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# Healthcare Issues for Transgender People Living in Northern Ireland

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## **Executive Summary**

This report examines healthcare issues for transgender people living in Northern Ireland. It highlights the social factors impacting transgender individual's sense of well-being as well as their experiences of healthcare service provision. The findings presented in the report were gathered through a series of focus groups and interviews that were conducted with members of Northern Ireland's transgender community as well as with health professionals that work with transgender service users. Although not comprehensive in its scope, the report highlights a number of important issues of relevance to policy makers in relation to ensuring that equality in healthcare service provision is assured and in the continuing improvement of the overarching standard of gender identity services.

### **Health concerns for transgender people**

Individuals that identify as transgender commonly do so because they come to associate, either intermittently or permanently, with a gender identity that is alternative to their assigned birth gender. This report found that many transgender respondents experience mental health concerns at some point in their life, with depression being the most frequent problem discussed. Poor mental well-being among interviewees was intimately linked to adverse social experiences, which included: social stigma, high levels of prejudice and discrimination, alienation from family and friends and social isolation. The combination of these social factors is often detrimental to transgender people's self-confidence and self-worth and has left many in the transgender community feeling marginalised from wider society because of their gender identity.

### **Healthcare experiences**

Transgender people access a range of healthcare services for a variety of reasons. A number of respondents reported experiencing inappropriate and even prejudicial treatment when accessing some healthcare services, which included health staff: using inappropriate pronouns, using and displaying old names in front of other patients, offering inappropriate services, providing inaccurate advice and refusing service provision. Such experiences were found to heighten respondent's emotional vulnerability, infringe upon their right to privacy and confidentiality and act to delay access to appropriate therapeutic support. This evidence shows that there are

urgent health equality issues for transgender people in Northern Ireland that must be addressed by the Department of Health, Social Services and Public Safety (DHSSPS).

### **Healthcare best practice**

Despite interviewees reporting a number of incidents in healthcare settings that were characterised by inappropriate behaviour some noted experiences of good working practice, these included health staff: asking service users which pronoun they would prefer to be referred in, using service users' preferred name, seeking accurate information of where to signpost service users to (if previously unaware of the appropriate channels of care) and not letting personal views or beliefs prevent them from their care of duty. Health staff were said to be in a unique position to help improve transgender individual's self-confidence and self-worth simply by taking the time to listen and talk to service users in a non-prejudicial manner.

### **Lack of awareness and the importance of training**

Almost universally respondents felt that health staff lacked awareness of gender identity issues and transgender people in general. This lack of awareness was seen to be the cause of inappropriate working practices and was linked to the systematic exclusion of transgender issues in professional training. Training was seen by both transgender individuals and healthcare professionals as vital for increasing awareness of gender identity issues and as a way of dispelling myths about transgender people among health staff. Undertaking training would empower health staff by increasing their awareness of good working practices and by providing them with a forum in which to challenge misconceptions that they might hold. Respondents felt that it was important that training included the participation of transgender people in order to facilitate reciprocal engagement.

### **Experiences of gender identity services**

Individuals that identify as transgender may undergo gender transition and come to live permanently in a gender identity other than their assigned birth gender. In Northern Ireland there is one regional gender identity clinic (GIC) based in the Greater Belfast area. Overall, the majority of respondents were satisfied with the services provided by the GIC and felt that it had improved mental health and well-being as well as their self-image. On the whole, interventions were found to be timely, person-centred and designed in relation to the perspective of service users and their relations. Despite general satisfaction, a number of respondents had complaints

regarding the limited number of staff at the GIC and difficulties in accessing the service for those who lived outside the Greater Belfast area. Accessibility issues were found to prevent some service users from accessing the innovative non-statutory peer support group that has been established under the auspices of the GIC. The establishment of a peer support group as well as a family support group initiative reveals the on-going attempts by the GIC to improve the services available to service users within tight budget constraints.

### **Emerging issues – gender variant children and transgender youth**

This report highlights some important issues in relation to the healthcare provision for gender variant children and transgender youth. Gender variant children and transgender youth are highly vulnerable to social alienation and transphobic bullying and require robust statutory support. Although far from comprehensive in its scope, this report suggests that there is a lack of awareness of gender dysphoria in individuals under the age of eighteen among relevant service providers. The experiences of one family reveals that this lack of awareness can have damaging consequences for the entire family and lead to the denial of appropriate therapeutic support for the child involved. Therefore, there is a need for the DHSSPS to ensure that there is an overarching service framework in place to meet the needs of gender variant children and transgender youth.

### **Recommendations**

1. Gender identity equality and diversity training should be offered to existing members of health staff on a priority basis.
2. Basic awareness training in gender identity issues should be made a mandatory requirement of the most common professional qualifications, including medicine, nursing and counselling.
3. Increased funding should be provided to the GIC in line with the increasing number of referrals to the service.
4. The DHSSPS should develop a comprehensive service framework for gender variant children and transgender youth.
5. Further research should be conducted into the healthcare needs of trans individuals.

# 1. Introduction

The transgender<sup>1</sup> community is comprised of a diverse number of individuals. People who identify as transgender, or trans, often do so because they identify with a gender identity that is different from their assigned biological sex either intermittently or permanently. Over the past two decades legislative developments have increased the legal protection available to members of the trans community. Meanwhile, there is heightened attention to the high level of prejudice and harassment trans people face at the hands of the general public and service providers. This new legal framework combined with increasing awareness of the discrimination levelled at the trans community has provided the impetus for service providers to develop inclusive organisational policy and models of best practice in relation to meeting the needs of trans service users.

Many trans people access the National Health Service (NHS)<sup>2</sup> for a range of services and some will be referred to specialist gender identity clinics (GICs). Research has found that there is considerable unhappiness among the trans community regarding healthcare provision in the UK due to frequent experiences of discrimination and prejudice. To date little has been written about the specific healthcare experiences of trans people living in Northern Ireland. This report aims to attend to this gap in knowledge by critically examining healthcare equality issues for Northern Ireland's trans community and the overarching standard of treatment in gender identity services. In so doing, the report presents valuable information to health staff and policy makers, as well as to trans individuals and their family and friends.

The findings presented in this report originate from a series of interviews and focus groups held between May 2010 and May 2011. The aim of the interviews and focus groups was to explore the factors impacting trans people's health and well-being as well as to discuss their experiences of healthcare service provision in Northern Ireland. After an initial round of data collection a draft version of the report was put out for consultation to members of the trans community and

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<sup>1</sup> See Appendix 2 for the definition of key terms.

<sup>2</sup> See Appendix 1 for a list of acronyms used throughout this report.

staff at Northern Ireland's GIC. The resulting feedback led to another series of focus groups that helped to strengthen the arguments put forth in the report. In total five individual interviews and seven focus groups were held with members of the trans community (twenty-seven individuals in total, some of who were interviewed on multiple occasions). Three focus groups were also held with staff at Northern Ireland's GIC and four interviews were carried out with private mental health professionals with experience working with trans clients (twelve individuals in total). It is important to note that this report is not a comprehensive audit of the healthcare services provided to trans individuals in Northern Ireland but rather a qualitative exploration of the key healthcare issues that adult trans people face. Each of the respondents quoted herein have been given a pseudonym in order to protect their anonymity.

The report begins by outlining the nuances within the trans community. Following this a review of relevant literature highlights key healthcare equality issues for trans people as well as exploring the overarching standard of treatment in gender identity services in the UK. Two chapters are then dedicated to the analysis of qualitative data: the first analyses the experiences of individuals that identify as trans in relation to healthcare service provision in Northern Ireland; the second explores the views of healthcare professionals who have professional experience working with trans clients. Following this a brief chapter highlights issues in healthcare provision for gender variant children and transgender youth. The report concludes with a number of recommendations that if implemented will increase equality in healthcare provision for trans service users and improve the gender identity service available in Northern Ireland.

## 2. The Trans Community

The terms transgender and trans refer to a broad spectrum of individuals who, to varying degrees and for a variety of reasons, present in a gender identity different from the one they were assigned at birth. Trans people may come from different racial, religious, ethnic, political and/or economic backgrounds yet share a degree of communal affinity based on their subjective experiences of *gender variance*. Gender variance is general used to describe an individual's behaviour and identity that is inconsistent with the cultural expectations of their assigned birth sex. The historical medicalisation of gender variant behaviour has led to clinical definition of different *gender identity disorders* (GIDs). GIDs are classified by the World Health Organisation (WHO) as personality and behavioural disorders.<sup>3</sup> There is increasing recognition that gender variant behaviour is influenced by an individual's pre-natal biological development and should not be considered to be a mental illness.

Gender variance may be experienced and embodied in different ways. Sometimes, gender variant behaviour that is initially expressed intermittently can become permanent. Individuals who undergo permanent gender transition are clinically defined as *transsexuals*. Individuals who have a dual, or fluid, gender identity are clinically defined as *transvestites*. These classifications have been criticised as creating artificial boundaries between trans people (Hird 2002), while their medical connotations have been viewed as fuelling the stigmatisation of trans people (Whittle 2000). This has led many people that may be defined as transsexual or transvestite to reject these labels and maintain a subjective gender identity, such as transgender or trans.

### Individuals who undergo gender transition

When gender variance is profound and persistent the individual may undergo gender transition and come to live permanently in a gender other than their assigned birth sex. This is usually referred to as transsexualism. There are no tests that provide an absolute diagnosis of transsexualism; therefore it must be diagnosed in accordance with the subjective experiences of

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<sup>3</sup> See <http://apps.who.int/classifications/apps/icd/icd10online/>.

the individual. Undergoing gender transition is neither a 'lifestyle' choice nor a mental illness, but a condition that is largely innate and somatic (Curtis et al. 2008). The manifestation of gender variant behaviour has been linked to biological factors that occur during foetal development (Reed et al. 2009). Individuals who experience gender variance have been found to suffer from depression and anxiety (Scottish Transgender Association nd). Undergoing gender transition has been found to improve mental well-being and quality of life (NHS 2008).

GICs provide a wide range of services to individuals undergoing physical gender transition. In the UK GICs follow the *Royal College of Psychiatrists Draft Good Practice Guidelines for the Assessment & Treatment of Gender Dysphoria*.<sup>4</sup> These national guidelines draw on the available evidence base of best practice to provide clear clinical pathways for an individual undergoing gender transition. They have been produced by the Royal College of Psychiatrists in collaboration with the Royal College of Physicians and Surgeons and other colleges and service user groups. The typical care pathway for an individual undergoing gender transition involves psychotherapeutic support, hormone therapy, a *real-life experience* (RLE) and/or surgery (see Barrett 1998).

In Northern Ireland there is one GIC that is housed within the Psychosexual Clinic as part of the Centre for Psychotherapy. It is a regional service that has been in existence since the 1960s. Currently, it is located in the Greater Belfast area. To access the service individuals must be referred by a general practitioner (GP), be over the age of eighteen and be a resident in Northern Ireland. Once referred, the individual undergoes an assessment to confirm their diagnosis before receiving psychotherapeutic support and beginning their gender transition. The GIC has four part-time and one full-time member of staff, all of who are fully accredited psychotherapists. Staff monitor service users' transition and facilitate a number of services, including mental health support, endocrinology, laser hair removal, speech and language therapy and, occasionally, image consultancy. The GIC is connected to eight sister clinics in England and Scotland with who they participate in a governance group.

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<sup>4</sup> See <http://www.rcpsych.ac.uk/pdf/Standards%20of%20Care%20Draft%20v8%203b%20final.pdf>.

Although most individuals will undergo gender confirmation treatment through the NHS, it is not uncommon for people to utilise private healthcare services, this may include: visiting private psychiatrists for hormone therapy prescriptions; attending private GICs; accessing private psychotherapeutic support; and, travelling outside of the UK for surgery (NHS 2008).

The UK has some of the most liberal policies and extensive legal protections for people who intend to or have undergone gender confirmation treatment within the European Union (Whittle et al. 2008). Through the Gender Recognition Act (GRA), individuals who have undergone gender transition may obtain a gender recognition certificate (GRC), which bestows legal recognition of their acquired gender, including in health and social care settings (DoH 2007). The GRA defines any information relating to a person's gender recognition application as 'protected information' and it is a criminal offence for anyone acquiring this protected information in an 'official capacity' to disclose it to a third party without the person's consent. Although there are a few exceptions,<sup>5</sup> in general it is necessary for all service providers who acquire knowledge of an individual's gender transition to maintain confidentiality and, if necessary, to get the person's written permission before discussing their history with anyone else. Disclosing protected information without the appropriate permission could result in a criminal conviction and a £5000 fine (Scottish Transgender Alliance nd).

In Northern Ireland it is illegal<sup>6</sup> for employers to discriminate on grounds of gender reassignment; organisations are vicariously liable if they do not take reasonable steps to prevent harassment on the grounds of gender reassignment by a third party; and, there is extended legal protection for individuals accessing goods, facilities, services and premises who have undergone or are undergoing gender confirmation (McBride and Hansson 2010).

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<sup>5</sup> Exceptions include if the information is required by a third party for the prevention or investigation of a crime or if the information is needed by medical professionals at a time when the trans person is too ill to be able to provide consent.

<sup>6</sup> See The Sex Discrimination (Gender Reassignment) Regulations (Northern Ireland) 1999 that amended the Sex Discrimination (Northern Ireland) Order 1976, the Sex Discrimination Order 1976 (Amendment) Regulations Northern Ireland) 2008 and the Sex Discrimination (Amendment of Legislation) Regulations 2008.

## Individuals who cross-dress

Today the terms transvestite, TV and/or cross-dresser are terms predominately applied to heterosexual men who intermittently present in a female persona. Although recognised as a mental disorder by the WHO the practice of cross-dressing is not a state of being that necessarily entails or requires specific medical intervention. Increasingly cross-dressing is becoming recognised as a mode of self-expression and not a pathological state of being for which there is a cure (Denman 2004). However, the stigma attached to cross-dressing practices leads many to suppress their cross-dressing that could impact the individual's mental health and well-being.

Currently, there are no legal statutes that offer protection to individuals who cross-dress and do not intend to undergo a process to reassign their gender under medical supervision (Mitchell and Howarth 2009). This has led some to criticise the GRA for not according individuals who cross-dress the same rights as individuals who undergo gender transition, stating that the definition of those to whom the GRA applies to is too narrow (Tirohl 2007; Whittle et al. 2007).

## Individuals with variations in sex development

Another group of individuals that may be classified or come to identify as trans are people that are born with both male and female sex signifiers. Such individuals may be referred to as intersex and be diagnosed with one of a number of biological conditions known as variations in sex development (VSD).<sup>7</sup> VSDs manifest in many different ways and stem from anomalies in foetal and/or infant development (Denman 2004). Two births in 100 have intersex factors, with one in 2,000–4,000 children born with 'ambiguous' genitals that combine male and female organs (DoH 2007).

One of the most common VSDs is androgen insensitivity syndrome (AIS). Individuals born with AIS have testosterone insensitivity, which leads a genetic male to appear feminine in their external physical appearance. Many children born with AIS are assigned as female at birth and raised as a girl. Such individuals encounter emotional difficulties at puberty when they fail to menstruate, including feelings of anxiety and insecurity about their future (Denman 2004). As a

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<sup>7</sup> See <http://www.isna.org/node/1066>; and, <http://www.intersexinitiative.org/articles/dsdfaq.html>.

result many people born with a VSD seek medical assistance, including accessing psychotherapeutic support as well as gender identity services to help them to live in their preferred gender (DoH 2007). Individuals born with VSDs may therefore come to identify as trans, while others will identify as men, women or another gendered identity. If the individual undergoes gender confirmation treatment and receives a GRC they will be legally recognised in that gender. If they do not, the individual will continue to be legally recognised in the gender assigned to them at birth.

### **Northern Ireland's trans community**

McBride and Hansson (2010) suggest that there are between 140 and 160 individuals affiliated with the three main trans support groups in Northern Ireland: The Butterfly Club, The Purple Group and the Oyster Group. Reed et al. (2009) have estimated that the number of people who have *presented* with GIDs in Northern Ireland is 8 per 100,000 (120) people (aged 16 and over). It is important to note that both of these figures refer to trans individuals who are *out*, as trans, to some degree and are therefore both likely to be an *underestimate* of the number of individuals who experience gender variance in Northern Ireland. Anecdotal information suggests that the majority of individuals who identify as trans in Northern Ireland are Caucasian, come from a variety of socio-economic backgrounds and throughout the country. Similar to other European countries (see Whittle et al. 2008), there are more trans women, that is individuals assigned to be male at birth who transition to female, in Northern Ireland than trans men, individuals assigned female at birth but who transition male.

### **Conclusion**

Trans people may present either intermittently or permanently in a gender other than the one they were assigned at birth. Service providers need to be aware of the similarities and differences within and between the different constituencies of the trans community. This is particularly pertinent for healthcare staff because individuals who present, either intermittently or permanently, in a gender opposite to the one assigned to them at birth commonly seek out psychotherapeutic support and/or undergo gender transition. In addition, legislative developments have made it illegal for health and social support services to discriminate against an individual who is intending to undergo, is undergoing or has undergone gender reassignment because of their gender identity.

### 3. Healthcare Issues for Trans People

Historically, research related to the trans community has primarily been conducted by medical professionals and largely focused on issues pertaining to aetiology, diagnosis and treatment of gender variance as a medical condition. In the past two decades research has begun to focus on the trans community's social experiences, including in healthcare provision. Research from the UK has shown that trans people risk harassment from the public and prejudice from service providers. Meanwhile, Northern Ireland's Department of Health, Social Services and Public Security (DHSSPS) has recently outlined an overarching standard of treatment in gender identity services as well as indicating that trans people face inequality in healthcare services. This chapter outlines the key findings from recent research and discusses them in relation to the main healthcare issues facing Northern Ireland's trans community.

#### Social factors impacting trans people's well-being

Previous research in Northern Ireland has largely focused on the degree to which trans individuals face social discrimination. Hansson and Hurley-Depret (2007) found that Northern Ireland's trans population face many forms of bigotry and hostility due to their gender identity. McBride and Hansson (2010) highlighted the extent of this *transphobia*,<sup>8</sup> revealing how trans people are subjected to discrimination and harassment from both members of the public and public service providers. This included transphobic incidents such as deliberate and repetitive use of inappropriate gender pronouns and prejudicial service provision. In line with this, McBride and Hansson (2010) state:

*“the inadequate provision of a public service...due to ignorance, insensitivity and/or intolerance of gender identity issues is a significant form of discrimination that can seriously impact upon an individual's emotional well-being and/or quality of life. One or more negative experiences when dealing with a specific institution...may cause a transgender individual to feel uncomfortable utilising that particular public service and/or facility again in the future”* (2010: 15).

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<sup>8</sup> Transphobia is commonly understood as emotional disgust and/or negative attitudes harboured towards gender non-conforming persons (Hill and Willoughby 2005; Bettcher 2007; Wentling 2007).

This view is supported by research from around the world that has shown that experiencing transphobic incidents is linked to increased risk of depression, self-harm and suicide (see Brown and Lim 2008; Clements-Nolle et al. 2006; Laird and Aston 2003; Mayock and Bryan 2009; Nemote et al. 2004). Meanwhile, trans people may become socially isolated because of familial breakdown, including exclusion from family events and domestic abuse (Brown and Lim 2008; Scottish Transgender Alliance 2008; Whittle et al. 2007). Furthermore, the stigmatisation of trans people means many will come to limit their social lives and contacts, which can evoke feelings of anxiety and depression (Whittle et al. 2007). This leads many trans people to be socially isolated (DHSSPS 2010b).

### **Inequality issues for trans people**

Northern Ireland's *Department of Health, Social Services and Public Safety* (DHSSPS) have recently conducted an audit of inequalities among section 75 equality groups and has highlighted that there are two equality issues specific to transgender people. First, the DHSSPS state that there is a "*[l]ack of awareness and understanding [among health staff] resulting in behaviour by health staff that can be profoundly humiliating*" (2010a: 22). This includes some health staff refusing "*to use the appropriate gender pronoun*" while "*[m]any make inappropriate assumptions about the person's sexual orientation*" (2010a: 22). The second equality/inequality issue noted in the audit regards "*[c]hoosing of appropriate services/ward*" as "*[m]any services are set up specifically for men or women e.g. sexual health services. These may exclude transgender people as they may need to access clinical services due to their birth gender not their true gender*" (2010: 22).

These issues of inequality are also reflected in the findings of research conducted within the UK that has found that trans people's experiences of healthcare are often characterised by discrimination and inadequate service delivery (Mitchell and Howarth 2009). This includes experiences of improper and even abusive treatment by healthcare staff (Laird and Aston 2003; Fish 2007), which may lead a person to avoid using healthcare services in the future (Whittle et al. 2008). Of particular relevance is the deliberate use of a wrong pronoun, which is experienced as offensive and can cause emotional distress (McBride and Hansson 2010). The pervasiveness of inappropriate service provision leads some trans individuals to feel that their gender identity

adversely affects the way they are treated by healthcare professionals (Whittle et al. 2007), which has led to suggestions that there is a culture of ignorance, insensitivity and discrimination in the health sector of trans people (Sperber et al. 2005). This culture of ignorance has been linked to a lack of awareness of gender identity issues and the conception that trans people are mentally ill (Whittle et al. 2008).

The issue of awareness is particular pertinent for GPs who play a crucial role in trans individual's healthcare (Whittle et al. 2007). GPs are often trans people's first point of contact with the health service and are often required to make refer service users on to gender identity services. However, GPs have been shown to be uninformed or badly informed about gender identity issues (Laird and Aston 2003; Sperber et al. 2005) and can be reluctant and even refuse to treat trans people (Mitchell and Howarth 2009). In a UK wide study, which surveyed the views of 599 individuals who identified as trans, Whittle et al. (2007) found that although 79% (482 of 599) of respondents felt that their GP was willing to help them 60% (365 of 599) stated that their GPs lacked the appropriate information to do so; and only 6% of respondents believed that their GPs were sufficiently knowledgeable, able and willing to help. Meanwhile, 19.5% of respondents stated that their GPs either did not want to help or refused to provide the healthcare services they required. Furthermore, in an audit conducted of 647 service users by the NHS (2008) although almost two thirds of respondents (62%) felt that their GP addressed their needs appropriately only 19% said their GP was knowledgeable about treatments and even fewer (12%) said their GP was able to explain to them what treatments were available. Meanwhile, 35% of respondents felt that the care provided at their GP surgery could be improved.

### **Overcoming healthcare inequality issues**

The DHSSPS (2010a) suggests that in order to overcome the inequality issues discussed above health staff should undergo equality and diversity training that includes *“transgender issues and should challenge attitudes that undermine people's identity”*; this the DHSSPS believe would *“[i]ncrease staff capacity to interrupt prejudicial behaviour and attitudes”* (2010a: 22). Furthermore, the DHSSPS believes it is important that staff recognise trans peoples' *“wishes and true gender and not to send them to a service or place them on a ward determined by the proposed clinical treatment”* (2010a: 22).

This potential solution is supported by research recommendations that have called for healthcare staff to be trained in regard to gender identity issues and the healthcare needs of trans people (Mitchell and Howarth 2009; Whittle et al. 2008). Whittle et al. (2007) have made several best practice recommendations for the training of health professionals, including ensuring that the staff development structure regularly raises issues about trans people's needs and rights. Training would need to include appropriate information surrounding the use of pronouns (Scottish Transgender Alliance nd) and guidance regarding trans people's privacy rights (DoH 2008). Whittle et al. (2007) also suggest that training should be supported through simple education and leaflet guidance for doctors, nurses and other healthcare staff on how to work with, and uphold the rights of, trans service users. Meanwhile, the NHS (2008) itself has stated that the widespread lack of awareness among health personnel and the high frequency of discriminatory incidents may require a more fundamental change through the incorporation of gender identity issues into general medical training for all doctors. Although general awareness among health staff is low the Department of Health (DoH) has produced a robust document that outlines appropriate guidance for the treatment of gender variant people (see Curtis et al. 2008).

The lack of awareness among health staff reveals there to be a certain level of ignorance of gender identity issues in the policy arena. The Equality and Human Rights Commission (nd) has highlighted a number of examples of how equality in health and social care provision can be improved for trans service users at the policy level, including creating trans-specific equality and human rights policy and creating procedures to respect trans patient privacy. The authors also suggest that the needs of trans service users may be better attended to if trans equality issues are included in equality impact assessments and by improving health survey accessibility to trans patients. Furthermore, they challenge policy makers to: consider trans specific needs in social care services, including improving support for trans survivors of rape and sexual abuse; promote trans equality; and, acknowledge older and disabled trans people's needs. The points raised by the Equality and Human Rights Commission highlight the urgent need for the DHSSPS to think comprehensively about the manner in which it respects, upholds and promotes the rights of trans people in policy in order to ensure equity in service provision.

### **Issues in gender identity clinic healthcare provision**

The mental well-being of some trans people can often be improved through psychotherapeutic support, hormone therapy and/or surgery (Curtis et al. 2008). The DHSSPS (2010b) has an

overarching standard of providing treatment and on-going care to people undergoing permanent gender transition, this includes having providing: hormone support, involving both psychiatry and endocrinology services; non-statutory peer support and mentoring to reduce isolation; and services that will, as part of their on-going treatment and care, help trans people improve their self-image in order to promote good mental health and well-being. The DHSSPS believes that interventions should be timely, improve trans people's mental health and well-being, reduce their risk of harassment and protect their personal safety. Furthermore, the DHSSPS states that a trans persons care plan should be designed "*from the perspective of the trans person, their family, carers and other professionals and changes negotiated on the basis of this*" (2010b: 201).

A number of problems have been found with the services provided at GICs in the UK. Although NHS GICs are generally run within the remit of NHS mental health services not all GICs provide general mental health support to trans people (Equality and Human Rights Commission nd). Meanwhile, research has found that trans people often experience long delays in accessing gender confirmation treatment through the NHS; and some trans people find that treatment guidelines can be applied in a restrictive manner that is incompatible with their needs (Curtis et al. 2008; Mitchell and Howarth 2009; NHS 2008; Whittle et al. 2007). Others have noted that psychiatrists at GICs have a renowned gatekeeping role and that they can be dogmatic in their views (Speer and Parsons 2006; West 2004); with concerns that gender specialists might only see individuals if they seek permanent gender transition and want to live as a heterosexual once transitioned (see Hines 2007).

The NHS (2008) has acknowledged that there is considerable unhappiness with some of the services it provides to trans people, which it admits is not patient focused. In light of this an audit was conducted to gauge the experiences of trans people utilising NHS services, which gained 647 responses over a 6 month period. The audit found that the mean waiting time from specialist referral to first appointment at a GIC was 30 weeks and the median was 22 weeks. However, for those who attended an NHS GIC the mean waiting time increased to 34 weeks and the median time increased to 26 weeks, indicating that NHS patients have longer waiting times than individuals who access private healthcare. Although, 98% of those who had surgery felt it was a positive or mainly positive experience and were happy with their outcomes only 39.5% of respondents were either totally happy with the care received at GICs or felt it had more good

than bad aspects. Meanwhile, 16% of respondents felt negatively or very negatively about the care they received. In line with these findings 49% of respondents felt that treatment at GICs could and should be improved. The audit raises important questions about the services provided at GICs and suggests they could be improved. The authors also point out that there is a lack of services afforded to individuals across the trans spectrum, including support for cross-dressers, as well as for partners and families of trans people.

In light of these problems it is increasingly being recognised that GICs should be person-centred and that trans people should not need to know for certain whether they want to undergo complete gender transition in order to access GICs (Scottish Transgender Alliance nd). GICs are now expected to recognise that trans people can have a wide range of sexual orientations, both in terms of their sexual histories and future intentions (GIREs 2006). There is also growing awareness that individuals may choose to live androgynously and not identify as either male or female. Therefore, GICs are increasingly being encouraged to allow individuals to explore their gender identity and not lead them into a gender role that they may later be uncomfortable with (Curtis et al. 2008). Thus, GICs should be flexible, patient-centred and aim to provide individual needs based care pathways incorporating local and specialised providers (NHS 2008).

## Conclusion

Research suggests that there exists a culture of ignorance and prejudice within the health sector that has led many trans people to experience discriminatory practices. Such experiences may have a detrimental effect on trans people and prevent some from accessing healthcare services. The prevalence of inappropriate behaviour and prejudicial attitudes has been linked to a systematic lack of awareness among health staff and policy makers of gender identity issues. Awareness training is seen as an important medium by which to increase health staff's understanding of gender identity issues and a way to empower them to meet the needs of trans clients both sensitively and effectively. Such training should be complimented though the development of trans-specific healthcare policies and procedures. Furthermore, although the services provided by GICs have been found to improve trans people's quality of life some service users are unhappy with the service they are provided with in NHS GICs and feel that they should be improved.

## 4. Views of the Trans Community

The relatively small size of the trans community in Northern Ireland means not all healthcare staff will have interacted with a trans person. Nevertheless trans people may for a variety of reasons seek out medical support and/or gender identity services. Healthcare professionals are in a strong position to provide trans people with support, however, they can also cause unwarranted distress to trans service users through bad working practices. This chapter analyses the healthcare experiences of trans people living in Northern Ireland and also examines the views of people undergoing gender transition at Northern Ireland's GIC. It begins by outlining the social factors that impact trans people's health and well-being.

### Social factors impacting trans people's health and well-being

The general low-level of awareness of gender identity issues and stigmatisation of gender variance means that many trans people face difficulties *coming out*.<sup>9</sup> Sarah noted that for most people coming out is not a choice: *"it's not wanting to do something, you have to do something...it's inside you and it gets worse and that's the problem."* The majority of the trans people interviewed for this study came out in their adult years. Many were in long-term relationships, had children and/or an established career at the time of coming out. Coming out for these individuals meant risking becoming alienated from their partner and children (as well as family and friends) and potentially facing difficulties in their workplace. However, in spite of such risks most felt compelled to come out because of the emotional strain of concealing their subjective gender identity, which affected them both psychologically and in their relationships. Fred described how he had feelings of gender variance from a young age; however, he was led to conceal his gender identity. Fred got married and had children but for years he suffered from depression due to his inability to be himself. This led him to feel *"jealous"* of and *"angry"* towards of his partner. After coming out Fred was able to stop taking anti-depressants and although he divorced he was able to forge a stronger relationship with his family: *"me and [my ex-partner] are more friendlier now then when we were married and we are closer now as a family."*

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<sup>9</sup> For more information about coming out as trans see LGBT Youth Scotland (nd).

Once an individual comes out and begins to present in a gender identity other than their birth gender in public, either intermittently or permanently, they are at risk of harassment. The majority of interviewees reported having experienced some form of transphobic incident, which varied from verbal abuse and physical attacks to malicious communications and criminal damage. Such incidents could be perpetrated randomly in public spaces or be targeted attacks on the individual and their home. In the immediate aftermath discussants described experiencing stress, fear as well as embarrassment depending on the nature of incident. Such experiences could have long-term psychological effects:

*Catherine: "If I was to go home... I would be close to [having] panic attacks. Because people know me there and even though my best friends are still down there I get panic attacks because socially that's where I got my worst ever abuse."*

The transphobic harassment Catherine received led her to move to a new city where she has made a new life for herself. However, as a result she has become alienated from her best friends because going home to see them instils her with a sense of panic. Other respondents described how the fear of receiving transphobic harassment made them anxious about socialising and using public spaces. This fear had led some to limit their social interactions, as Sandra revealed: *"for me to go out from my own home and to feel confident it has to be four am when there is nobody about."* The risk of receiving abuse and harassment therefore means some trans people isolate themselves. This can potentially lead some to engage in risky practices that could impact their health:

*Thomas: "Because you're not getting the attention or you're not getting the love...a lot [of trans individuals] do end up getting into the likes of prostitution and casual prostitution just purely for the affection and to break that isolation and loneliness as well."*

## **Healthcare issues for trans people**

Almost universally respondents felt that the majority of health staff lacked awareness of gender identity issues and, in general, are ignorant about the trans community. In line with this a

number of interviewees reported experiencing inappropriate behaviour that had left them feeling hurt and humiliated. Some interviewees recounted how they had been called by an inappropriate gender pronoun and/or their old name. Both were experienced as disrespectful and caused significant embarrassment and distress. Michelle explained how when:

*“I was having a really bad panic attack.. [hospital staff] kept saying “he, he, he.” And they called out my old name in front of the waiting area”*

Hospital staff’s actions caused Michelle unwarranted distress and exacerbated her fragile emotional state and left her feeling that the *“health service is transphobic.”* Similar experiences of health staff using an inappropriate pronoun and/or name were linked to administrative protocols. In many instances the individual had previously requested that their name and gender be changed on their medical records. Some were told they were required to produce a GRC, which is only attainable after a minimum of living two years in an acquired gender; while others were told it was simply not possible to change the gender on medical records. In a number of cases the individual’s gender was changed to ‘unspecified.’ Unaltered records could lead to potentially embarrassing situations in healthcare settings and lead inappropriate pronouns and/or names to be used in official correspondence. The inability to change medical records was a significant cause of frustration among interviewees. It was seen to lead to breaches of confidentiality that effectively ‘outed’ the individual to all members of staff who viewed their records. It could also cause inappropriate pronouns and names to be shown in public reception areas and waiting rooms. Jane discussed how a friend of hers felt *“extremely humiliated”* because her old (male) name was displayed in a busy GP waiting room. Jane’s friend felt this encroached upon her right to anonymity and approached reception staff but they refused to change her details in spite of the distress it was causing. Jane felt that staff should have been more considerate and changed her friend’s medical records:

*“for the sake of saving her a little bit of dignity and giving her that little bit of privacy because she didn’t want everybody turning round and laughing at her in the reception. But that does happen to her.”*

However, Catherine revealed how some of the potential difficulties caused by unaltered or inaccurate medical records could be eased if health staff took a sensitive approach:

*"I was in [the hospital] myself and it said on the form, 'name: Catherine Smith, gender: indetermined.' And the staff came up to me and said "which would you prefer, mister or miss?" I said "miss preferably.""*

In this instance health staff took into consideration Catherine's feelings and asked her what pronoun she would prefer to be referred to as, rather than impose their own assumptions. This respectful enquiry acknowledged Catherine's right to self-determination and is an example of good practice. The experience was an important moment for Catherine as her *"goal...is to be accepted as a woman no question."* However, not all respondents found health staff to be so respectful of their right to self-determination, as Monica's discussion of when she required a bed on a hospital ward highlights:

*"The last time I went into hospital – I actually went in because of an overdose – they had said that there were no private rooms available to put me in and that I would have to go in to the male dorm."*

Despite living as a woman and presenting in a female persona hospital staff offered Monica a place in a male dorm and went against good practice. By disregarding Monica's embodied gender identity hospital staff not only heightened Monica's emotional vulnerability but could have also exposed her to transphobia from other patients. Monica was eventually placed in a private ward but did not receive the care she expected:

*"I was actually asking them to come and sit with me but they wouldn't come near me. I was just left in the room with the door closed...Every other time I was in hospital I had a totally different service somebody was sitting with me but this time it was if I had the plague."*

On this occasion Monica felt that her gender identity affected the way hospital staff treated her. Another respondent, Claire, recounted a similar experience when a doctor appeared to refuse to provide routine care after finding out she was trans: *“his attitude totally changed when I told him I was going for gender reassignment...I think I scared him off.”* Experiencing, and also hearing about, such incidents greatly shaped some respondent’s perceptions of the health service and may dissuade some from accessing healthcare provision in the future. The close-knit nature of the trans community means that if one person has a negative experience this will often be communicated to the rest of community. The inappropriate actions of one member of staff can therefore ripple out beyond the individual service user. Many respondents felt that health staff’s prejudicial behaviour was not necessarily the individual’s fault but caused by a lack of awareness and inadequate training:

Claire: *“I would say it was a lack of knowledge and of information not outwardly a stance of discriminating against you. In my mind it wouldn’t be anything they would do on purpose it would just be stupidity...it doesn’t compute with what they have been taught.”*

Naomi: *“It is just down to training and awareness.”*

This lack of awareness was seen as systemic, particularly among GPs:

Monica: *“The main problem for the trans community is that doctors don’t know a lot...I recently signed up to a new doctor and the first time I went...they were like “well what are you?” He didn’t have a clue!”*

Although Monica said that she did not mind *“explaining a few things”* to her GP, his total ignorance of trans issues left her feeling *“angry”* and *“upset.”* GPs are often the first point of contact an individual will have with the health service regarding their gender identity and a negative response may have a damaging affect. Furthermore, if the individual requires an assessment at a GIC they will need a referral from their GP. GPs are therefore pivotal in ensuring trans people gain access to appropriate healthcare provision and support. Many interviewees, however, reported experiencing difficulties in their interactions with GPs:

Matthew: *"I had a problem with my first GP when I was coming out. I said I was supposed to be man and he refused to refer me. Obviously I changed my GP because that GP didn't have a clue and wasn't aware of the issues so I had to find a more accepting GP."*

Claire: *"I had to change my GP because of the same sort of thing. One doctor turned around and told me that I wouldn't be able to have sex, she didn't have a clue what she was talking about...I ended up changing GP and the GP I have now is really understanding."*

Samantha: *"We realise how woefully inadequate the GPs are. They have no idea what transgender or gender dysphoria is...Some of them think it is nonsense. I've heard of one GP that said bring all your female clothes and we will burn them and that will cure you".*

Without awareness of gender identity issues GPs may offer grossly inaccurate advice and prevent the individual from accessing appropriate services. Approaching a GP regarding one's gender identity was described as an emotionally challenging event that required a great deal of courage. Receiving a negative response from their GP delayed a number of respondents from accessing appropriate therapeutic support for many years. Fred described how when he first presented to his GP he was told *"you're only imagining it."* This led him to suppress his gender identity for fifteen years and, consequently, he suffered from mental health issues, including depression. Sarah further contextualised this point by discussing the ramifications of her GP's lack of a sensitive approach:

*"I went in to the doctor and I had to ask her two or three times, I didn't want it put on the medical records I just wanted to talk to her first, but she wouldn't agree to it. So that's when I went to London. I started [illicit] hormones and then I had problems and I had to go to the doctor."*

The response Sarah received from her GP led her to make the decision to self-medicate by using hormones purchased privately. This, in turn, resulted in her having health complications for which she required medical assistance. Hormone therapy is a delicate process and should only be done under medical supervision in order to carefully monitor the level of dosage received and

also to ensure that the hormones used are safe. Denial of appropriate treatment could lead some to self-medicate and unintentionally harm themselves.

Not all respondents reported having negative experiences with their GPs. Some described their interactions as “*positive*”, while others found it to be a “*formality*”. Respondents explained how even though their GPs did possess great awareness of gender identity issues they did not prevent them from accessing appropriate care:

Thomas: *“When I first presented to [my GP]...she just quite openly said ‘look I don’t have a notion about this, I don’t know how you go about it, I don’t know what you do about it but if you sit there I’ll make a few phones calls’ and I sat with her for an hour and she phoned round the country until she found out where to send me and who to send it over to. She didn’t look particularly pleased about it but at the same time she didn’t say “ there is nothing I can do about it away you go.”*

Tanya: *“See my GP didn’t know a lot about transgenderism but she stayed in late and found all the information on the internet. Not only that but she printed it off and gave it to all the doctors in the surgery in case I couldn’t actually see her.”*

Here we see three examples of good practice. First, despite lacking awareness these GPs sought out the relevant information required. Accurate information and effective operational tools are readily available on the internet.<sup>10</sup> With initiative GPs, and other health staff, can access a wealth of information that will enable them to meet the needs of trans service users. Second, health staff should be proactive and share any information they find useful with other members of staff in order to ensure consistency in service provision. Third, although Thomas reported that his GP did not “*look particularly pleased*” she still carried out her duty of care effectively. It is important that GPs, and other healthcare staff, do not let their personal feelings regarding trans people interfere with their professional duty of care.

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<sup>10</sup> See Appendix 3 for a list of websites useful websites.

A lack of awareness can foster misconceptions and lead to prejudicial service provision. In particular a number of respondents stated how they felt that *“religious beliefs”* could negatively shape healthcare personnel’s perception of trans people. Thomas described how some doctors: *“have their own opinions, political views and religious beliefs that transcends into their work practice...Religiously they think it is abnormal.”* This leads some doctors to mistakenly view gender identity issues as *“a sexual fetish or sexual choice”* and perceive trans people to be *“not quite right in the head.”* Other respondents shared this view that health personnel inaccurately consider trans people to be mentally ill, Alice said: *“I would make that assumption but it would only be my assumption. It’s just the way they come across.”*

The experiences discussed above primarily relate to one demographic of the trans community, namely individuals who are undergoing or have undergone gender transition. Individuals who cross-dress have a degree of freedom where they present in their alternative gender identity. The social stigma attached to trans identities means most people that cross-dress will choose not to utilise healthcare facilities in their alternative gender identity. This, to an extent, frees them of the burden of encountering the bad working practices described above. However, individuals who cross-dress may access healthcare services to discuss their gender identity if it is impacting on their well-being and/or social relationships. Furthermore, it is not inconceivable that people cross-dressing could come into contact with healthcare personnel during the course of an emergency. In this regard, the examples of good practice discussed above would apply, including: use of a gender appropriate name and pronoun (or asking the individual’s preference if unsure); ensuring the person is placed on a gender appropriate or private ward; and treating the individual with the same high standard of care as any other patient.

### **Issues in gender identity services**

The majority of interviewees did not begin their transition until later in life. The social factors that impact trans people’s mental well-being, discussed above, mean individuals who suppress their gender identity often have low self-esteem, suffer from feelings of depression and some may have contemplated self-harm and even suicide. It is often when an individual has reached such a low point that they seek out specialist gender identity services. Danny stated how *“virtually everybody is depressed when they first come [to the GIC].”* Claire explained how *“I came here when I was in a very bad state, an extremely bad state, I was mentally ill.”* For this reason

mental health services at the GIC are of great importance. The large majority of respondents felt that the psychotherapeutic support they received at the GIC had improved their mental health and well-being as well as their self-image. Most interviewees stated that they were happier now than before being referred to the service and were pleased with the overall service they have received. Meanwhile, the GIC in Northern Ireland was said to be favourable in comparison to similar services elsewhere, as Tony stated: *“compared to a lot of other countries and a lot of areas in England we [in Northern Ireland] are further ahead.”* This view was affirmed by respondents that had accessed GICs elsewhere in the UK. However, one respondent described feeling *“anxious”* and *“upset”* at what she perceived to be the inconsistent nature of her psychotherapy appointments at the GIC. Another interviewee was unhappy with the quality of the mental health provision he received:

*“You go in with a problem at all and it’s dismissed very quickly...there are still an awful lot people still come out with an awful lot of problems and even after they’ve gone through the entire transition they are lonely, depressed people because they [the GIC] haven’t dealt with the underlying problems.”*

The various of factors that impact trans people’s mental health and well-being means each individual’s transition must be managed on a case by case basis. Respondents discussed how the needs of family members, partners, children and also issues related to employment, are taken into consideration the on-going support they are provided. Chris noted how staff *“help and support us, and our partners and our family throughout our lives.”* For example, in an attempt to reconcile the differences between Catherine and her family staff at the GIC wrote to her parents and offered to meet them in order discuss her transition. Jane discussed how staff helped her and her partner to deal with the difficult task of informing social services of her transition because she had children. Meanwhile, a number of respondents praised a recent initiative to begin to hold social evenings for partners and family members in order to give them an opportunity to meet with others in a similar situation and to talk with staff. Furthermore, Jane discussed how prior to beginning her real life experience staff helped with careful *“groundwork”* to ensure that her employers and colleagues were accurately informed of her transition to decrease the likelihood of negative consequences in her workplace. These are just some

examples that reveal the person-centred nature of the GIC and the way in which staff take into account and involve service users' family, partners and children in their transition.

Many, but not all, respondents were currently receiving hormone therapy. On the whole hormone therapy was managed by staff at the GIC. Only one interviewee reported having access to an endocrinologist. A number of discussants had undergone surgery, many of who felt that the requirement to fly to England for surgery was problematic *"because travelling after having surgery isn't really beneficial to you."* The majority of surgical procedures trans individuals undergo are painful and, to an extent, immobilising. They are often required to fly back to Northern Ireland soon after surgery without adequate time to fully recuperate. Furthermore, they may be required to make this daunting trip alone. Although respondents felt it was beneficial to have access to experienced surgeons in England a number of people expressed a desire for surgical services to be provided within Northern Ireland: *"I think it would be an improvement if they had the surgery here."* Meanwhile, some of those who had undergone surgical operations were unhappy with the aftercare they received:

Rebecca: *"the service that you get post-op regarding GPs and hospital is woeful because in five to seven days I saw three different doctors and received three different responses in regards to the surgery. Half the things they say to you would actually make you hit your head off a wall to stop you going crazy thinking about it."*

Almost all interviewees felt that they had experienced some form of 'delay' at the GIC. This could either be a perceived delay in further psychotherapeutic support, their real life experience and/or undergoing surgical procedures. Many recognised that 'delays' in their transition were due to their personal circumstances. A number of interviewees felt that 'delays' were linked to the limited number of staff at the GIC: *"it isn't the fault of the staff here it is because they don't have a full-time secretary... [it] is effecting the transition and is holding things back needlessly."* Other respondents were more critical of the length of their transition:

Catherine: *"See unfortunately the NHS it's slow".*

Sarah: *"It's dead slow it's stuck... they expect you to live two years as a female [without surgery] but those two years turn into three or four...or five years".*

The Royal College of Psychiatrist's national guidelines for gender transition are designed to ensure that an individual undergoing transition is socially and emotionally able to cope with the demands of the process. These guidelines, which are tailored to an individual's circumstances, will mean each person's transition will take different lengths of time. This may lead people to compare the length of their transition with others and as a result perceive there to be 'delays' in their progress. This can cause significant *"frustration"* and *"anger."* One respondent discussed how he felt that the guidelines that the GIC used led to a 'one size fits all' approach:

Thomas: *"It's been fairly straightforward, frustrating at times because of 'red tape'...They have this one umbrella and everybody has to go through it. For those who don't have any sort of problems at all it is extremely frustrating but...it is obviously there for a reason. It must help some who do have problems coping or have had other factors in their life that affects their ability to change and to cope with it."*

Another respondent reported that her dislike for the service offered at the GIC led her to access a private service: *"I wanted somebody different [to the GIC]...so I went private and didn't have a bother."* However, the majority of respondents recognised the importance of managing the progress of their transition in line with their personal life in order to ensure they were adequately prepared to undergo any permanent body modification:

Deborah: *"My experience of the clinic is that it has been very responsive to me and moves at my pace rather than trying to force anything. "*

Claire: *"That's exactly right because it moves at your own pace. They give you an initial period of assessment and you move along at your own pace in response to how you were assessed."*

Many respondents expressed an appreciation of the pace of their transition in hindsight; feeling it allowed them, as Catherine put it, to *“be right in my own mind.”* In line with this, the majority of discussants expressed a belief that the GIC was ‘patient focused’ and was not concerned with imposing a restrictive, ‘one-size fits all’ treatment model on them:

Jackie: *“To me they are not just talking about gender reassignment surgery and hormones they want to know, especially when you’re doing your real life experience, how your life is turning out and how your health is being affected [by your transition].”*

Undergoing gender transition enables individuals to physically embody their innate gender identity. It is a process of immense social and physical change for the individual and their families. Thomas described the way in which the gender transition, especially in the early stages of one’s transition, affects an individual:

*“You go through this real androgynous [stage]...you’re not quite female, you’re not quite male and that...leaves you open to all sorts of ridicule...Not only is there an isolation of your family who perhaps reject you or your friends who reject you, you start to create that isolation yourself.”*

The high level of social isolation among service users led to the establishment of the Oyster Group, a non-statutory peer support group run under the auspices of the GIC, in 2007. This initiative is part of the GICs attempt to attend to the social needs of trans people, not simply their medical needs. The support group meets regularly, at least once a month, and provides an important space for people undergoing gender transition to meet one another and discuss issues of importance to them as individuals and as a community. Respondents felt that the Oyster Group was one of the most a vital support mechanisms available to them and was described as invaluable in the early stages of the transition process. Samantha described the support group as *“a life saver.”* Peer support was felt to greatly compliment the clinical advice provided by staff at the GIC. Claire explained how the advice she had received has *“prevented me from finding things out for myself the hard way...In a retrospective way it reduces your risk [of harassment].”* The support group provides people with a forum in which to get and give practical support and

advice. Meanwhile, the Oyster Group is increasingly becoming active in terms of advocating on behalf of the transgender community. Furthermore, they are working to attend to gaps in service provision, including the setting up of a Northern Ireland specific information based website and initiating a befriending project in collaboration with Gay Lesbian Youth Northern Ireland (GLYNI) to provide support to trans youth.

The Oyster Group meetings are held in the premises of the GIC. This helps to ensure protection and a high level of individual anonymity for participants; however, as it is held at night and is located in the Greater Belfast area it is impractical for some service users to attend, especially individuals that live outside the Greater Belfast area. For example, individuals who live in County Fermanagh or County Londonderry would have to make a four hour round-trip for the two hour meeting. A respondent from the Foyle area stated:

*"I actually haven't been [to the Oyster Group] in three years and so many months because I couldn't afford it at first but then when I could afford because I got work...it would have meant getting a train... from [work] to Belfast and back again...and then getting [home] around twelve o'clock. And then [I would have to] work the next day... I just couldn't do it."*

Another respondent who lives in the Foyle area stated: *"it is wrong [the distance] you have to travel."* The impracticality of attending the Oyster Group for those who live in outside of the Greater Belfast area therefore limits access to the primary peer support group for individuals undergoing gender transition in Northern Ireland. The time consuming nature of accessing the GIC was felt to be a major inconvenience and a number respondents residing outside of the Greater Belfast area expressed support for the provision of regional gender specialist health services:

Sarah: *"There is only one specialist in Northern Ireland, which I see as totally wrong!"*

Monica: *"Yeah. I think there should be another couple of doctors."*

Catherine: *"There was talk of a specialist going to be based in Altnagelvin."*

Monica: *"I think that would be better because there is a lot of trans in the area."*

Overall, the majority of service users were happy with the services provided at the GIC, however, some felt that it could be improved *"in an ideal world."* In particular there was a concern among some respondents about the length of time between appointments:

Jane: *"There's times when you just want to pick the phone up and come down here and talk to [staff]. It's no use talking to a GP because you need to talk to someone with knowledge of the concerns that we have. You have to wait three or four weeks and that can sometimes be an exceptionally long time."*

Respondents felt the length of time that they had to wait for an appointment was because due to the limited number of staff at the GIC. They noted that additional staff, particularly another consultant and a full-time administrator, would increase the availability of clinicians for consultations and prevent administrative delays. Respondents felt that increasing the number of staff at the GIC would decrease waiting times and improve the service the GIC was able to provide.

Another respondent spoke positively of a weekly drop-in service that was in operation in another part of the UK. The weekly drop-in session enabled service users to see consultants without the need to make an appointment. The majority of interviewees felt that a similar service in Northern Ireland would be greatly beneficial as it would increase access to appropriate support and decrease waiting times. However, many interviewees recognised that without an increase in staff numbers at the GIC such an initiative was not likely in the immediate future.

## **Conclusion**

The stigmatisation of gender variant behaviour and the general ignorance of trans people means individuals who come out as trans face multiple, interconnected social challenges that impact on their mental health and well-being. Such challenges will be shaped by an individual's personal circumstances. The ability of respondents to cope with such pressures is greatly influenced by

the support they received from family and friends, as well as from health staff. However, due to a lack of awareness and appropriate training many health staff are inadequately prepared to meet the healthcare needs of trans people. This can result in prejudicial practices that not only humiliate service users but may prevent them from accessing appropriate services. Meanwhile, issues surrounding the updating of medical records were found to be of significant concern for respondents due to the potential for breaches in confidentiality. Northern Ireland's GIC was discussed favourably by the majority of service users who felt it had helped to improve their mental health and well-being as well as their quality of life. However, a number raised issues of concern regarding the location of the GIC and staffing issues, which were found to limit access to peer support and lead to lengthy waiting times between consultations respectively.

## 5. Views of Health Professionals

In interviews and focus groups with both private healthcare professionals, who have experience working with trans clients, and staff at Northern Ireland's GIC. Through their working experiences these healthcare professionals have gained an insight into the social factors impressing upon trans individuals, related mental health concerns and the manner in which health staff can work to overcome them. This chapter reinforces and expands upon many of the points raised by trans respondents, which were discussed in the previous chapter.

### Social factors impacting trans people's health and well-being

Respondents discussed how the social pressures impacting on trans people lead some to perceive themselves as *"abnormal."* People do not naturally perceive themselves to be 'abnormal' but are rather conditioned to do so through their social interactions with others. Experiencing transphobic incidents, being called by the wrong pronoun and/or name will lead some to feel that they are 'abnormal'. A specialist counsellor discussed how such feelings could affect trans people's sense of worth, stating how it *"affects their [trans people's] confidence, their self-worth, their self-esteem, [and] their ability to maintain a relationship."* This counsellor felt that over-time such feelings could manifest as *"internalised transphobia"* and lead some people to develop a sense of self-loathing of oneself as trans. Another counsellor, who has worked with trans clients for a number of years, felt such negative self-perceptions stemmed from *"a lack of understanding from other people, family and friends particularly."* Experiencing rejection from family, friends, and society in general, will affect each individual differently. However, this counsellor highlighted how this lack of understanding had the potential to permeate into different facets of an individual's life:

*"I think it's trying to be accepted is the big issue and then that filters through into all types of other things like risky sexual behaviour, alcohol and drug misuse and a lot of isolation."*

Risky sexual behaviour and substance misuse are areas of concern that require greater analytical attention than this report is able to provide as it was not a topic discussed in-depth by respondents. However, social isolation was an issue consistently raised by interviewees as a

factor impacting trans people's mental health and well-being. A psychotherapist based in the Belfast area, with over thirty years of professional experience, discussed how social isolation could impact an individual:

*"Isolation has a really major effect on mental health. People start developing symptoms and they end up losing touch with family and friends and that increases the problem."*

For individuals with low levels of self-esteem and confidence becoming socially isolated and losing their intimate support network of friends and family will reduce their capacity to deal with mental health problems. Staff at the GIC described social isolation as a *"nightmare scenario"* that increases the vulnerability of the individual and is *"incredibly detrimental to their mental health."* Staff at the GIC stated that *"depression"* was the most common mental health concern that they encountered among service users. They explained that the reasons that people become depressed are diverse and dependent on the individual's social context and psychological history. Staff at the GIC noted how the prevalence of depression among trans people makes them a *"high risk group"* of suicide.

Social isolation is a major hurdle for trans people to overcome, as the lack of understanding and acceptance of the trans community reduces the number of safe socialising spaces. The growth of the internet<sup>11</sup> and the proliferation of trans-specific community forums have helped in recent years to reduce social isolation within the trans community to a certain degree. As this specialist counsellor explains:

*"One to one contact, yes, there would be isolation. But the internet is a life saver. I don't know how it would have been years ago without the internet."*

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<sup>11</sup> For a discussion surrounding the benefits the internet has brought to the trans community see Whittle (1998).

The social networking capabilities of the internet have, in a sense, created new socialising opportunities for trans people. Online forums enable people to discuss their experiences, get and give advice and make friends without the risk of going out in public and facing harassment; as a result, the internet presents opportunities for people to replace, to an extent, the support network that they may have lost. Meanwhile, the internet is also of vital importance as it has made a wealth of information accessible to individuals that are exploring their gender identity.<sup>12</sup> The availability of accurate information about gender identity issues on the internet was viewed by staff at the GIC as an integral factor in the growing number of individuals accessing the service.<sup>13</sup> Despite the benefits of the internet staff at the GIC noted *“there has to be an element of caution exercised when there are isolated and vulnerable people accessing the internet, not just trans that’s a general rule”*.

## Healthcare issues for trans people

Interviewees discussed the tendency for some health staff to behave inappropriately and even prejudicially towards trans people. A member of staff at the GIC discussed this clearly:

*“It does happen in the health service as well, where someone who’s clearly [presenting] in a particular gender [and] because a particular clinician decides that this is a lot of nonsense and because the original name is such and such, they’re called Mr So and So [even though] they’re obviously dressed as a woman and they [trans people] are humiliated by [such] incidents.”*

One counsellor discussed how such experiences not only act to *“humiliate”* the person, potentially reinforcing feelings of ‘abnormality’ and impact their *“confidence”* and *“self-esteem”*, but may also shape their healthcare seeking behaviour: *“[trans people] are reluctant to access healthcare services for that fear...[of] not being accepted.”* Discussing the point further, the counsellor highlighted a possible cause for the apparent lack of acceptance of trans people within sections of the medical community:

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<sup>12</sup> See Appendix 3 for a list of useful websites.

<sup>13</sup> For a discussion on the increasing number of individuals presenting at GICs see Reed et al. (2009).

*“Within the medical profession...it [trans issues] is considered quite a freak type issue...trans is still considered a serious mental health problem.”*

The perception of trans people as seriously mentally ill is contrary to contemporary perspectives of the aetiology of GIDs.<sup>14</sup> Nevertheless, the belief that trans people have a serious mental health problem continues to shape some medical professionals’ view of trans individuals. People with mental illnesses are often unjustly stigmatised and the inaccurate perception of trans people as mentally ill may cause some health staff to act prejudicially towards them. The counsellor, quoted above, continued by stating how such a view may lead some health staff to view the healthcare needs of trans people as beyond their therapeutic remit and refuse support:

*“I can only speak in the counselling/psychotherapy aspect of it, but if a trans person is accessing somebody’s service, [they say] “no they need to see a psychiatrist.”*

It is not only the perception of trans people as mentally ill that can shape medical professionals’ attitudes towards trans service users but also their own personal beliefs. Asked to discuss what factors may influence health staff’s views of trans people one counsellor responded:

*“Definitely religion, [for some] it’s a moral behaviour. It’s just about sex and it’s about something perverted.”*

Religious faith is an important aspect of many people’s life and often structures an individual’s moral standpoint. Strong religious convictions, combined with a lack of awareness of gender identity issues, may lead some health staff to hold gross misconceptions about trans people. Allowing such moral perspectives to pervade into one’s therapeutic practice and affect one’s duty of care is highly unprofessional and could lead to prejudicial behaviour. Another counsellor reaffirmed this point stating how some medical professionals *“are not able to separate themselves from their profession.”* A psychotherapist explained how this problematic situation is

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<sup>14</sup> For information regarding the aetiology of gender variant behaviour see GIRES (2008b).

not necessarily the fault of the individual but connected to larger systematic failings in the education of health staff:

*“[In Northern Ireland] you have quite a high number of people with an overtly Christian background...[and] none of the training I have been involved in or seen...[has covered issues of] gender.”*

The lack of gender identity issues on professional training qualifications was confirmed by a number of respondents. One therapist stated that *“very few professional therapy training includes anything about sexual orientation, let alone gender identity.”* This structural deficiency was seen as a major contributing factor in the prevalence of misconceptions of gender identity issues among health staff and the existence of bad working practices in healthcare settings.<sup>15</sup> One counsellor discussed how a lack of training could lead some to conflate the trans community with the lesbian, gay and bisexual (LGB) community:

*“it is my experience that gender identity issues and trans issues are very much confused with sexual orientation.”* For such reasons this counsellor felt that: *“there always needs to be specific training on trans issues, my experience has been that if you include it with the LGB it will get lost.”*

All of the health professionals interviewed in the current research had gained awareness of gender identity issues through a combination of undertaking specialist training courses, personal research and professional experience. Respondents felt that without appropriate training<sup>16</sup> health staff are unlikely to develop an awareness of gender identity issues or knowledge of the appropriate way to interact with trans people. Training is thus seen to present health staff with the opportunity to explore and overcome misconceptions and prejudices that they may foster

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<sup>15</sup> For a discussion on the relationship between training and bad working practices in healthcare settings see Davis (2007).

<sup>16</sup> For a discussion on the relationship between misconceptions and prejudice among service providers and a lack of appropriate education and awareness training of trans issues (see McBride and Hansson 2010).

about trans people, as one therapist stated: “[health staff] should be challenged in terms of their own phobic responses.” In light of these points, a counsellor discussed the importance of awareness training:

*“There is definitely a need for awareness training, even if it is just the difference between a transvestite and transsexual. Although they belong in the same category they are very different...There are overlaps...and contradictions...and then you’ve got androgynous and intersex...There is very little known about it. In terms of doctors they do need basic awareness training. They need to know the differences...[and] where to signpost them [trans people] to.”*

Health professionals felt that basic awareness training in gender identity issues and in good working practices, including correct pronoun use and the respect for confidentiality, would help to improve healthcare provision for trans people. Meanwhile, it was felt that if GPs and other health staff had an awareness of the appropriate channels of care they would not act, intentionally or not, to impede trans people from accessing the care they require. Realising the importance of trans awareness training for health staff Northern Ireland’s GIC team began to “work with the [Queen’s University Belfast] medical school... [by holding] seminars on transgenderism and...[enabling students to] meet during the seminars with transgendered individuals.” The seminars are two hours in length and are held two or three times a year with medical students in their final year and who intending to specialise in psychiatry. They are structured to give medical students an overview of the biological basis of gender development and the common psychiatric problems associated with gender. Medical students are then informed about the work of the GIC and introduced to a client of the clinic. The involvement of service users in the training of health professionals was viewed as essential, with engagement being seen as a primary mechanism to confront misconceptions. This point was reinforced by a service user of the GIC, who has taken part in the seminars, who stated:

*“You can give people all...the books to read but until they actually sit down and meet somebody and get the chance to sit down and talk with them and see that I am pretty normal like everybody else.”*

Engagement and interaction, not simply book-based training, is of vital importance because of its ability to provide a forum in which attitudes can be changed. Interaction with a trans individual during awareness training provides health staff with an interpersonal experience that humanises gender identity issues. The large majority of both new and established health professionals will never have received such an opportunity and will therefore lack basic awareness of gender identity issues. This is unfortunate because of health professionals' unique position to have a positive effect on the lives of trans people. One counsellor discussed how healthcare staff can support trans people *"by increasing their confidence and their self-esteem."* Another counsellor added that healthcare staff could do this through *"very basic"* means, including taking the time to: *"ask them what does it feel like? How do they feel about themselves? What is it like for them going through this kind of a process?"* By treating trans people 'normally' and by talking and listening to the individual about their feelings and state of mind health staff can act to reduce trans people's feelings of alienation and isolation. This 'normal' interaction will in turn help to increase their confidence levels and self-esteem by creating a sense of acceptance that may be lacking in other areas of their life.

## Issues in gender identity healthcare provision

The primary role of the GIC is to provide therapeutic support to adults that have been referred to the service because of gender identity issues. Before gaining access to the GIC's services the individual is sent a questionnaire to complete. GIC staff explained that the time between this preliminary assessment and the individual coming to the clinic to undergo an intensive mental health assessment is usually between four to six weeks. Staff highlighted the importance of *"fast-tracking"* service users:

*"the clinical reason for taking them on straight away is because we know it [GID] is a condition with a high rate of suicide if it is not treated properly. When they are taken on and treated that doesn't happen...if you have a high risk group you don't want them sitting on a waiting list for five or six months."*

Staff linked the high risk of suicide among service users to the mental health problems that many service users present with when referred. All members of staff at the GIC are fully accredited psychotherapists and this enables them to *"manage a lot of disturbance and mental health*

*distress within the team.*” After an initial period of psychotherapeutic support and continued assessment service users may be offered hormone therapy. Staff noted how hormone therapy is largely managed within the GIC and would only require the input of an endocrinologist if the individual was under the age of twenty-five. This age stipulation is due to biological developmental factors. After receiving hormone therapy and undergoing a RLE service users may also be eligible for surgical treatment. Surgery is commonly viewed as the apex of an individual’s transition, however, surgery may bring with it new challenges:

*“I think sometimes there is an idea that once they have had their surgery they will be fine...it’s a big psychological shift for them and they need as much support and sometimes more after surgery as they do before because...there are other options and real relationship opportunities.”*

Staff at the GIC recognise the importance of on-going support for service users: *“we don’t say we will see you a couple of times and then away you go.”* Another member of staff added: *“it all depends on the individual, we offer support for as long as the patient wants to come after surgery and in most cases they do want to maintain contact with the clinic.”* On-going support is important to help service users with the psychological implications of undergoing surgery and to deal with any mental health concerns that may develop. This on-going support is not offered by all GICs in the UK and is an example of the comprehensive level of support that Northern Ireland’s GIC provides to service users.

The GIC also attempt to attend to some of the social issues that impact service users’ health and well-being. One therapist discussed the importance of attending to the social needs of trans people, suggesting that familial issues should form an integral element of trans people’s healthcare:

*“Catering for children and parents, or partners, that’s a really big thing. If your husband comes home and tells you “oh by the way I am not really a man I’m a woman,” what that woman goes through is absolutely huge.”*

Discussing this point further the therapist stated:

*“A person can have their gender identity really hidden from their partner so some of the reasons why people access our [counselling] services could be because: “I need to tell my partner that this is who I am and how is this going to affect our relationship?”*

An individual's decision to undergo gender transition will not only have dramatic physical, psychological and social effects on an individual but it will also impact the lives of family members. It is for this reason that the GIC attempt to integrate the needs of service users' families and have initiated a support group for relatives. This, along with the establishment of the Oyster Group, signals the GIC's attempts to support individuals undergoing transition not just psychologically but also socially. Staff at the GIC felt these initiatives were important developments in service provision, which worked to reduce social isolation among service users while also increasing the mechanisms of support available to service users and their relations. An important element in the success of the peer support group was the involvement of an external facilitator who has helped to maintain a distinction between the activities of the group and the GIC's clinical practice:

*“We felt that they [service users] needed something for themselves that's why we felt it was very important to get an outside facilitator because we also didn't want to damage the clinical relationship that we have...you can't have your foot in both camps...It is very much their group.”*

Integrating service users wider interpersonal circumstances into their transition pathway was viewed by staff as vital in ensuring that the individual was mentally and socially prepared for their transition. This means each individual's progress during their transition is at a speed that is right for them. However, staff recognised that some clients may view this cautious approach as 'delaying' their progress and may lead some to become unhappy at times. In order to allay fears of such a nature and to attend to other issues service users have regarding service provision a focus group has been established. This focus group is held roughly every four months. Representatives of the Oyster Group and staff meet in order to discuss common issues of

concern. This venture was felt to be beneficial by staff as it has facilitated greater dialogue between them and service users:

*"I think the group has found the focus group really useful, it's how we meet up and talk to the group...We have a very good dialogue from them to us and us to them, in a very organised way."*

Staff at the GIC said that individuals who cross-dress but do not seek to live full-time in a gender identity opposite to their birth gender are unlikely to be referred to their services. One counsellor discussed how he felt that currently there was an imbalance in the services available to the trans community:

*"I think a lot of the services that exist are geared towards people under-going gender reassignment surgery. For those that don't quite fall into that sort of aspect of being trans then provisions are fairly limited. I know of a [private] service...that covers the whole [trans] umbrella."*

Trans individuals who cross-dress and/or have a fluid gender identity yet do not seek to undergo permanent gender transition are therefore likely to access services that do not specialise in gender identity issues.<sup>17</sup> This may lead such individuals to encounter ineffective and/or inappropriate health services that are not attuned to the specificity of their needs.

Another area that respondents felt required greater attention in gender identity services was that of sexual health. One counsellor felt that there was currently a low level of awareness of sexual health issues among trans individuals and that it required greater focus in healthcare provision. This included a need to educate trans individuals about issues pertaining to sexual health and encouraging them to utilise sexual healthcare provision:

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<sup>17</sup> In Northern Ireland there is a dedicated private counselling service for trans people, Gender Essence, which is based in Belfast. This service offers counselling services to trans people and their families.

*“I think sexual health is a very important thing and for some reason it seems...that trans people are not accessing sexual health services...There is a lot of exploitation of trans people I find in terms of things like prostitution...There is a lot of issues around...sexual health generally...[however] it’s given little consideration in many ways.”*

Generally staff at the GIC felt that they provided an effective and patient-focused service. However, staff felt that an obstacle to improving the service further was the pressures placed on them by funding and limited numbers of staff. They noted that the clinic has seen *“an enormous increase in referrals... [because] people are more willing to come forward and its less stigmatised.”* The significant increase in referrals that the GIC has received,<sup>18</sup> however, has not been reflected in a similar increase in funding. To date the GIC has managed to meet the demands of this increase in workload without the standard of support they provide being affected. Furthermore, they have established non-statutory peer support groups for service users and family members without any additional cost. Staff felt that if the increase in referrals was to continue without an increase in available resources the service the GIC is able to provide could be affected:

*“for the first time today we saw a patient and it was difficult to see who was going to take on them on immediately because we are just saturated. We had more staff when I started than we have now despite the huge increase in growth patterns.”*

## **Conclusion**

The stigmatisation of trans people lead many to feel ‘abnormal’ and have a low sense of self-worth. Healthcare professionals can support trans people overcome these issues through a sympathetic and compassionate approach. However, a lack of training has led few healthcare staff to have an adequate awareness of gender identity issues preventing them from having the knowledge of how to meet the needs of trans service users. Basic awareness training and some degree of engagement with trans people will empower health staff to overcome latent

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<sup>18</sup> For information regarding the increase in the number of people presenting with gender dysphoria in the UK see Reed et al. (2009).

prejudices and ensure they uphold trans people's rights. Although staff at the GIC have been innovative with the resources at their disposal and introduced a number of beneficial new services for their clients, they are currently reaching a point of saturation. The significant increase in referrals they have received over the past few years has not been matched by a similar increase in resources. This raises questions as to whether the GIC will be able to continue to provide the high standard of service in the coming years.

## 6. Gender Variant Children and Trans Youth

Northern Ireland's GIC is an adult only service. Consequently, this report has focused on healthcare provision for trans people over the age of eighteen. However, during the course of the research a number of issues arose around healthcare provision for gender variant children and trans youth. This brief chapter highlights some of the emerging issues regarding the healthcare provision for trans people under the age of eighteen in order to encourage greater focus in both research and policy of this neglected area.

### Gender variant children

The majority of trans people experience gender variance from as young as two years old.<sup>19</sup> Claire stated: *"most [trans] people I know have been living with it [gender dysphoria] since they were very young the issue is coming out with it and saying this who I am."* Although uncommon, some children express profound long-standing gender variant behaviour that leads their parents to seek medical advice. Such behaviour is a natural, albeit infrequent, variation in child development. Gender variant children often have associated feelings of emotional distress due to the social stigma attached to their behaviour, which places them at risk of alienation from peers and transphobic bullying at school.<sup>20</sup> Meanwhile parents, and other family members, may have difficulties in coming to terms with their child's gender identity and, if a transition occurs, some may experience a sense of grief. It is therefore important that there is sensitive and informed support mechanisms in place to help the child, and their family, to understand the options available to them and to prevent any potential difficulties that may arise.

The parents of Alex discussed their experiences of the healthcare provision that they had received. Alex was determined to be a girl at birth yet displayed *"tomboyish"* behaviour from a young age. As Alex grew older his masculine behaviour became more profound and by the age of nine his gender identity was becoming a source of distress for him. Issues such as his name, his clothing and the use of public toilets were problematic issues for Alex who wanted to live

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<sup>19</sup> For more information about gender variant children see DoH (2007).

<sup>20</sup> For more information on transphobic bullying in schools see GIRES (2008a).

permanently as a boy but was expected to behave and dress like a girl. Alex became increasingly “quiet” and “shy.” His parents noticed that he was becoming unhappy, especially in social settings such as school, and felt that this change in behaviour was due to the social pressures inhibiting him from expressing his gender identity. Supportive of their child’s wishes they sought medical advice.

Alex and his parents visited a GP who diagnosed Alex as being gender dysphoric. Following this the GP referred Alex to his local Child and Adolescent Mental Health Service (CAMHS)<sup>21</sup> in order for him to be referred to the UK’s only gender identity service for children and young people under the age of eighteen, which is based in the Tavistock and Portman NHS Foundation Trust, London. This specialist service has a multi-disciplinary team of psychiatrists, psychologists, social workers, psychotherapists and paediatricians, who assess, monitor and support gender variant children and their families. The service accepts referrals from across the UK, commonly through regional CAMHSs. However, Alex’s parents reported experiencing a complete “lack of understanding” from CAMHS, as well as from the Education and Library Board (ELB) and the social workers assigned to the case. This combined lack of understand resulted in criminal proceedings in which the parents were accused of child abuse and taken to court. The parents were dismayed at this response and described the experience of being taken to court by organisations they had turned to for help as “hard,” “upsetting” and “terrifying.” Even more distressing for the parents was the feeling that this legal process had silenced Alex’s voice and his right to self-determination. Furthermore, the added stress of the court case put unwarranted stress and strain on everyone in the family. The parents, however, described with relief how they received a supportive response from the judge who helped to ensure that Alex received the specialist support that he required. Nevertheless, it took almost one year from Alex’s initial contact with his GP to his first appointment at the specialist child gender identity service in London. This is unacceptable considering adults who are referred to the Northern Ireland’s GIC are commonly seen within four to six weeks.

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<sup>21</sup> Unfortunately, no interviews were held with staff members of CAMHS due to constraints of time.

Since accessing the specialist service Alex has been able to express himself more freely and has become happier. As well as visiting the specialist child service in London Alex is also receiving one-to-one counselling sessions with CAMHS. Although the family's situation has greatly improved the parents still feel that there is "fear" and "paranoia" surrounding gender variant children among statutory agencies. This organisational anxiety they felt leads agencies to act with self-concerned caution rather than carrying out their statutory duty of care for the child involved. Their case highlights major concerns about healthcare provision for gender variant children in Northern Ireland. It suggests that there is limited awareness of the healthcare needs of gender variant children in relevant agencies, including CAMHS, social services and the ELB, that may act to impede access to appropriate support and care. Any delay in therapeutic support is likely to have a detrimental impact on the health and well-being of the child and their family. Alex's parent hoped that their experiences would mean no other family goes through the traumatic experiences that they have had to endure as Helen, Alex's mother, said: *"the ignorance, uneducated and prejudice views that we have encountered are appalling."*

## Trans youth

Increasingly young people are coming out as trans in their adolescent years. This is in part due to the greater availability of information through the media and the internet. The current research, however, was unable to gather the views of any trans youth. Nevertheless, a number of key issues that affect trans youth arose in interviews conducted with adults who discussed their experiences during adolescence. Adolescence was described as a particularly difficult period for trans people who often experience intense anguish as their body develops during puberty. If the person comes out at this stage in their life they must also cope with the social pressures of school and the risk of transphobic bullying. Furthermore, parents, family and/or friends may refuse to accept their gender identity.<sup>22</sup> This potential combination of events places trans youth at a high risk from familial alienation and social isolation that could reduce their ability to cope with mental health problems and may also place them in economic hardship. If the young person, or their family, seeks medical assistance they are likely to be referred to their local CAMHS service for support.

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<sup>22</sup> For more information regarding experiences of familial breakdown, becoming excluded from family events and domestic abuse see Brown and Lim (2008); Scottish Transgender Alliance (2008); and, Whittle et al. (2007).

Staff at the GIC felt that CAMHS currently praised the services offered by CAMHS, with one member of staff stating: *“they have addressed the problem so actively...they are also very well prepared.”* In recent years the GIC has developed a collaborative system with CAMHS that has been designed to make the young people’s transition from youth services to adult services smoother. Through this collaboration trans youth who are about to turn eighteen begin to have joined sessions with GIC and CAMHS staff. Such sessions are intended to give the person a chance to become familiar with adult services and how they differ from youth services. Combining the experiences of staff from CAMHS and the GIC means that service users *“get a very integrated service.”* This collaboration was viewed as a success by staff at the GIC who explained that in the past three years fourteen young people have ‘graduated’ from CAMHS into the GIC, with a further three more expected to do the same in the near future. This collaborative work has thus added to the workload of staff at the GIC, which has produced an *“influx”* of young clients with no additional resources. Consequently, GIC staff felt that it would be beneficial for Northern Ireland to have a dedicated CAMHS consultant for trans youth, however, they realised that this may not be viable because of the relatively small number of individuals that would utilise the service. Nevertheless, increased funding would enable the GIC and CAMHS to better support the increasing number of individuals presenting with GID in their adolescence.

## **Conclusion**

The brief insights presented in this chapter highlight some emerging healthcare issues for trans people under the age of eighteen. The experiences of one family, which were characterised by a complete lack of empathy, showed there to be limited awareness among certain service providers of the needs of gender variant children. Meanwhile, staff at the GIC report that positive work is being undertaken to ensure that trans youth are given robust and joined-up therapeutic support. This suggests that Northern Ireland is currently lacking an overarching standard of treatment for trans people under the age of eighteen; or, if such a framework exists it is not being utilised in a consistent manner across the country. The DHSSPS must therefore work to put in place an acceptable standard of care for trans people under the age of eighteen and ensure it is consistently applied throughout Northern Ireland.

## Conclusion

This report has sought to analyse healthcare issues for adult trans people living in Northern Ireland. It has highlighted the social factors impacting trans people's sense of well-being as well as their experiences of healthcare service provision. Although not comprehensive in its scope, this report has illuminated important issues in regards to healthcare equality and the overarching standards of treatment provided to people undergoing permanent gender transition.

The experiences presented in this report confirm that there are urgent healthcare equality issues for trans people in Northern Ireland that must be addressed by the DHSSPS. The evidence shows that there is a lack of awareness of gender identity issues and trans people in general among health staff, which has led staff not only to use inappropriate pronouns and names but also attempt to place trans people on gender inappropriate hospital wards. More worryingly this lack of awareness has led some GPs to give grossly inaccurate, and insensitive, advice to trans service users and, in some cases, led to a denial of appropriate and adequate care. Another key equality issue highlighted in this report, but yet to be acknowledged by the DHSSPS, regards the management of medical records of people undergoing gender transition. This report found that trans service users have extremely varied experiences when trying to change their medical records to reflect their gender transition. This suggests that there is a lack of coherent guidelines for staff to follow in relation to the alteration and updating of medical records for individuals undergoing permanent gender transition. This is an urgent issue that must be attended to by the DHSSPS as inaccurate medical records were found to place service users in situations that compromised their confidentiality and caused them extreme embarrassment.

This report advocates that a potential solution to overcome these issues of inequality is for health staff to receive gender identity equality and diversity training. Trans awareness training should be part of a robust staff development structure. It should focus on the diversity of the trans community as well as the differences between gender identity issues and sexual orientation. Any training should involve the participation of representatives from the trans community and be aimed at challenging misconceptions and preventing prejudicial behaviour. Ideally equality training should be supported through practical leaflet guidance for doctors, nurses and other healthcare staff on relevant good practice, how and where to refer trans

service users to and how to uphold trans people's rights. Furthermore, this report advocates the need for the incorporation of gender identity issues into professional medical syllabuses.

The evidence presented in this report has implications for the DHSSPS's overarching standard of providing treatment and on-going care to people undergoing permanent gender transition. It has found that Northern Ireland's GIC offers adult service users psychotherapeutic support, hormone therapy and surgery. Access to endocrinology services were found to be predominately limited to individuals under the age of twenty-five. Meanwhile, the GIC has helped to establish strong non-statutory peer support and mentoring services, which are helping to reduce isolation. Furthermore, the GIC provides on-going treatment and care that is helping service users to improve their self-image and their mental health and well-being. These interventions, on the whole, were found to be timely (although there was a disjuncture between service users' and service providers' conception of 'timely'), person-centred and designed in relation to the perspective of service users and their relations. However, it is questionable whether it is reasonable to expect the GIC to reduce service users' risk of harassment and protect their personal safety given the unpredictable nature of transphobic harassment.

Although the GIC currently appears to be meeting the DHSSPS's overarching standard of treatment and on-going support for people undergoing permanent gender transition, its long-term ability to do so is being strained due to financial constraints and staffing limitations. Increase funding could help establish beneficial initiatives such as weekly drop-in sessions, regional sessional clinics and regional peer-support groups. Finally, this report did not find evidence that a consistent overarching standard of treatment exists for gender variant children and trans youth. There is therefore an urgent need to put such a framework in place to ensure trans people from across Northern Ireland, regardless of age, have access to appropriate and adequate healthcare service provision.

## Recommendations

1. An equality and diversity training module, which focuses on gender identity issues, should be offered to existing members of health staff on a priority basis. This training should include the participation of trans people and be complimented through the production of a leaflet for health staff, which focuses on: relevant good practice, how and where to refer trans service users to and how to uphold trans people's rights.
2. Basic awareness training in gender identity issues should be made a mandatory requirement of the most common professional qualifications, including medicine, nursing and counselling.
3. A patient satisfaction survey should be conducted of clients of Northern Ireland's GIC in order to see the manner in which such services can be improved.
4. Increased funding should be provided to the GIC in line with the increasing number of referrals to the service.
5. Increased funding should be provided to non-statutory trans peer-support groups.
6. The GIC should hold regular drop-in sessions that do not require an appointment to attend.
7. The GIC should offer a periodic sessional clinic outside of the Greater Belfast area.
8. The DHSSPS should develop a comprehensive service framework for gender variant children and trans youth. This should be developed in collaboration with representatives of the trans community and gender identity specialists.
9. The DHSSPS should develop guidelines for updating the medical records of individuals undergoing permanent gender transition.
10. The DHSSPS should create a trans-specific equality and human rights policy.
11. Further research should be conducted into the healthcare needs of trans individuals living in Northern Ireland to address issues raised in this report that could not be fully explored, including: issues relating to the needs of gender variant children, trans youth and older trans people, as well as issues of sexual health and substance misuse.

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## Appendix 1 – Acronyms

AIS	–	Androgen Insensitivity Syndrome
CAMHS	–	Children and Adolescent Mental Health Services
DoH	–	Department of Health
DHSSPS	–	Department of Health, Social Services and Public Safety
GIC	–	Gender Identity Clinic
GID	–	Gender Identity Disorder
GLYNI	–	Gay Lesbian Youth Northern Ireland
GP	–	General Practitioner
GRA	–	Gender Recognition Act
GRC	–	Gender Recognition Certificate
LGB	–	Lesbian, Gay and Bisexual
LGBT	–	Lesbian, Gay, Bisexual and Transgender
NHS	–	National Health Service
RCP	–	Royal College of Psychiatrists
RLE	–	Real Life Experience
TV	–	Transvestite
VSD	–	Variations of Sex Development
WHO	–	World Health Organisation

## Appendix 2 – Glossary of terms

- Acquired gender – The legal gender conferred upon an individual upon receiving a gender recognition certificate.
- Alternative gender – Adoption of a gender identity, through clothing and mannerisms, other to the one typically associated with the sex assigned at birth.
- Androgynous – Gender identity that conflates male and female characteristics.
- Biological sex – The sex assigned at birth owing to specific biological characteristics regardless of an individual’s gender identity.
- Coming out – To announce oneself to be trans.
- Cross dresser – An individual who assumes a gender identity that is different from the one typically associated with their birth gender intermittently.
- Intersex – An individual born with either a) both male and female sexual characteristics and organs; or b) unambiguous sexual characteristics.
- Gender confirmation treatment – The medical treatment pathway for individuals seeking to ‘change’ gender, which may include a combination of psychotherapeutic support, hormone therapy and/or surgery.
- Gender identity – An individual’s innate feeling of being male or female, or of being neither or both.
- Gender variant behaviour – Behaviour that is culturally not typically associated with an individual’s phenotype.
- Out – To be publically known, to varying degrees, as trans.
- Outed – To be socially revealed to be trans unwittingly or unwontedly.
- Pass/Passing – To be socially accepted in the gender in which one is presenting.
- Presenting – Public ‘presentation’ of a gender identity, typically refers to an individual dressing and behaviour in a gender identity other than the one associated with the sex assigned at birth.
- Real life experience – The stage in an individual’s transition when they begin living full-time in a gender role other than the one typically associated with sex assigned at birth.
- Sex – See biological sex.

- Trans – A commonly used shorthand for transgender.
- Trans man – An individual assigned at birth female but whose gender identity is male.
- Trans identities – The totality of identities possible within the spectrum of transgender.
- Trans woman – An individual assigned at birth male but whose gender identity is female.
- Transgender – A collective term used to describe individuals who present either intermittently or permanently in a gender role opposite to the sex assigned to them at birth.
- Transition – The social, psychological and physical process of ‘changing’ gender.
- Transsexual – An individual who seeks gender confirmation treatment and to live permanently in the gender role opposite to the sex assigned to them at birth.

## Appendix 3 – Useful websites

- a:gender – a:gender is the support network for staff in government departments / agencies who have changed or need to change permanently their perceived gender, or who identify as intersex.  
(<http://www.agender.org.uk/>)
- Belfast Butterfly Club – The Belfast Butterfly Club acts as a support network for transgendered people and their families by providing education and information.  
(<http://www.belfastbutterflyclub.co.uk/>)
- Gender Essence – Gender essence is a specialist professional counseling organization based in Belfast that aims to provide emotional and therapeutic support to members of the transgender community, including include friends, family members and children.  
(<http://www.genderessence.co.uk/>)
- Gender Identity Research Education Society – GIRES is a research based charity that has developed good practice guidelines, education programmes and literature, all of which are available on their website.  
(<http://www.gires.org.uk/>)
- NHS Transgender Health – Section of the NHS website aimed at providing useful information for trans individuals and their families.  
(<http://www.nhs.uk/Livewell/Transhealth/Pages/Transhealthhome.aspx>)
- Pink Therapy – The UK's largest independent therapy organisation working with gender and sexual minority clients.  
(<http://www.pinktherapy.com/>)
- Press for Change – UK based political lobbying and educational organisation. That provide legal advice, training and consultancy for employers and organisations.  
(<http://www.pfc.org.uk/>)
- Scottish Transgender Alliance – The Scottish Transgender Alliance website offers guidance to service providers and employers on transgender equality issues and good practice. It also provides information to support transgender people in understanding and accessing their human rights.  
(<http://www.scottishtrans.org/>)
- Gender Identity Development Unit at the Tavistock and Portman NHS Foundation Trust – Service for children and young people (up to the age of 18) and their families who are experiencing difficulties in the development of their gender identity. This includes children who are unhappy  
(<http://www.tavistockandportman.nhs.uk/>)

childrenyoungpeoplegenderidentityissues)

with their biological sex.

The Beaumont Society  
(<http://www.beaumontsociety.org.uk>)

- The Beaumont Society is a London based association for trans people. It aims to provide a means of help and communication between members, in order to reduce emotional stress, eliminate the guilt and so aid better understanding of them by their families and friends.