FAMILY MATTERS (2005)

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Families and Transsexualism – a better understanding

Abstract

This article examines the experiences of families in which a family member has transitioned, or is in the process of transitioning, to live according to the opposite gender role to that assigned at birth. Evidence is gleaned from those taking part in one of the 11 workshops (run in various geographical locations around the UK by GIRES[i], assisted by Mermaids[ii] and Depend[iii]. Evaluation forms (see example at Appendix A.) were routinely provided for all participants (n=180) of whom 111(62%) completed them. Permission has been given for the responses to be used anonymously. Later follow-up is limited as some people will have moved on psychologically and/or geographically. Others have become kept in touch informally with one or more of the three groups involved. In addition to the comments on the forms, many of the insights, are personal and anecdotal, emanating from the team members who have all had many years of experience working in, and for, the trans community. These insights cannot necessarily be quantified, but neither can they be ignored:

"Not everything that can be counted counts, and not everything that counts can be counted" (Albert Einstein).

Transsexualism within a family inevitably puts huge strains on relationships, creating a high risk of rejection of the trans person, just when support is most needed. Poor support from the family is a recognised prognostic factor for a trans person's experience of regret, following gender confirmation surgery (Landén, 1999)[1].

So, for many, acceptance within the family setting is an important ingredient in the successful rehabilitation of the individual in the new gender role. Engagement with the family should, therefore, should be considered as part of the care package offered to trans individuals, and undertaken with their consent. However, the workshops are specifically focussed on the needs of other family members, and are distinct from the clinical practices providing treatment for the trans individuals concerned. Further follow-up studies to assess the value of this approach to family support would be of benefit.

Support and education for families may help to mitigate the pain and loss associated with the transition process, and may often prevent deterioration of, or lead to significant improvements in, ongoing relationships. The first part of the article covers the kind of information which is welcomed by families: terminology, etiology, emotional responses, and elements of treatment and transition. The workshops provide a caring and confidential environment for the expression of the complex emotions experienced both by trans people and by their family members; this includes the disruption to sexual relationships in the case of partners and spouses.

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[i] Gender Identity Research and Education Society (GIRES); admin@gires.org.uk ; http://www.gires.org.uk
tel: 01372 -

[ii] MERMAIDS offers telephone and e-mail support to young people experiencing gender variance, and their families: mermaids@freeuk.com, helpline 07020 935066 (12 noon till 9 pm.).

[iii] DEPEND offers e-mail support for trans people and their partners/significant others:info@depend.org.uk

Families and Transsexualism – a better understanding

1.1. Atypical gender development may give rise to a (*core*) *gender identity*, which is incongruent with the *phenotype*. Individuals experiencing this rare condition having been raised, from birth, in the *gender role* which is consistent with their phenotype, suffer great discomfort with both phenotype and the associated gender role. This discomfort is usually described as gender dysphoria which, in its profound and persistent form, is called transsexualism. This is typically addressed by transitioning to live in the opposite gender role, supported by medical treatment to align the physical characteristics with the core gender identity. Most of the families attending in the workshops had a family member at an early stage of the transition journey.

1.2. Gender dysphoria has been estimated to occur in approximately 0.00818% [1 in 12,225] of the adult population[2]. However, these figures are likely to be a significant underestimate as the number of individuals presenting for treatment, both adults and children, is now growing rapidly[3]. Extrapolating from numbers presenting for surgery throughout the UK, estimated to be approximately 5,000 [4] leads to a prevalence estimate of approximately 10,000 adults at various stages of treatment[iv]. Moreover, the impact of this condition is considerably wider, since transsexual people do not exist in a vacuum; they have families: parents, partners, children, siblings; if they're lucky, they have a job and work colleagues; they have a social life, friends and neighbours. This elaborate interweaving of supportive emotional bonds which gives life its meaning, and the income which sustains it, is jeopardised by the public revelation of what has been, often for many years, an entirely private, even secret, pain.

1.3. Transsexualism is a complex condition. As outlined below, there are a variety of possible etiological pathways leading to the experience of gender dysphoria; these are likely to vary from individual to individual 5. The influences on outcomes are multifactorial, depending not only on individual circumstances, but on cultural norms and mores. In cultures where greater allowance is made for gender expression which is less distinctly bi-modal - male or female - the discomfort of those experiencing transsexualism seems considerably lessened. It is suggested by Connolly that the likelihood of associated psychological stress may thereby be reduced 6. Autobiographical accounts of adult trans individuals indicate an early awareness of discomfort that is often not articulated during childhood. Severely gender dysphoric young people frequently experience considerable pressure to comply with the gender role expectations of family and society. Thus treatment is often delayed for many years7, 8, 9, 10.

1.4. Traditionally, over the last thirty years or so, transsexualism has been regarded as a kind of mental illness. It appears in the International Classification of Diseases (1993)11 under the broad heading 'psychiatric

[iv] The Wilson study: of those experiencing gender dysphoria, one third were undergoing counselling, one third were on hormones (pre-genital surgery) and one third were post surgery. Therefore, the surgery figure for the UK should be multiplied by three to arrive at the overall prevalence figure or gender dysphoria. Other estimates of prevalence are even higher, e.g. 1:500 (Conway, 2002, see reference 3).

disorders' and also in the Diagnostic and Statistical Manual of Mental Disorders (2000)[12]. However, over the last few years many studies have indicated a different interpretation which puts greater emphasis on biological evidence emerging from a number of diverse, but inter-related research studies, seen in the light of the personal experiences and insights of trans people themselves [13], [14].

1.5. Transsexualism is now regarded, by many, as part of a wider picture of atypical sex differentiation of genitalia, gonads and brain, including inconsistencies both within each element of differentiation and between the different elements. Each atypical sex differentiation manifestation may be statistically extremely rare, but taken together, according to the studies of Blackless et al., [15] and Fausto-Sterling, published in 2000 [16] they affect about one birth in a hundred.

1.6. The evidence for an innate biological predisposition for transsexualism is supported by a number of studies which implicate genetic triggers and/or atypical hormonal input at the fetal stage [17]. For instance, according to transsexualism Hines [18] unusually high prenatal androgens may be associated with female to male whereas unusually low prenatal androgen levels, sometimes present in particular chromosome disorders, or due to medication of the pregnant mother, may be associated with male to female transsexualism [19], [20], [21], [22], [23]. Genetic links are also postulated on the evidence of various studies on twins and other instances of co-occurrences of gender dysphoria within families, as well as findings of unusual repeat-polymorphisms of certain genes in some transsexual individuals [24], [25], [26], [27]. There is no evidence that nurturing and socialisation in contradiction to the phenotype can cause transsexualism, nor that nurture which is entirely consistent with the phenotype can prevent it [28]. There is further clear evidence from the histories of conditions involving anomalies of genitalia, that gender identity may resolve independently of genital appearance, even when that appearance and the assigned identity are enhanced by medical and social interventions [29], [30], [31], [32],[33], [34], [35], [36], [37], [38], [39], [40].

1.7. In two statistically robust post-mortem studies of small cohorts of transsexual individuals, a small area of the brain, known to be sex-dimorphic, has been shown to have the potential for neural differentiation in opposition to genital and gonadal characteristics. Considered in the context of the other research, cited above, these brain studies support the paradigm that the neurobiology of the brain may be an important element in the development of transsexualism [41], [42].

<u>Family Support</u>

2.1. It is intuitively understood, not only from the experiences of trans individuals, but from the wider experience in the general population, that we all do better with support, and better still, if that support comes from our nearest and dearest. A Swedish study by Landén carried out in the 1990s, indicated that 3.8% of transsexual people regretted having undergone gender confirmation surgery (otherwise sex reassignment surgery) and, not surprisingly, one of the *"prognostic factors for regret*

was a poor support from the family" [43]. Yet despite this, it is only relatively recently that some of the gender identity clinics (GICs), responsible for treating transsexual people in the UK, have begun to acknowledge that family members may play a vital role in achieving the best possible outcomes of treatment. As the workshops revealed, many families have felt completely alienated from the treatment process. Yet Istar Lev (2004) [44], working in New York, says that her aim is *"to include ... families as much as is reasonably possible through all phases of treatment".* She adds that *"families should be regarded as connected, like a system".*

2.2. It may also be inferred from Landén's study that those whose transition is delayed are statistically more prone to regret. In some, the consolidation of adverse physical characteristics, through puberty and beyond, making it harder to 'pass' in the new social role, may contribute to a less favourable outcome. In addition, the frustration caused by delay aggravates the already emotionally painful and complicated situations for trans people; the longer the delay, the more complex the family situation is likely to become. So, the increased potential for rejection by family members, and the consequent experience of loss, may well be causal factors in the raised incidence of regret in that group. Partnerships and marriages may be well-established, children may be born, children of trans people may be experiencing their own adolescence and be dealing with all its destabilising effects; parents of trans folk become elderly and more likely to be unwell and unable to deal with shock; siblings may be in relationships or embarking on new ones, they may also have their own families to consider. Trans folk are often well aware of the disruption which their transition will occasion, and it is not unusual to hear them say that they have delayed transition until their children were grown up, or until after a family wedding, until parents had died, and some have waited until a partner or spouse has died, only finally undergoing transition in their late sixties, seventies, or even later 45.

2.3. Despite these efforts at damage limitation, the ripple effect usually impacts first, and most severely, on close family members. Owing to the rarity of the condition, the associated stigma and the desire for secrecy, these families tend to be widely dispersed and out of touch with each other. Several of those attending the workshops said it was their first opportunity to speak openly about their situation, and their pain. Many specifically rated their most important 'gain', as the opportunity to share their experiences and emotions with others in the same situation (n=80). Some family members travelled for many hours to attend a workshop because, locally, there was nobody to whom they could talk.

2.4. Clearly, once 'transition' to live in the opposite gender role has occurred, even the most enlightened families are likely to experience extreme stress which, not surprisingly, often leads to irreparable damage to relationships. The typical 'triadic' treatment as proposed in the Harry Benjamin Guidelines, sixth edition 46: hormones ==> real life experience (RLE, living full-time in the new gender role) ==> surgery can lead to excellent outcomes for the individuals concerned, but much depends on the fortitude of individuals and their particular social circumstances. There will almost always be loss, and occasionally there are regrets 47, 48.

Opposing needs and concerns

3.1. Ironically, the unselfish motives underlying delay in seeking treatment may backfire. One of the greatest impediments to sustaining good relationships, is the sense of urgency which follows this long abstinence from obtaining treatment. Once a trans person has finally reached the point where transition is imperative, he or she may become completely focussed on the need to achieve the change as quickly as possible; treatment, and the need to live and be accepted in accordance with the opposite gender is, at this time, the first and sometimes the overriding concern of the trans individual. It's 'do or die' - sometimes quite literally. Suicidal feelings prior to embarking on transition are common, but once the gender discomfort is medically addressed, these feelings usually subside [49, 50,51, 52, 53, 54, 55, 56].

3.2. Trans people are sometimes impatient with the resistance shown by families and others. They may feel that they have always been constrained by societal norms, they have lived according to everyone else's rules and requirements, suppressing their own needs. This is *their* time; they are finally going to be allowed to be themselves. Families, on the other hand, having lived, usually in total ignorance of the real situation, are shocked at what appears to them to be a sudden and disastrous decision, and they want the process of change to slow down, preferably to a complete standstill. From the family's perspective, the trans person may seem oblivious to the need for time for the family members to adjust to the changed situation; families often experience disorientation, anger and grief. Siblings and parents find it slightly easier to accommodate to the situation, than do partners and spouses, who may be bitter about what they see as a breach of trust and, for some, a betrayal of marriage vows. In these cases particularly, there may be a polarisation of positions. There may be mutual accusations of selfishness.

3.3. This keen sense of betrayal, of disintegration of the family unit, may reach a level of grief that transcends even the loss occasioned by the death of a partner. The latter situation evokes sympathy and support. Society follows rites and behaviours which are culturally recognised responses to death; it has a devastating, but understood, place in society, whereas partners of trans folk are often emotionally unsupported in their intense grief. There is no culturally recognised rite of passage for the partner of an individual who has transitioned. The focus of their grief, the trans partner, is still alive and is, often, keen to remain a part of this unusual family group. Yet rejection and alienation are common[57, 58, 59, 60] and, sometimes a cloak of secrecy descends, leading to prolonged isolation of partners as well as of trans people themselves. Partners attending the workshops often comment that this experience has broken the sense of isolation; as one partner put it "*I don't feel isolated and alone now".*

3.4. Fears about the outcome of the sexual relationship is the cause of much anguish. This is not misplaced, since serious disruption is likely. Outcomes will only emerge over time. For those that remain together, some will share a homosexual relationship, others find comfort in a close, loving but

asexual, bond[61]. Many trans people are often not entirely certain where their post-transition sexual orientation will take them, some retain their former sexual orientation after surgery, but others, having lived pre surgery as, for instance, heterosexual men, may subsequently be more comfortable living as heterosexual women[62].

3.5. Hormone treatment impacts on the sex lives of trans people and their partners: trans women's libido is lowered by anti-androgen and oestrogen treatments, whilst trans men's is heightened once testosterone treatment starts. Fears and uncertainties are aggravated by the unwelcome prospect of genital surgery which, confirms, irreversibly, the altered physical sex of the trans person. Surgical techniques are now more sophisticated and erotic sensation is usually preserved, but an obvious complication in this situation is that, for instance, the female partner of a trans woman may be distinctly uncomfortable, not only with the prospect of changed intimate sexual behaviour, but also with being publicly perceived as lesbian; it undermines her own sense of self. So, couples who do stay together in a same-sex relationship have to find a way through this personal and public minefield of uncertainties. It can be achieved however, where love, trust and loyalty outweigh other factors.

3.6. Where there are children, it may appear to the non-trans parent that the trans parent is abandoning the parental role. Occasionally, the transsexual condition is perceived as a perversion which puts children at risk. Other family members tend to be protective towards them, although the children themselves, especially the younger ones, are capable of adapting well, so long as they are not manipulated by adults hostile to the trans individual and/or the transition process [63, 64].

3.7. Some Clinics impose elements of the triadic therapy, especially RLE, in a rigid way[65] without taking account of individual circumstances, or accepting any responsibility for providing the extra support and flexibility that would be more likely to limit the collateral damage to relationships – in the family and in employment. Thus the so-called real life experience, far from anticipating a reasonable, if altered, way of life, may ensure that it becomes an isolating, and an expensive, business. Trans people frequently find themselves living in impoverished surroundings, isolated from friends and family and either out of work or struggling in their employment situation. Yet they are required to make a 'success' of RLE in order to continue to access treatment. Transsexual people may be torn between, on the one hand, the demands of the Clinic, in conjunction with their own impatience to make progress and, on the other hand, the need to appease distressed family members who form the core of the 'real world' in which their 'real life experience' has to take place. If timely intervention has the potential to ameliorate relationships between trans people and their families and prevent complete break-down, then common sense dictates that some responsibility be assumed, by those providing treatment, for the impact of that treatment on the families of the service-users.

Family Workshops

4.1. Evidence drawn from the experience of running workshops for families in the UK has led to the identification of the most commonly sought, and appreciated, approaches to providing help. It is essential that the facilitators of the workshops have, themselves, experienced the dilemmas and the pains that those attending workshops are living through. The team includes members drawn from three organisations working in the field; they include parents and partners of transsexual people, usually including a trans/non trans couple whose relationship has survived the transition process, and a trans woman and a trans man, who have been living in the 'new' gender for several years.

4.2. Ground rules for the workshops dictate mutual respect, and absolute confidentiality. It is essential that those attending be reassured that nothing emerging during the workshops will be shared with clinicians who are providing treatment, and who are often the 'gatekeepers' to further treatment. Transsexual people are encouraged to attend these workshops, but only if accompanied by partners or other family members. Over the course of 10 workshops run to date, the 180 individuals who have attended, included parents, partners and spouses, children, siblings, grandparents, cousins and, occasionally, friends and neighbours.

4.3. The aims of the workshops are to help families to support the trans person through the process of change, and to maintain and improve family relationships as far as possible, by:

a) assisting the family to come to terms with the new situation, encouraging both realism and optimism, regarding the future
b) helping both the trans individuals and their families to gain some insight into each other's points of view
d) encouraging families to explore and share their feelings with others in the same situation, and
e) providing appropriate information about: atypical gender development as a medical condition, the process of transition, the medical treatment, the wider consequences, and other support networks

4.4. The workshops are loosely structured. Team members introduce themselves so that family members are able to identify those who share their own experiences. Despite the tension in the room, it's important to establish a welcoming atmosphere. Comments from those attending the workshops showed that we were able to provide an *"informal, relaxed, open atmosphere, with friendly, helpful and sincere people".* All are given the opportunity to say a little about themselves if they so wish. Occasionally, family members are too distraught to speak at the outset. They must not be pressured, of course, but must be allowed to open up in their own time.

4.5. A brief, simple presentation (overheads or PowerPoint) follows, to impart some understanding of the underlying biology of the condition, as outlined in paragraphs 1.4 – 1.6. Originally, this was not part of the workshop, because we deemed it would too 'indigestible' in such an emotionally charged atmosphere, but early feedback forms indicated that such information would be appreciated. This was borne out by the comments

following its introduction to later workshops. In the more recent secondary (February 2006) follow-up, one mother wrote that the workshop information helped "*very, very much. Very easy to comprehend...*<u>*better*</u> (mother's underlining) *than the medical profession*".

4.6. One trans woman commented that it was "*very useful having an independent (referenced) medical explanation… for people to see that it's a genuine condition".* A spouse said "...*at last, some proper information!"* A parent commented that *"understanding and knowledge that upbringing was not at fault (had brought) relief from guilt".* Another said *"I found the Gender Dysphoria article very interesting and useful and I hope to use it to help others understand…"* Landén's conclusions [66] reinforce the view that '*those who believed that transsexualism is caused by psychological factors had a more restrictive view on transsexualism than people who held a biological view'*. It follows that families will share the 'less restrictive view' if they understand that there are likely to be biological factors involved in the development of gender dysphoria. Transsexualism is nobody's 'fault' – nobody is to blame – not parents, not partners, and certainly not trans people themselves. It is simply part of the natural variation in the human condition. Information of this kind seems to enable family members to move on from *why*, and start to concentrate on *how* they might address the more important issues of support and integration of the trans relative.

4.7. It has also been found to be beneficial to show a list of the hurdles, obstacles and treatments that trans people must go through, in order to achieve all aspects of medical, social and legal transition. Apart from being useful in raising subjects that may not have been discussed within family groups, this information regarding the monumental task undertaken by trans people in order to achieve all these ends, undermines any lingering perception that they may be merely indulging a whim. For trans parents, whose contact with their children has become problematic, literature is provided explaining the court procedures involved in obtaining Contact Orders and, also, sympathetically-written information sheets to assist parents in the difficult task of explaining their changing situation to their children [67].

4.8. It is also enormously helpful to show a list of the anticipated range of emotions that family members feel. Sometimes, it enlightens the trans individuals, and comforts other family members, just to see "denial, anger, grief, fear, embarrassment, guilt..." etc., in black and white, which gives them "permission" to admit to, and to discuss those emotions with each other. One family member commented "they explained things and articulated things one had perhaps shied away from. I liked the open, frank, acknowledging of one's emotions – not dodging issues".

4.9. These are all ideas that are carried over into the next stage of the workshop, arguably, the most valuable; the large group divides into three smaller groups: all transsexual people remain together, partners and spouses form a second group, and parents and siblings a third. A relevant team member facilitates each group. This separate space enables individuals to share their most intimate and pressing concerns and unhappiness, without fear of hurting the feelings of the trans relative, and

vice versa. In this supportive and non-threatening environment, many emotions are unleashed and given safe expression. Comments on the feedback forms demonstrated the value of *"knowing that you are not alone, being able to talk to others, companionship, willingness to share"*. Family members said that they drew strength from sharing their experiences with others, they *"gained comfort in the knowledge that others have the same problems"* and *"confidence, knowledge, insight, reassurance, comfort, encouragement – I liked all aspects of the workshop".* Expressing and coming to terms with their own emotional turmoil, enables families to provide a better level of support for trans people.

4.10. Families need to hear, and to be heard. One family member said, *"it was easy to speak and ask questions and we felt that we were listened to"*, another said that she *"liked the chance to listen to other people's stories and express (her) feelings."*

4.11. Wherever it can be achieved, tactfully, it is helpful to use the 'new' name and pronouns for the trans person, even where the family is not yet able to do this. This has the effect of 'normalising' the new situation, and is useful in promoting acceptance. One parent commented that she had learnt *"to say 'she' and use her name, to say daughter instead of son".* A difficult issue that the family members of the workshop team address, is that it is inappropriate and ultimately may be counter-productive, to oppose the process of transition. Families, in the early days following disclosure, may believe that they can halt this process. They can, and often do, put huge emotional pressure on the trans person to draw back from transition. It is part of the role of the team members to explain that although some level of negotiation may be possible, regarding issues such as the timing of wider disclosure for instance, implacable opposition may succeed only in continuing to *suppress* the outward expression of the trans individual's core gender identity, thereby heightening the stress experienced, but without in any way *changing* that identity.

4.12. Accepting one's powerlessness in these situations is hard, but families cannot 'cure' the condition; they cannot prevent transition, nor indeed, do they have the right to try to do so. That is not to say that people experiencing severe gender dysphoria never decide on a more modest solution than full transition; they sometimes do. But the impetus needs to come from within the trans individual, not from outside pressure. Team members, as bystanders to the transition of their own child, partner etc. have, themselves, experienced the very same sense of helplessness in the face of forces beyond their control. They are, therefore, better able to convey this rather brutal message to family members who are relatively new to this situation, more readily than can medical professionals.

4.13. Later all the families foregather over tea and biscuits, and all are free to mingle as they please. Recent additional follow-up (February 2006) asking whether, in hindsight, the workshop had helped, at the time, and subsequently, in the family situation, elicited comments such as*: "what helped me most was meeting others in the same situation. ...it certainly played a part in the happy outcome that we are still together as partners*

and that most of our family are supportive: Family members found it reassuring to talk with a trans member of the team and *"get to know a 'completed' trans person"*, already living a stable life, post-transition. One family member commented that she had learnt that there was *"light at the end of the tunnel and relationships can still work".* Couples who were struggling to remain together were grateful *"for the lifeline".* At this stage too, it is noteworthy that some family members who had been quite literally unable to speak at the beginning of the afternoon, found that the floodgates were now open and they had gained *"an ability to share".* Where special problems are identified within the groups, these are addressed, if possible, by an appropriate member of the team. For instance, some family members have deep-rooted Christian beliefs which they feel are incompatible with transsexualism. A Christian trans member of the team would be alerted and asked to talk with the family about this issue.

4.14. Before leaving each other's company the groups come together in their original circle to exchange any final words of help, comfort or advice that anyone wishes to offer. Those attending the workshop are encouraged to liaise with each other, and, preferably, to organise a local support group in their own area. Information about existing contact and support groups is provided.

4.15. The team members are only too well aware that it is the families that do not seek help, who may be in the most need of help. One family member highlighted this: "How do you reach people like us who need help but refuse to acknowledge it?" In answer to that, we must return to our starting point, and recommend that more GICs take responsibility for pro-actively engaging families, especially partners, in planning for the future wellbeing of their trans service-users. Obviously, this has to be with the consent of the trans person, and cannot be enforced. But, the continued integration of trans people within the family – arguably the most important part of their world – may be, for many, the key to 'successful' transition.

4.16. Evaluation forms, completed by families, reinforce the wisdom of involving them in the treatment process. Of those completing the forms, 101 (n=111, 91%) said they would attend further workshops if the opportunity arose. Not all of those completing these forms had any contact with GICs, but of those that did, in answer to the question, "are there any other services you would like GICs to provide for families, 100% answered "yes" or, more emphatically, in the words of one recently transitioned trans woman, "Yes, absolutely – the 'system' ignores families completely". A variety of suggestions were offered, not only by family members, but by trans people themselves, about ways in which families could be brought into the fold: attending appointments, being put in touch with other families, being provided with information, educating patients' employers – and their GPs! One wife pleaded, *"treat families as normal people instead of playing God";* another *cri de coeur* from a mother, herself a medical professional, was especially apt: *"be with us, not put us and our loved-ones in a straitjacket, tramlined process, this is about individuals – not a simple one way problem".*

4.17. Indeed the problem is very far from simple, and it goes well beyond the individuals involved. The discomfort of both trans people and their families is seriously aggravated by the rigidity of a society that still fails to recognise the wide diversity of natural development in human beings. Even though contemporary notions of equality between men and women have reduced the male/female divide, contemporary culture still punishes those who transgress the binary model.

If ever there was a situation which needed to be addressed holistically, this is it.

APPENDIX A

QUESTIONNAIRE FOR WORKSHOP – SUPPORT FOR FAMILIES 24/9/05

It would be of great help if you completed this questionnaire. This would enable us to ensure that we are meeting families' real needs at future workshops, and to show health professionals how to help families.

Name...(leave blank if you wish)

1 – IN WHAT WAYS WAS THE INFORMATION WE SENT YOU BEFORE THE WORKSHOP USEFUL, OR NOT ?

2 – WHAT DO YOU THINK YOU GAINED FROM TODAY'S WORKSHOP ?

3 – DID YOU FEEL THE WORKSHOP WAS: TOO LONG ? TOO SHORT ? JUST RIGHT ?

4 – WHAT DID YOU **LIKE** ABOUT TODAY'S WORKSHOP ?

5 - WHAT DID YOU **NOT LIKE** ABUT TODAY'S WORKSHOP ?

6 - DO YOU HAVE ANY SUGGESTIONS FOR IMPROVING THE WORKSHOP ?

7 – WOULD YOU ATTEND OTHER WORKSHOPS ? YES/NO

IF YES – WHAT SUBJECTS WOULD YOU LIKE COVERED ?

IF NO – WHY ?

8 – DO YOU FEEL MORE COULD BE DONE BY THE GENDER IDENTITY CLINICS TO HELP FAMILIES OF PEOPLE BEING TREATED THERE ? IF YES- IN WHAT WAYS ?

9 – ARE THERE ANY OTHER SERVICES YOU WOULD LIKE THE GENDER CLINICS TO PROVIDE FOR FAMILIES ?

10 – IF WE ENSURE YOUR ANONYMITY, MAY WE PRESENT YOUR COMMENTS TO THE GENDER IDENTITY CLINICS AND OTHER HEALTH ORGANISATIONS ?

APPENDIX B

Recently follow-up forms were sent to all those for whom addresses were available. Just one question was asked:

IN HINDSIGHT, DO YOU FEEL THAT THE FAMILY WORKSHOP HELPED, AT THE TIME, AND SUBSEQUENTLY, IN YOUR FAMILY SITUATION?

PLEASE ADD ANY FURTHER COMMENTS:

IN ADDITION, AND ON THE SAME CONFIDENTIAL BASIS AS ABOVE, WOULD YOU BE WILLING/UNWILLING FOR ANY FOLLOW-UP COMMENTS TO BE USED ?

....

Samples of actual answers received:

1) Meeting other parents and their children in similar situations, and those past surgery, helped a great deal towards overcoming this enormous challenge which lay before us. We also had a better understanding of how and why this gender problem arises. Our son is now our daughter (post surgery, and happy with herself....she will be "two years old" in April!

2) The workshop was a revelation. It gave us facts about Gender Dysphoria (we had only recently found out our daughter is transgender). It enabled us to meet other people who were involved themselves in various ways. We came away feeling comforted, less alone and much more knowledgeable. We also made useful contacts. We would definitely attend another one!

3) It was extremely helpful. The workshop was held shortly after we found out our son was a M to F trans person. As well as being very informative regarding the facts about (the condition) it provided an opportunity to meet other people in similar situations to ours. We were able to share our experiences and now have a supportive network to help us and our daughter to face the future. The workshop made us feel less alone and our world less 'weird'.

4) Yes – essential in understanding and clarifying my feelings once I was told. I am now using this information to get me through what will be the most difficult time. I am starting to grieve the 'death' of my husband and partner, and starting my life anew with just my three children and myself.

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