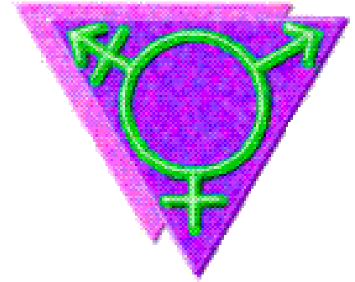

February 2007

Response to Draft Good Practice Guidelines for the Assessment & Treatment of Gender Dysphoria

Polygender Scotland is a community group that aims to provide social and peer support for any person who identifies as Androgyne, Genderqueer, Polygender or other non-binary gender identity. We are based in Edinburgh and have a small but growing membership.

I currently sit on the Transgender Reference Group at the LGBT Centre for Health & Wellbeing as a representative of Polygender Scotland. As such I was fully involved and fully endorse the group's response to the Draft Good Practice Guidelines for the Assessment & Treatment of Gender Dysphoria.

I do wish however to expand upon the concerns that members of Polygender Scotland and others who have a non-traditional and non-binary gender identity have with these guidelines.

By failing to explicitly make reference to the existence of people with non-traditional and non-binary gender identities it reinforces the impression that we do not exist. Furthermore it implies that we experience a lesser degree of Gender Dysphoria than transsexuals. This implication is incorrect. Whilst the Gender Dysphoria we experience is different to that experienced by transsexuals, it is no less real. Indeed it is amplified by society's refusal to acknowledge our very existence.

The following is an extract from the experiences of one of our members:

"I am 38 years old and have been actively dealing with the fact my gender does not tie in with the sex of my body for the last year. One of the reasons it has taken so long to be able to start dealing with this is that I do not feel clearly male or female, but a bit of both and a third thing. I'm not sure if it is a third thing or if being both makes a third thing. The popular view is that if I am transgendered I should feel like a man in a woman's body. Clearly I don't, and there is no clearly defined role in the world for what I do feel."

This refusal by society at large, and gender clinics in particular to acknowledge the existence of gender identities other than the traditionally accepted binary of man/woman can lead to a number of outcomes that are not desirable because the person feels they have no other option.

1. The person may attempt to self medicate by purchasing hormones off the internet. Assuming they get what they pay for (an assumption that is at best uncertain) they still run the risk of taking hormones without proper supervision
2. The person may instead fully transition to the 'opposite' sex. This is unlikely to provide the solution to their dysphoria as they do not identify as either of the traditional binary gender identities.

Instead gender clinics should seek to work with the person to identify the correct path for them as a unique individual. There are a number of different paths that people may choose. These include:

1. Low level hormone therapy
2. Standard level hormone therapy
3. Some surgery

Or indeed combinations of the above. It should be noted that the surgery they seek may or may not be the same as that sought by transsexuals. This should not be viewed as a problem.

It's also important to mention the language that the trans person may use to describe themselves. They may well describe a 'male' self and a 'female' self. This should not be considered indicative of any form of psychosis or pathology unless there are other apparent symptoms. Instead a clinician should be aware that the English language is imperfectly capable of expressing non-binary gender identities and the trans person may simply be trying to 'make the best of a bad job' in terms of expressing their identity.

It should be noted that throughout the non-binary gendered community there is a range of new terminology, pronouns and titles that are becoming established to try and address this lack in the English language. One instance of this would be the use of the plural pronouns as singular, non-gendered pronouns. Clinicians should be encouraged to research this terminology and to use it when they see non-binary gendered people.

I also wish to take issue with the draft guidelines implicit assumption that a clinician has the right to validate or invalidate a person's identity. The clinicians role is simply to act as a guide and mentor through the process of transition. Our concerns are that rather these guidelines seek to empower a clinician to act as a 'Gatekeeper' with the power to inform a trans person that their gender identity does not fit the prescribed form and is therefore wrong.

It should be a fundamental principle of all services, let alone gender identity services, that when someone's identity contradicts what a form or text book says it should be, it is the **form or textbook** that is wrong, not the person.

I would also like to share another extract of the experiences of one of our members:

"I referred myself to Dr Myskow last April and was fortunate enough to get a cancellation appointment in a few weeks. Overall it has been a positive experience. She does seem to have some understanding of how things are for me, but does seem more used to people who wish to transition. I have made no decision about that at this time. It may be that I would be happier coming at this from the other side, but that is a big decision to make. It is more likely that parts of that process may be appropriate and parts would not. Again, this does not fit with society's binary view of gender. As a result, I have no idea if Dr Myskow would support that. That is something I shall discuss with her at a future point.

Dr Myskow has said that it is fine if it takes years to sort this out and to find a way forward. I did feel that there was a little pressure along the lines of transitioning, but she has since reassured me this is not the case. Assuming there are no medical interventions, my big

challenge will be the menopause. As with puberty, my body will go through changes that will feel alien. I have no idea how I will cope with this, but do feel there is now a source of support. If there are things that we can do medically to ease that, then I am sure they will be done.

My understanding is that most gender specialists are not as supportive of those in this situation. Having reached the point where it became imperative that I deal with this, to find that I did not fall into the right category to get medical support if necessary would have been very difficult. It is frightening to think that geography makes such a difference. I think there should be more recognition for people in my situation. Just because things are not entirely clear cut does not mean there should not be guidelines – if anything it is more important."

As you can see, they had a positive experience working with Dr Myskow. Indeed other feedback I've received about Dr Myskow indicates that she is a highly regarded and knowledgeable clinician working in the field by those trans people that I know who've been treated by her. Bearing this in mind, it is simply ludicrous that as these guidelines stand she would be not be considered competent to make decisions regarding trans peoples surgery as she is neither a psychiatrist nor a psychologist. It seems that far from implementing good practice, the purpose of these guidelines is to entrench the discredited methods of the largest English gender clinics as the only acceptable approach.

There is one further issue that I would like to draw to you attention. As I'm sure you are aware, Scots and English law is different. Under Scots law people have the right to make autonomous decisions about their own healthcare from the age of 16, not 18 as it is in England. However as your guidelines currently stand, they risk contravening Scots law by the insistence that trans people should not be able to have irreversible surgery until they are 18. As these guidelines are meant to be applied throughout the UK they should reflect this difference, otherwise they risk being thrown out by a court of law at the first instance of being challenged.

Regards

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