Trans Awareness: A Response to "Transsexualism" (Chapter 7) in *Some Issues in Human Sexuality*

Trans Awareness Group

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Section 1 - Introduction

In 2005 our church ran a series of "Hot Topic" discussions, one of which focussed on Transgender issues. The present group was formed from people attending that discussion in order to explore the issues further.

A Transsexual person is someone whose internal Gender Identity (the inner sense of "I am a man," or "I am a woman,") is opposite to that of their biological sex. Transgender is an umbrella term covering a range of gender variant behaviour ranging from someone who cross-dresses occasionally through to the transsexual person who undergoes Gender Reassignment and lives as a member of the sex opposite to their biological birth sex. Gender Reassignment is a complex process involving legal changes and medical treatment (usually including hormones and surgery). Some people who undergo Gender Reassignment prefer to refer to themselves as transgendered rather than transsexual as the main issue is one of gender not sex.

The primary aim of the group was to raise awareness and understanding of transgender issues among its own members to equip itself to become a resource for raising awareness in the parish and ultimately perhaps the deanery and diocese. As a starting point the group explored the "Critical questions raised by the debate about transsexualism" (House of Bishops 2003, 243) in Section 7.4 of Chapter 7 "Transsexualism" of *Some Issues in Human Sexuality.* The group then went on to consider related topic areas. This report has been produced following the same order as *Some Issues in Human Sexuality* for ease of cross-referencing and to show the development of the discussion as the group continued to meet.

The summary of discussions in this report has been kept brief but more detail can be found in the appendices where indicated. Issues numbered A-G are issues addressed in the Report of the House of Bishops. Subsequent sections were additional issues the group felt needed to be considered

Section 2 – Discussion of Questions from the Report of the House of Bishops

A. A question about what it means to be a person (paragraphs 7.4.2 – 7.4.6)

The group agreed there were many aspects to being a person: spiritual, physical, mental, emotional, interdependency on others. Being made in the image of God encompassed qualities and characteristics rather than mere physical characteristics. God is multi-faceted so contains all aspects of what is found in humankind.

It was agreed that Western society emphasises conformity to bi-polar gender roles, which results in children making the distinction at an early age, but this rigid expectation also creates suffering for trans-children.

Initial discussions clarified that the terms Sex and Gender had different meanings and should not be used interchangeably. Exploratory debate resulted in the following understanding of terminology:

Sex related to biologically definable details such as external genitalia, chromosomes and bodily appearance such as hirsutism

Gender related to how masculine or feminine a person was. This was more behavioural than biological and was closely related to the role in society.

Intersex a term describing people whose biological sex is ambiguous, eg as a result of having unusual combinations of chromosomes or ambiguous external genitalia. (See Appendix B)

See glossary for further explanations of terminology used in this report.

B. A question about Divine Order (paragraph 7.4.7)

In considering "What constitutes the sex given to us by God?" (Bishops 2003, 244) the group looked at a summary of work done in the 1950s and 1960s by Dr John Money (formerly the director of the Psychohormonal Research Unit of the John Hopkins University School of Medicine, Baltimore, USA) showing variables in sex and gender. A copy of the table is included as Appendix A. It was noted that while sex was essentially biological, gender was related to a person's role in society and therefore gender identity was an issue of self-perception.

Genesis 1.27 asserts "Male and female he created them" (RSV). While noting that Adam and Eve were presented as examples of male and female perfection, the group felt this was too simplistic given the medical reality as now understood. In regarding everyone as a blend of male and female this is still in the image of God and consistent with Genesis 1.27. It was important to see sex/gender variation as a form of natural diversity rather than as an illness.

It was agreed that as intersex and transpeople existed they had been created by God. It was important, therefore, for transpeople to be true to their God-given gender. Treatment to align the body to the gender identity was seen in the same light as repairing a heart defect to improve the quality of life.

The group did not feel that gender dysphoria was a consequence of the fallen-ness of creation, because of medical evidence that it was part of the natural diversity of creation. The inability of society to accept and embrace diversity was a consequence of fallen-ness.

The group had concerns that the questions in the report had been framed in a way which invited a negative response rather than open exploration. It was also concerned that the chapter had been written without reference to any medical resources and was therefore not appropriately contextualised.

C. Questions about the Bible (paragraph 7.4.8)

As preparation for this section members had considered Chapter 2 of the Report, which they had found to be densely written and, again, not encouraging open debate. The group agreed that in studying the Bible it was important to be consistent in approach, taking into account both the original meaning of the text and its interpretation for today's society.

The group highlighted the importance of considering the context of Bible passages when considering transgender issues and attitudes. The dimorphic distinction in Genesis 1-2 was offering an ideal and was written before there was any scientific understanding even of reproduction, much less of genetics.

The cross-dressing prohibition in Deuteronomy 22.5: "A woman shall not wear anything that pertains to a man, nor shall a man put on a woman's garment," (RSV) was designed to distinguish the Israelites from local tribes who practised cross-dressing fertility rites and

temple prostitution. (Brown 1990, 104) Today it is perfectly acceptable for women to wear trousers in most cultures. The rule is placed in the middle of a collection of miscellaneous laws including a prohibition on the use of wool/linen mix cloth for ordinary people:

"You shall not wear a mingled stuff, wool and linen together," (Deuteronomy 22.11 RSV).

No-one would consider this binding today, when mixed fibres (eg polyester/cotton or wool/lycra) are commonplace and acceptable to all.

The description of the tabernacle in Exodus 26.31 indicates that an unusual mixture of fabrics is holy:

"Make a curtain of fine linen woven with blue, purple, and red wool." (Good News Bible)

This has positive echoes in the views of North American Indians who accord honour and respect to transpeople as their shamans.

The position of eunuchs in Biblical society was interesting, as they had originally been despised because they no longer had the ability to procreate. However, by the time of Isaiah eunuchs were allowed into the worshipping community and in the New Testament (Acts 8) there is no suggestion that the Ethiopian eunuch had a lesser status as a Christian once he had submitted to baptism, therefore the group felt that transgendered people should be welcomed equally. The Trans debate also forms a continuum from the debate in Acts 15 about the need for circumcision of the Gentiles. Because the first Christians were Jewish converts it took some time before it was acceptable for Gentiles to be allowed to become Christians without first submitting to the Jewish rite of circumcision. In the same way transgendered people are viewed by some groups as a race apart who cannot be accepted as Christians without first submitting to conformity of sex and gender.

There was debate in the group about the healing of lepers and their restoration into the community. The segregation of lepers because of the community's fear was seen as parallel with transgendered people and also with AIDS sufferers particularly in developing countries (eg South Africa) where the condition is not fully understood.

It was noted that there were two prevalent views by transpeople themselves in relation to their own condition. Some see themselves as a biological error or a "mistake of nature," whereas others feel that their transgender status is deliberately from God:

> "For thou didst form my inward parts,
> Thou didst knit me together in my mother's womb.
> I praise thee, for thou art
> Fearful and wonderful.
> Wonderful are thy works!"
>
> (Psalm 139, 13-14. RSV)

D. Questions about Medical Intervention (paragraphs 7.4.9 – 7.4.15)

There were serious concerns about the lack of understanding shown in the report about medical treatments and also the implication that this was a one-step change by a single operation. Gender Reassignment is a process consisting of legal changes (of name and gender) as well as medical treatment which usually includes lifelong cross sex hormone treatment followed by surgery. No reference had been made to intermediate treatments such as electrolysis and speech therapy, which are usually essential for transwomen. Although for transwomen there is often a single (major) operation to reconfigure the genitals, for transmen there are three distinct stages of surgery: mastectomy, hysterectomy and phalloplasty which is itself made up of a number of distinct operations. It is worth noting

that while most transwomen do want genital surgery, for transmen the situation is different. Most transmen do want mastectomy but many decide not to proceed with phalloplasty - some because the end product is not satisfactory, others for ideological reasons: "I don't need a penis to be a man" (Lee Gale)[1].

As in earlier sections of the report the implication seemed to be that the only appropriate psychological help should be to condition the person to live as a member of their biological birth sex. The group felt that a holistic approach to treatment was necessary, including counselling/psychotherapy to identify the appropriate path for each person on an individual basis. Some transpeople have issues arising from past bad experiences to do with being trans and need counselling/psychotherapy to come to terms with these experiences, ie psychological healing to enable the transperson to live successfully in their new identity. Such counselling may be beneficial either pre- or post-transition. Regarding the ethics of surgery, comparison was made with people who suffer psychologically because of prominent ears, for example, for whom corrective surgical intervention is regarded as acceptable.

In discussing the appropriateness of using NHS resources for transgender surgery it was felt important to take as a key criterion the likely post-operative quality of life. Current medical opinion is that treatment by hormones and surgery is for many people the best option:

> "The studies which have been carried out indicate that a treatment model using the principles described above is highly successful, with some suggesting up to a 97% success rate." (Reid 1996,6)

One of the issues raised by the Bishops' report was that transition "destroys the capacity of the post-operative transsexual to have children." (Bishops 2003, 247) The issue of losing reproductive capacity seems to be based on the assumption that the transgendered person would inevitably have become a parent by remaining in their birth sex, but the ability to carry/father a child is not guaranteed, as the number of childless couples seeking fertility treatment proves. Furthermore, it was felt that if there was an issue about the loss of eggs and sperm these could be harvested and donated for use by others.

The group also had concerns about the impact on children whose parent was "persuaded" to remain in their birth sex, marry and reproduce as a "cure." This cure is the approach taken by the Parakaleo ministry which gives as its mission statement: "The ministry mentors those seeking to re-establish their God given gender identity and destiny." (http://www.parakaleo.co.uk/) Although this appears to be welcoming and to support open exploration, the focus of the organisation is to encourage people to remain in their birth sex and to actively discourage them from exploring all options available, as the Parakaleo ministry perceive "God given gender identity" and birth sex as the same thing and asserts in its "frequently asked questions" section of the website that: "Christians should be willing to support in every possible way the struggles of transsexual people to accept their true birth sex." In many cases, people who have attempted such a "cure" have sought reassignment later, with consequently greater disruption and distress to their spouses and children, than would have been the case had they not been persuaded to marry and have children.

[1] "Love It" magazine, 12-18 June 2007, p24-25

E. Questions about Marriage and Birth Certificates (paragraph 7.4.16)

It was noted that the Gender Recognition Act 2004 had been passed since publication of the Bishops' report and a summary of its provisions was reviewed by the Group. Particular note was taken of the opt-out clause permitting Church of England clergy to refuse to marry anyone they suspected of holding a Gender Recognition Certificate (later extended by Statutory Instrument 2005 No.54 to cover ministers of all religions). The Gender Recognition Certificate (GRC) gives full legal status in the acquired gender and the replacement birth certificate issued is in the standard format.

The report talks about the "pre-operative transsexual." It was felt that this terminology was unclear, as it seemed from context to be used in the report only to apply to a person living in their birth gender, but the term could equally apply to a trans-person with a GRC who had not undergone any surgery. Surgery is not a mandatory condition for the granting of a GRC.

Application for a GRC is not mandatory and any pre-existing marriage remains valid in law until a GRC has been granted. The Group found it difficult to see why married transpersons should inevitably want a divorce, since if the marriage was strong enough to survive the transition period then it seemed unreasonable to insist on it being ended. It was noted that in order to obtain a full GRC a married transperson must first obtain a divorce, but the parties could then immediately contract a Civil Partnership.

There was concern at the suggestion in the report that a Christian marriage was only valid if it could produce children. Although children are a facet of Christian marriage, they are not an inevitable consequence and the emphasis on procreation has shifted in modern society. This is part of a much wider debate, since such a view also militates against the marriage of the elderly, impotent men, and women who have, for medical reasons, undergone hysterectomy, which the Group did not believe was the intention. The debate being proffered in the report therefore seemed to be starting from a false premise.

F. Questions about Transsexuals in the Life of the Church (paragraph 7.4.17)

For the meeting addressing this section of the chapter, the Group invited a guest speaker who was a trans-priest. The difference in protective legislation for religious, rather than secular employees, was highlighted. For example, the Church of England has chosen to claim exemption from compliance with Equal Opportunities Legislation, which permits the Church to dismiss an employee on grounds of sex, marital status, disability, race, colour, nationality, ethnic origin, religion, sexual orientation or age all of which would be illegal for a secular employer. Furthermore, in secular employment decisions made by civil courts create binding precedents on other courts, whereas decisions made by a Bishop are not binding on other Bishops.

The Group found it difficult to comprehend the Evangelical Alliance position that transpeople could not be priests because by their lifestyle they were setting a "wrong" example for their congregations. This seemed to be linked to the Old Testament requirement that priests must be physically perfect (Leviticus 21:16-24) but this did not seem congruent with modern attitudes towards priests with physical disabilities. An alternative approach is to see a trans-priest as offering a positive role-model to other transpeople.

A further issue was that of allowing transpeople to be baptised/confirmed/receive communion. This had parallels with the status of divorced people within the church for many years. The group felt that it was important to recognise the love of God in the

situation and to value the person as an individual for what they had to offer the Church. To debar transpeople from these sacraments when they may be leading a devout Christian lifestyle seemed, in itself, un-Christian and not in keeping with Acts 10:15: "What God has made clean, you must not call profane" (NRSV)

In terms of support for pre and post-operative transsexual people three basic concepts were identified:

1. Be willing to listen
2. Recognise the need of the transperson to talk about their situation
3. The emphasis should be on loving and caring for one another at all times –which might include simple things like taking care to use the correct gender pronoun to show respect for the person's identity.

In discussing the challenges transsexual people posed for the church that was seeking to support them it was agreed that there was an issue of pastoral support for the congregation (see later) as some congregation members may be uncomfortable because this is outside their own experience and some may even choose to leave.

G. A Question about Discipleship (paragraphs 7.4.18 – 7.4.22)

In response to the question "What does it mean for a transsexual person to live in obedience to Christ?" the group felt that essentially this was the same for all Christians, whether transgendered or not:

1. Love God
2. Love your neighbour
3. Prepare to be changed (2 Corinthians 5.17) "So if anyone is in Christ, there is a new creation;" (NRSV)

The report focussed on whether obedience involved accepting a given biological identity or whether seeking a "new post-operative identity," (Bishops 2003, 249) was acceptable. This failed to recognise that surgery was not the only way of changing external appearance. It also failed to acknowledge that the person post-transition still retained the same gender identity but with the body adjusted to correct society's perceptions and expectations.

The group were concerned that although people with physical intersex conditions were allowed, even expected, to be surgically adjusted to fit in, people with psychological intersex conditions were not.

Regarding the issue of what constitutes our God-given identity, it was felt that this had wider implications. The report's assertion that "our bodies are part of who we are," (Bishops 2003, 249) can be seen to imply that a psychological male in a female body is a valid identity. The difficulty is that society cannot accept the dichotomy, yet an insistence on conformity to a totally male or totally female identity limits an individual's response to God's creative potential.

The group also queried the ultimate relevance of the body to identity. For example, a person in a wheelchair in full possession of all their mental faculties is still a person, whereas in an able-bodied individual with Alzheimer's disease the person seems to have been lost.

Ultimately it was felt that any consideration of theological grounds for accepting the incongruence of mind with body needed to be rooted in an understanding of the medical issues.

Section 3 – Further topics discussed by the group, not addressed in the Report of the House of Bishops

H. Stages in the Trans Journey

The group came to recognise that transition was a process with a number of stages and aspects as follows:

1. Social change, which involved telling family and friends of the decision to transition and asking them to use a new name and appropriate pronouns.
2. Legal/official change: this involved formally changing one's name and being registered with various official bodies in the post-transition gender (Tax Office, passport, driving licence, work records, pensions, banks etc).
3. Medical changes which may include hormones and/or surgery.

It was also noted that gender and sexual orientation were not interchangeable terms, nor were they interdependent. Gender defined whether a person identified as male or female, whereas sexual orientation referred to whether they identified as heterosexual or homosexual. Sexual orientation could change after transition, or it might remain the same but be defined differently. Eg a biological male with a female gender identity may be sexually attracted to women and pre-transition would be defined as a heterosexual male but post-transition as a homosexual female.

I. Partner Issues

The meeting for this discussion was led by the wife of a transman. There was discussion of a number of statements from partners of transpeople and how these might be responded to. These statements are appended to this report as Appendix C. The debate highlighted the following issues which could arise for partners of transpeople.

1. Even where partners have always recognised the underlying gender identity this does not prepare them for the demands the transition process will make on them and their relationship. They may not expect to need support – but may well find they need it later on.
2. Some relationships break up because there is too great a change to be able to adapt. Others survive, by accepting that there is a journey to be made by the partner and also by the relationship itself. This applies equally to same-sex or mixed-sex relationships.
3. Lesbian partners of FTMs often feel their own identities threatened by being seen in a heterosexual relationship.
4. Sometimes survival means clinging to the everyday things and going through the usual motions.
5. Pain of betrayal often felt by those partners for whom the transition is entirely unexpected.
6. Many people who transition change homes and jobs afterwards to start a new life. This can also further isolate a partner because of the secrecy involved.

J. Children

This discussion topic was considered from two aspects: that of transchildren (children having gender identity issues) and children in families where one or more of the parents had transitioned.

i) Transchildren

The only Unit in the country dealing with gender dysphoric children is that run by Dr Domenico di Ceglie at the Portman Clinic in London. It was noted that only a few children who have gender identity issues go on to be transgendered as adults. eg not all tomboys are trans and caution is needed as assumptions can be damaging. In fact it was more common for the children seen by the Unit to become homosexual or bisexual. Dr di Ceglie's approach to exploring gender issues with the child and its family and school was felt to be a positive one.

The Group were concerned to discover that "suicide attempts in adolescence are frequent," (di Ceglie 2000) in children suffering from gender dysphoria, particularly given that in modern society male/female gender roles were no longer rigid. However, some families still have very rigid gender expectations and the issues are not entirely to do with role.

The Group considered material from the Sci:dentity project being undertaken at Goldsmiths College, University of London. Some children do not identify as specifically male or female, but as "gender queer": either a blend of male and female or alternatively neither male nor female. The key factor in offering support is to encourage an environment of conversation and openness

Support for transchildren and their families is provided by the support group "Mermaids."

ii) Children of Transparents

The group watched an excerpt from the documentary "My Mums used to be Men" about Louise, a 9-year old being brought up by her natural father who had transitioned and was now living as a woman with a partner who was also MTF. The programme had been made to try to address the bad publicity given to the family by lurid newspaper reporting. The group noted that Louise was happy, outgoing, confident and well-adjusted who had not thought of her family as "weird" until the press told her it was. Louise was not disadvantaged by having transparents but was adversely affected by bad publicity.

K. Pastoral Issues within the Church

The group focussed on pastoral issues which were raised both for the transperson and also for other congregation members. It was agreed that the contents of a booklet (*The Transsexual Person is My Neighbour: Pastoral Guidelines for Christian Clergy, Pastors and Congregations*) by Rev Dr Christina Beardsley were useful and largely based on common-sense. It was agreed that it was important to have such a resource available.

The importance of befriending both the transperson and family was recognised, as it was easy to overlook partners, children and other family members, all of whom were affected by the transition process.

Questions were also raised about the name which should be recorded on the electoral roll: was this required to be the legal name or the baptismal name, as these would differ if the person transitioned post-baptism.

The raising of awareness about transgender issues was agreed to be relevant even where no transperson was known to the congregation, since it may encourage those who were afraid of their status being known or welcome transpeople who might otherwise be concerned about the reception they would receive. One of the problems for congregations seemed to be a fear of saying the wrong thing or asking intrusive questions. This could be lessened by raising awareness to create an open environment for discussion. Leaflets or short articles in church magazines might be a way to promote awareness of the issues and make people feel less awkward about asking questions.

The Group also looked at some case studies from Department of Health bereavement booklet and felt that a similar set of guidelines should be produced by the church. The Department of Health guidelines were thought to be very good at raising special issues and highlighting the extra sensitivity needed:

1. A transwoman with no gender recognition certificate (GRC) but living as female and all other documentation female: guidelines to mortuary staff and coroner are to record death as female. May create issues for funeral if eg wife has never accepted transition and is organising the funeral and wants the transwoman referred to by male names. Does the person taking the funeral use male or female names? Special pastoral care needed.
2. A transwoman with GRC – death must be recorded as female and trans status cannot be disclosed because of legal protection surrounding GRC.

It was noted that clergy need to be clear when taking a trans funeral whether this can be referred to in the address. The law protects people who have a gender recognition certificate: their previous gender is confidential so that revealing it, if learned in an official capacity, is a criminal offence and carries a heavy fine (Gender Recognition Act 2004). However, some families will feel the trans-status is integral to the person and will feel that it should be mentioned – this will vary from person to person. For their own protection, it was felt that clergy should get this agreement in writing.

The Group recommended that there should be a diocesan expert who is aware of support networks and legislation and can be called upon to give advice where situations involving transpeople arise.

Section 4 – Recommendations and Conclusion

Summary of Recommendations

1. The need to contextualise the religious debate in the light of modern medical and psychological understanding.

2. A willingness to be open about the issues and to encourage supportive debate.

3. The appointment of a diocesan expert who is aware of support networks and legislation who can be called on to give advice where situations involving transpeople arise, particularly in view of the legal obligations imposed by the Gender Recognition Act 2004.

4. When a member of the congregation transitions, confidential pastoral support should be offered to the transperson if required (for example regular meetings to discuss issues as they arise). It is emphasised that the supporter is not expected to be an expert on trans issues – the most important qualities being non-judgemental openmindedness and a willingness to listen. Similar support should also be available for partner/family, ideally with a different individual.

5. Clarification required about whether the Church authorities require a person's legal or baptismal name to be used on the electoral roll.

6. The production of a guidance leaflet for clergy involved in funerals of transpeople.

7. The inclusion of transgender issues in the pastoral training of priests and Readers.

Conclusion

The group felt that although the Report of the House of Bishops raised a number of important areas it had taken a very literal view of Biblical texts without taking historical and social contexts into account. It also appeared that no consultation with medical or psychological specialists had taken place to try to gain any factual insight into the issues. Nor was there any evidence that the working group had spoken to any transgendered people in the preparation of its report. There were also concerns that the report had been written in such a way as to encourage a negative attitude to transgendered people. Perhaps as a consequence the report had also failed to address issues about the pastoral care of families and congregations.

It was recognised by the group that there had been a number of legislative changes since the House of Bishops had produced their report and ongoing debate was therefore still needed.

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Glossary of Terminology

Bi-polar gender	The belief that there are only two genders which are distinct from each other and have no intermediate state. ie a person is either a man or a woman and cannot be some combination of both.
Birth Sex	Sex assigned at birth based on the appearance of the genitals. It is also the sex recorded on the birth certificate.
FTM	A person born with a female body who has a male gender identity. Formerly "female to male transsexual" it is now better to refer to "female to male transperson," as not all FTMs desire surgery and/or hormones.
Gender	Whether a person is perceived by society as a man or as a woman. Gender is assigned at birth, based on the appearance of the genitals, as for most people their gender is the same as their birth sex.
Gender Confirmation Surgery	Also known as Gender Reassignment Surgery: surgery used to modify a transperson's sexual characteristics. For further details see the NHS Direct Health Encyclopaedia (http://www.nhsdirect.nhs.uk/)
Gender Dysphoria	Where there is conflict between the gender assigned a person at birth and the person's internal gender identity. Gender Dysphoria (sometimes referred to as Gender Identity Disorder) is now the medical term given to the condition previously labelled transsexualism.
Gender Identity	The gender one perceives oneself to be. A person's internal sense of "I am a man," or "I am a woman." For most people their gender identity is the same as their birth sex.
Gender Queer	Similar to third gender. Some people who identify as gender queer see themselves as being a mixture of male and female (ie BOTH man AND woman rather than EITHER /OR.) Other gender queer people identify as NEITHER male NOR female.
Gender Reassignment	Some people use this term to refer to the whole transition process. Other people use the term to refer to the gender confirmation surgery.

Gender Recognition Certificate (GRC)	Once a transperson has been living as a member of the gender which accords with their gender identity for at least 2 years they may apply for a GRC. This certificate does not require surgery but does require medical evidence including a diagnosis of gender dysphoria. Once a GRC has been issued the transperson is able to obtain a new birth certificate which now shows their birth sex as being that of their gender identity. This is now their sex for all legal purposes (including marriage).
Intersex	A person whose sex is ambiguous either because the external physical characteristics are ambiguous or because of unusual combinations of chromosomes. (See Appendix B)
MTF	A person born with a male body who has a female gender identity. Formerly "male to female transsexual" it is now better to refer to "male to female transperson," as not all MTFs desire surgery and/or hormones.
Post-transition	A person who has changed their name legally, who is living successfully in the gender of their gender identity and who has completed all the surgery they desire. They may or may not have a Gender Recognition Certificate.
Pre-transition	This can either refer to: i) a person who has not formally changed their name, has not started medical treatment and has not yet seen a gender specialist or even approached their GP or a counsellor. or ii) a person who is seeing a gender specialist, who may have legally changed their name but who has not yet received any medical treatment (hormones or surgery).
Sex	Male or Female biological identity defined by primary and secondary sexual characteristics (external genitalia, chromosomes, hirsutism, breast development etc)
Sexual Orientation	describes whether a person is sexually attracted to a member of their own sex (homosexual), to a member of the opposite sex (heterosexual) or to both sexes (bisexual). Rarely an individual may be attracted to neither sex (asexual). Transgender/ transexuality is not an aspect of sexual orientation. Transpeople may be homosexual, heterosexual, bisexual or asexual.
Third gender	The belief that some people do not fit into the bi-polar gender model. Such people consider themselves to be neither men nor women but to be a member of a third gender.

Transgender	This word has several uses which can be confusing: i) as distinct from transsexual to refer to transpeople who do not have Gender Confirmation surgery but who may live permanently as a member of the gender which is the same as their gender identity. ii) as synonymous with transsexual. The term transgender being preferred as the main issue is one of gender not sex. iii) as a general umbrella term covering a range of behaviour outside the bi-polar gender norm. ie includes the full range of behaviour from occasional cross-dressing to full gender reassignment and permanently living in the gender role opposite to the birth sex.
Transition	The process whereby a transperson ceases living as a member of the gender of their birth sex and begins to live permanently as a member of the gender which is in accordance with their gender identity. This is a long process which involves legal change of name and gender, usually hormones and usually gender confirmation surgery.
Transman	Preferred term for FTM
Transperson, Transpeople	A person whose gender identity is the opposite of their birth sex. While many transpeople undergo Gender Reassignment not all have hormones and/or surgery. Some transpeople do not live permanently as members of the same gender as their gender identity.
Transsexual	This is an adjective referring to a person who suffers from transsexualism. It is not appropriate to use “transsexual” as a noun as this reduces people to the level of their medical condition. (cf “the appendectomy.”)
Transsexual person	A person who was born with the physical attributes of one sex but whose gender identity is of the opposite sex. The conflict is resolved by living permanently as a member of the sex which accords with the gender identity and by medical treatment to harmonise physical features with the sex of the gender identity.
Transsexualism	See Gender Dysphoria
Transwoman	Preferred term for MTF

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Websites

Changing Attitude - Supporting Lesbian, Gay, Bisexual & Transgendered Christians in the Anglican Church http://www.changingattitude.org.uk/

Depend – information and support for friends and families of transpeople. http://www.depend.org.uk/

GIRES – Gender Identity Research & Education Society http://www.gires.org.uk/

Inclusive Church – working for the inclusion of all people (including transpeople) in the Anglican Church http://www.inclusivechurch2.net/

ISNA, 1993-2006, Intersex Society of North America http://www.isna.org/

Mermaids - for transgendered children and their parents. http://www.mermaids.freeuk.com/

NHS Direct, Health Encyclopaedia. http://www.nhsdirect.nhs.uk/

Press for Change – Trans activism, especially political, legal and medical. http://www.pfc.org.uk/

Sibyls - Christian Transgendered Spirituality group http://www.sibyls.co.uk/

The Gender Trust – support for trans people and their families. http://www.gendertrust.org.uk/

Television Programmes

My Mums Used to be Men, 2007. Producer/director: Julie Beanland. True North Productions

APPENDIX A

Money's 8 variables of sex and gender

	Female	Male
1. Chromosomal sex	XX chromosomes	XY chromosomes
2. Gonadal sex	Ovaries	Testes
3. Prenatal hormones	Testosterone absent	Testosterone present
4. Internal accessory organs	Fallopian tubes, uterus, upper vagina	Prostate and seminal vesicles
5. External genitals	Clitoris, inner and outer labia, vaginal opening	Penis and scrotum
6. Hormones at puberty	Oestrogen and progesterone	Testosterone
7. Assigned Gender	Gender assigned on the appearance of external genitals at birth Gender in which the child is reared	
8. Gender Identity	The gender one perceives oneself to be. A person's internal sense of "I am a man," or "I am a woman."	

Source: Hyde, J.S., DeLamater, J. 1997. *Understanding Human Sexuality. 6th edition.* New York: McGraw-Hill, p107-8

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APPENDIX B COMMON INTERSEX CONDITIONS

The table shows some common intersex conditions where the (23rd pair of) chromosomes differ from the usual pattern found in human males (XY) and females (XX). This table is not exhaustive and other chromosome arrangements are found (eg XYY). In general the conditions shown in the table are ones where the physical body (phenotype) differs from the usual male or female body.

1. Turner's Syndrome – XO

This is a female with a missing X chromosome. The internal reproductive organs do not develop neither do the breasts. At birth the appearance is that of a normal female and often the condition is not detected until puberty when there is no menstruation. The woman lives in society as a woman albeit infertile.

2. Klinefelter's Syndrome – XXY

This is a male with an extra X chromosome. The baby boy is born with penis and testes but in the adult the testes produce no sperm. The adult man has a female fat distribution and may develop breasts (which may be surgically removed). The adult usually lives in society as a man, albeit infertile. However, in some cases the person has developed a female gender identity and lives in society as a woman.

3. Androgen Insensitivity Syndrome – XY

This person appears at birth to be a normal female yet has the male pattern of chromosomes (XY).

In the normal pattern of embryo development, for the first 3 months there is no difference between the male and the female. After 3 months, the presence of the Y chromosome in the male causes the production of male hormones which in turn cause the male genitals and reproductive organs to develop. In the absence of male hormones the embryo develops female genitals and reproductive organs (the female is the default).

In the condition known as Androgen Insensitivity Syndrome, the embryo has the Y chromosome and male hormones are produced, however, the cells are unable to respond to the male hormones. In this case the default scenario is enacted and the embryo develops female genitals but no female internal reproductive organs. In addition, the presence of the Y chromosome causes testes to form but these are contained inside the body.

At birth the AIS baby appears to have normal female genitals and she is brought up as a girl. Again this condition is not usually discovered until puberty. The adolescent appears physically to be a normal girl (without breasts and periods) and has a female gender identity. As far as she and society are concerned she is female (even though she has male chromosomes) and she lives in society as an infertile woman.

4. <u>Adrenal Hyperplasia – XX</u>

This is a condition in which the chromosomes follow the female pattern but the adrenal glands of the developing embryo cause the production of male hormones (androgens). These androgens cause masculinisation of the external genitalia. The masculinisation may only be partial – in which case the person appears female but with an enlarged clitoris. This baby is designated female and may well have the normal womb and ovaries. The child is socialised as a girl, but may exhibit masculine behaviour (tomboy).

In extreme cases of more complete masculinisation the baby may have normal appearing male genitals and be brought up as a boy. However, the presence of XX chromosomes may lead to the development of breasts and internal reproductive organs which can cause menstruation (through the penis). This condition is often undiagnosed until puberty by which time the adolescent's gender identity is often fixed as male. Surgery removes the breasts and female reproductive organs and the adult lives in society as an infertile man (with female XX chromosomes).

Common Intersex Conditions

Chromosomes	Condition	Body	Remarks	Frequency
XX	Average female	Female	Breasts. Womb and Ovaries, menstruation	
XY	Average male	Male	Penis & Testes, Deep voice, Facial hair	
XO	Turner's Syndrome	Appears Female	No Womb or Ovaries. No Menstruation	
XXY	Klinefelter's Syndrome	Appears Male	Penis & Testes as average male. Female body fat distribution May develop breasts.	1 in 1000
XY	Androgen Insensitivity Syndrome	Appears Female	Does not respond to male hormones. Body appears female. No Womb or Ovaries. No Menstruation. May have testes inside body.	1 in 20 000
XX	Adrenal Hyperplasia	Appears Female	Enlarged Clitoris. Womb, Ovaries, Menstruation	1 in 20 000
		Appears Male	Normal looking Penis, or partial Penis May have Womb & Ovaries. May Menstruate.	

See Intersex Society of North America. http://www.isna.org/

APPENDIX C

Partner Issues

Read the following statements and consider what issues they raise and what an appropriate response might be.

1. "I always knew X was a man and so it was no surprise when he decided to transition."

2. "I don't go with men. I've identified as a lesbian since I was twenty. If X is a man now – what does that make me?"

3. "I don't have relationships with men – I was abused by my stepfather from the age of twelve. The thought of X having a penis freaks me out."

4. "I love my wife – she's the mother of my sons. Why does she want to do this to me?" (This is intended to be a male speaker whose wife has decided to transition FTM.)

5. "I don't know if I can cope with this – it isn't what I bargained for – but it's the best relationship I've had and it's worth hanging onto."
   (This could be either a male or a female speaker.)

6. "Just carry on as though everything is normal."

7. "We came out publicly in a lesbian relationship – no more lies – we were going to be completely open. Now with X changing it's all secrecy and lies again."

8. "I met X after his transition – and I love him very much but I don't want my family to know"