-funded/local authority/lottery funding to none at all. This latter finding perhaps underpins a further striking flaw in current services: half of the voluntary sector respondents (and three of the statutory authority respondents) identified group support as being needed for transgender adults in their area.

Summary of Key Research Findings: Generic Services

Equality impact assessments were evidenced by some statutory sector agencies, but few of these appeared to adequately recognise, detail or plan for the issues which might affect generic service accessibility to transgender people. This was to some extent counterbalanced by evidence of some initiatives within the statutory sector to improve such awareness.

There also appeared to be very limited awareness of current transgender usage of generic services.

Summary of Key Research Findings: Staffing and Training

The most important findings within this section were that there were very few dedicated/specialist staff employed to meet transgender service needs within either the statutory or voluntary sector samples and that 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 low levels of specialist transgender services within the statutory sector. However two voluntary sector staff were very experienced, with access to transgender literature, many 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 by statutory sector respondents. However there were some training initiatives for transgender issues that were also apparent within the statutory sector sample.

Summary of Key Research Findings: Policy Statements and Staff Guidelines

There was evidence of limited 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.

Chapter Four: Surveys One and Two (Part One)

Summary of Key Research Findings: Attribute Information

Every one of the forty seven people who took part in survey one was of white origin.

No transgender participants aged under 16 (this age group consists of 17% of the Scottish population) and very few transgender people aged 66 or over, took part in this research.

Those who described themselves as 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. However six participants of survey one described themselves as 'intersex' (one) or 'other' (five), whilst seven participants of survey two described themselves as 'intersex' (two) or 'other' (five).

Transgender people 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) (survey one). 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) (survey one). 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.

Of the twenty five participants to survey one who described themselves as biological males, thirteen described their gender identity and current gender role as female, one described their gender identity as male and their current gender role as male, two described their gender identity as transgender and their current gender role as male, one described their gender identity as transgender and their current gender role as female, two described their gender identity as 'other' and their current gender role as female, three described their gender identity as female and their current gender role as transgender, one described both their gender identity and their current transgender role as transgender, and one described both their gender identity and their current transgender role as 'other'.

Of the thirteen participants to survey one who described themselves as biological females, eight described their gender identity and current gender role as male, one described their gender identity as transgender and their current gender role as male, one described their

gender identity as transgender and their current gender role as female, one described their gender identity as male and their current gender role as transgender, one described both their gender identity and their current transgender role as transgender, and one described both their gender identity and their current transgender role as 'other'.

In survey one, almost a third of participants (fourteen of forty seven) lived with their husband/wife/partner (with (three) or without (eleven) children) (table eleven). In survey two a slightly higher percentage (35%) of participants lived with their husband/wife/partner (with (three) or without (seven) children). Approximately 10% of participants in both surveys lived with their parents.

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%).

Cross tabulating current gender role with home circumstances indicated that, for survey one, four participants in a male role, twelve in a female role, five in a transgender role, and one 'other' were living alone (twenty two in total, (47%) from forty seven participants). A three way cross tabulation of current gender role, home circumstances and gender role preference, 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.

In survey two, numbers of participants living alone were three (male role), six (female role) and two (transgender role), a total of eleven (38%) from twenty nine participants. A three way cross tabulation of current gender role, home circumstances and gender identity indicated that five of the six people living in a female role described their gender identity as female (one described it as 'other') suggesting that they had made a gender role transition, while only one of the three people living alone in a male role identified with a male gender identity (two described this as 'other').

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.

Of the five of thirteen (38%) of those with a long-term sickness or disability with a female gender identity, three had changed their role to female, whilst two were in the process of changing role. Similarly of the three of thirteen (23%) who had a long-term sickness or disability with a male gender identity, just one had changed their role to male, whilst two were currently changing role. Lastly, of the remaining five people (38%) with a long-term sickness or disability, who described their current gender role as 'other', two said that they would like to change their gender role, one was in the process of doing so, one responded 'other' and one had developed an androgyne gender role.

Summary of Key Research Findings : Coming to Terms with Being Transgender

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); 41% identified with transgender (14%) or 'other' categories (27%) including 'genderfluid', 'genderqueer', 'intergender', and 'polygender'. 14% of biological males and 26% of biological females identified with the term transgender. There was a slightly greater likelihood for participants in the 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'.

Of the twenty four participants who described their original gender role as male, 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 almost 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 over a half 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.

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 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. It was evident from three way cross tabulation that eight of the nine respondents in a current male gender role and with a male gender identity, rated transgender support groups in the three highest categories for support with gender identity issues, (with no respondent rating transgender support groups in the three lowest categories for such support). Conversely, of the thirteen respondents in a current female gender role, and with a female gender identity, just five rated transgender support groups in the three highest categories, with two respondents rating them in the three lowest categories. It is not clear why there should be such a difference in these quite distinct sets of ratings, and why transgender groups appear to have been less likely to have met the needs of 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. A three way cross tabulation with current gender role did not suggest significant differences in the way FtM or MtF respondents perceived support with gender identity or being transgender from gender specialists, counsellors or psychiatrists.

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 worker on gender identity issues. 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 or even clarity to one's personal sense of gender identity or of being transgender.

Summary of Key Research Findings: Transitional Issues

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 worker in making plans for the future, though ten others said that they did not need such support. In total, thirteen 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 said that they would value advice greatly on making plans for the future including perhaps for a gender transition, six were currently in a female role, three in a male, and one in a transgender role. Surprisingly perhaps, 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 uncertain.

A little over a half (57%: twenty seven of forty seven) of respondents to survey one had changed their gender role to match their gender identity. Thirteen biological males, five biological females and five of 'other' or unspecified biological sex had completed a transition to an apparently binary gender role; six biological males and three biological females were in the process of transition, and two of each biological sex said that they would like to change their gender role to match their gender identity.

Two biological males and one biological female said that they had developed a gender role which reflected a bi-gender identity, as both male and female, and one intersex person said that they had developed a gender role to reflect their androgyne gender identity (indicating at least four of forty seven, or 9% of 'transcenders' in the survey), taking the total of those who had changed their gender role to match their gender identity to twenty seven.

Adding those who would like to change their gender role to match their gender identity (four) and those who were in the process of changing their gender role to match their gender identity (nine) gave a total of forty of forty seven (85%) who indicated that they fell within a 'migrating' category.

Two and three way cross tabulations of current gender role with transition status and age identified four people in a transgender role who would like to change this to match their gender identity. Of these four people, two were biological females under the age of 35 and two were biologically male over the age of 56. Three people in a current male role, four in a female role, and two in a transgender role were in the process of changing their gender role to match their gender identity. Seven people in a current male role and fifteen in a female role said that they had changed their gender role to match their gender identity, whilst one person in each of the current male and female role categories said that they had developed a gender role which reflected their 'bi-gender identity as both male and female'.

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'.

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.

Transgender groups were rated the most highly valued source of support re helping to undertake a transition for fourteen of forty (35%) respondents to survey one. A three way cross tabulation indicated that seven of the nine respondents in a current male gender role and with a male gender identity, rated transgender support groups in the three highest categories for support with transition issues, (with no respondent rating transgender support groups in the three lowest categories for such support). But, as with issues of gender identity above (although perhaps even more surprisingly) of the thirteen respondents in a current female gender role, and with a female gender identity, only six individuals rated transgender support groups in the three highest categories, with four respondents rating them in the three lowest categories. Once again, it is not clear why transgender groups appear to have been less likely to have met the needs of MtF rather than FtM individuals regarding support with undertaking a transition.

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, nine respondents 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.

Almost twice as many close friends were rated in the three columns of highest importance than the three columns of lowest importance for support during a transition. However, a further three way cross tabulation indicated that eight 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 transition issues (with just one respondent rating close friends in the three lowest categories for such support). Conversely, of the fourteen respondents in a current female gender role, and with a female gender identity, only a little under a half (seven) rated close friends in the three highest categories for support with transition issues, with four respondents rating them in the three lowest categories. These findings reinforce the earlier data which indicate the tendency for friends to be rated less highly for support with gender identity issues by MtF than by FtM people.

A three way cross tabulation indicated that 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 transition issues, (with just one respondent rating family members in the three lowest categories for such support). Conversely, of the fourteen respondents in a current female gender role, and with a female gender identity, just two rated family members in the three highest categories, with four respondents rating them in the three lowest categories. These findings reinforce the earlier data which indicate a tendency for family members to be rated less highly for support with gender identity issues by MtF than by FtM people.

A three way cross tabulation indicated that three of the ten respondents in a current male gender role and with a male gender identity, rated the G.I.C. in the three highest categories for support with transition issues, (with just one respondent rating the G.I.C. in the three lowest categories for such support). Conversely, of the fourteen respondents in a current female gender role, and with a female gender identity, seven rated the G.I.C. in the three highest categories, with four respondents rating them in the three lowest categories.

A further three way cross tabulation also indicated that three of the ten respondents in a current male gender role and with a male gender identity, rated counsellors or psychiatrists in the three highest categories for support with transition issues, (with three respondents rating counsellors or psychiatrists in the three lowest categories for such support). Conversely, of the fourteen respondents in a current female gender role, and with a female gender identity, eight rated counsellors or psychiatrists in the three highest categories, with three respondents rating them in the three lowest categories.

From additional data described above, it may be that FtM individuals are more likely to find sources of support 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.

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 highlighting Whittle et al's finding that 21% of GPs did not want to help transgender people (2007: 16).

Online information and support was viewed with caution regarding reliability and trustworthiness.

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 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.

Chapter Five: Surveys One and Two (Part Two)

Summary of Key Research Findings: Support to Family Members

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). None of 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.

Cross tabulating current gender role with support to family members about transition, indicated broadly similar ratios of family members who had received no support, for those respondents in current gender roles of male (ten of fifteen), female (fourteen of twenty one), transgender (three of seven) and 'other' (two of three).

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 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.

Of the ten people who thought that their family members would value transgender information/advice greatly, four were currently living in a male and five in a female gender role.

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 the public airing of 'family business'.

It is perhaps surprising that the percentages of biological males (42%, five of twelve) and biological females (30%, three of ten) who thought that their families would greatly value this support do not differ more than they do. However, when those who would value such support a little are included, the percentages of biological males (58%, seven of twelve) and biological females (40%, four of ten) perhaps reflect the notion of greater familial levels of acceptance of trans-men than trans-women found by Whittle et al (2007: 69), despite the relatively low numbers of respondents: five of those currently in a male gender role said that they would value such advice greatly (three) or a little (two), whilst seven of those currently in a female gender role said that they would value this greatly (six) or a little (one).

Summary of Key Research Findings: Assistance with Documentation

Transgender support groups were rated as of the highest importance by over half of participants (eighteen of thirty three) as a source of advice regarding 'helping you to change your documentation'.

A three way cross tabulation indicated that respondents in both male and female gender roles were fairly equal in their rating of transgender support groups in the three highest categories for support with documentation changes. Ratings of G.I.C. and G.P. support (the other main sources of advice and support on documentation issues) were similarly fairly evenly spread between those with male or female gender roles, with a slight tendency for respondents with male gender roles and gender identities to find G.P. support more helpful on this matter.

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), and half of respondents currently living in a male role (five of ten) and 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 support from a social or care worker, and six had received such support with documentation in the past.

Twenty seven of forty seven (57%) of 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.

Chapter Six: Surveys One and Two (Part Three)

Summary of Key Research Findings: Mental Health Issues and Gender Identity

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 these respondents (eight of twenty) as a source of advice and support regarding a health problem or disability linked with being transgender, and a further cross tabulation indicates that those respondents in a male role with a male gender identity rated this support similarly to those in a female role with a female gender identity.

Ratings of support from transgender groups were spread fairly evenly between those who responded who were living in a male gender role, with a male gender identity, and those who were living in a female gender role with a female gender identity.

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 gender identity issues, (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.

Social and care workers received very low ratings of importance, in general.

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 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 and seven of ten respondents currently in a male role said that they would value this advice greatly (three) or a little (four). 58% of biological males (seven of twelve) and 20% of biological females (two of ten) said that they would value this information greatly but once again, including those who would value this assistance a little evened out these differences.

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.

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

Summary of Key Research Findings: Support with Long-Term Ill Health, Disability, Old Age

Eighteen of forty seven (37%) of 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 a long-term physical/mental ill health problem, disability, etc.

The percentage of biological females with a mental health condition (41%) was much 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. Three way cross tabulation indicated that of those with a long-term condition, all of those who were currently in a male or female gender role and had the same gender identity, had transitioned to this role.

Cross tabulation indicated that 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. Three way cross tabulation indicated that of those with a mental health condition, all of those who were currently in a male or female gender role and who had the same gender identity, had transitioned to this role.

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.

Perhaps surprisingly, levels of family support with long-term health issues, though relatively low, were similarly rated by those in both a male and female gender role. Social and care workers received very low ratings of importance, in general.

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

A three way cross tabulation indicated that of those receiving social care support, all of those who were currently in a male or female gender role and had the same gender identity had transitioned to this role. In addition, five people were living in either a transgender role (four) or an 'other' role (one). The eleventh respondent did not indicate their current gender status.

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.

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

Summary of Key Research Findings: Post Transitional and Societal Issues

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. 38% (five) of biological females and 23% (six) of biological males would value this support greatly, but when those who would value the support a little were included, the percentages were identical at 46% (twelve biological males, six biological females).

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), clearly indicating that the need for support was, for most, no longer centred around transitional issues and the transition period.

Over a half (sixteen of twenty seven) of respondents to survey two said that they would value support from a social or care worker greatly (twelve) or a little (four) to address the consequences of social rejection/abuse. Numbers saying 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, but once again including those who would value this assistance a little reduced this difference considerably, (eight (66%) and five (50%) respectively).

A three way cross tabulation indicated that three respondents currently living in a male gender role, seven in a female gender role (each of whom described themselves as having the same gender identity) one in a transgender role, and one in an 'other' role said that they would value such advice greatly. Two further male role respondents and two further 'other' respondents said they would value such support a little. 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. Just two of twenty seven respondents to survey two said that they had not experienced social rejection/abuse.

Twelve of twenty seven respondents to survey two said that they would value support from a social or care worker greatly (seven) or a little (five) 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, but including those who would value this support a little altered these figures to 50% (six of twelve) and 40% (four of ten) respectively.

Further three way cross tabulation with current gender role indicated that two respondents in a male gender role, four in a female role (each of whom described themselves as having the same gender identity as their gender role) and one in a transgender role, said that they would value such support greatly. These numbers increased to five (male role), five (female

role), one (transgender) and one 'other' when those who would value such support a little were included.

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.

Fourteen of twenty seven respondents to survey two said that they would value support greatly (ten) or a little (four) to address transgender related differences /disagreements with neighbours, colleagues etc. Numbers saying they would value this support greatly, 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 but including those who would value this assistance a little reduced these differences considerably to 58% (seven of twelve) and 50% (five of ten) respectively.

A further three way cross tabulation indicated that four respondents currently living in a male gender role (two of whom also described their gender identity as male), five in a female gender role (all of whom described their gender identity as female) and one in a transgender role, said that they would value such advice greatly, whilst two further 'male role' respondents and two further 'other' respondents said they would value such support a little.

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.

Fifteen of twenty seven respondents to survey two said that they would value support greatly (twelve) or a little (three) 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. Including those who would value this assistance a little, altered these percentages to 66% and 40% respectively (the ratio of biological males to biological females was 4:3 for this survey). Numbers saying they would value this support greatly, tended to rise with age up to the age group 46 to 55.

A further three way cross tabulation indicated that three respondents currently living in a male gender role (two of whom also described their gender identity as male), six in a female gender role (all of whom described their gender identity as female), two in a transgender role, and one in an 'other' role, said that they would value advice with establishing a more confident community presence, greatly, whilst two further male role respondents and one further 'other' respondent said they would value such support a little.

One person was currently receiving such support from a social/care worker, and two had received this in the past. A third (nine of twenty seven) of respondents said that they would not value or did not need such support.

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