Pathway: 4D
Critical Studies tutor: Alex Marraccini
Studio tutor: John Seth

Dear Colin's Audience,

As a trans person who wants access to healthcare, I can confirm that this is art.

Thanks,

Jo.

Firstly, some context on why I wrote this and its context within (my) art: I consider this manifesto to be an artwork in itself, similar to artists' manifestos throughout history, as well as more directly political manifestos, such as The Queer Nation Manifesto. My practice currently resides in writing of this style and I consider this to be another work in this series.

This manifesto starts with a bunch of disclaimers and content warnings because trans history is complicated, even the word trans is complicated. Firstly, be warned that the following will include use of outdated trans terminology, transphobia, intersex discrimination, mentions of self harm and suicide, plus references to dysphoria, genitals, and surgery. Please tread carefully.

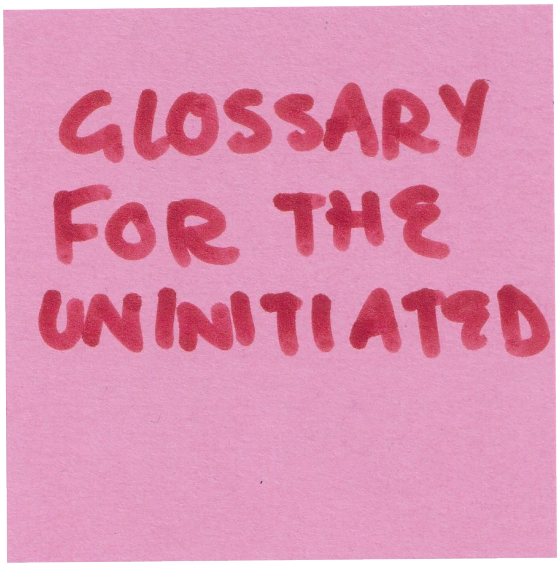
I have chosen to use the word trans here in accordance to modern definitions of the word as an umbrella term for anyone who identifies as a different gender to the one they were assigned at birth. Not all trans people choose, or are able, to medically transition. This does not mean they are any less trans than those who do medically alter their body to more closely align with their internal understanding of their gender. However, this work aims to address medical transition and how it is/has/can be accessed by trans people in the UK. Some of the earliest people to medically transition would likely not have used the word trans. Some of them used words such as transexual and transvestite, or may have insisted that they had their sex assigned incorrectly at birth. Although it is difficult to retrospectively refer to people from history as trans, the people in this essay, who I refer to as such, have all chosen to permanently change their bodies with the aim of looking more like a different sex, thus undeniably aligning with the aforementioned modern definition of trans.

Although my primary intention is to draw conclusions about access to medical transition for trans people in the UK, this essay will reference more international sources. When the first few doctors were starting to realise that trans people were real and that they might need something more than therapy, they communicated and collaborated across countries purely because there were so few resources available. Similarly, trans people themselves would travel to different countries to access the treatment they needed. For example, after Christine Jorgensen was made famous for having medically transitioned in Denmark, many trans people

travelled there in the hopes of accessing the same treatment (Benjamin, 1966, et al.). Trans people also travelled in order to avoid persecution for certain legalities, such as the law in the US and UK that banned the castration of functionally healthy male genitals (Queer as Fact, 2020, et al.).

I should also acknowledge that I have my own biases on this topic. I was assigned female at birth and identify as trans because I don't identify as a woman. I have gone through hormone replacement therapy (testosterone) - although I don't currently take hormones - and I have had top surgery. Although I asked the NHS for both of these things, I eventually ended up paying for both treatments privately. My experiences have also been impacted by me being white and lower-middle class.

It is also important to acknowledge that this essay will likely only skim the surface of an incredibly complex and often undocumented history. Ultimately, I am using historical examples to draw conclusions about trans healthcare in the present day; this is not intended to be a comprehensive overview of trans medical history. I've chosen not to discuss the work of Magnus Hirschfeld in this essay because, although he did groundbreaking research in the field of giving trans people what they need, due to Nazi book burning, the vast majority of his work was destroyed, and a lot of what was left has only been rediscovered relatively recently (Bauer, 2017, et al.). Therefore, I don't think his work had so much of a knock-on effect into present day trans healthcare.



The following manifesto isn't intended for the average cis reader or for someone just coming out. It's for those deep into trans politics, for anyone stuck on a waiting list, for anyone emotionally or financially invested in UK trans healthcare. If that is not the case, please read the following glossary before embarking any further.

Assigned sex
The sex written on your birth certificate when you are born, usually based on your genitals.

Cisgender
"often shortened to 'cis' this term refers to someone whose gender matches their assignment at birth" (Vincent, 2018, et al.)

Cisnormativity
"The belief that being cisgender is normal and being transgender is abnormal, and the structures and systems caused and sustained by this belief." (CN Lester, Masculinites, 2020, et al.)

Detransition
The process someone may go through to undo the medical/social transitioning they've undertaken so as to return to living as the gender they were assigned at birth.

Dysphoria
Medical term referring to the distress caused by the difference between a trans person's gender identity and sex assigned at birth. This can be physical dysphoria, about the body; or social dysphoria, about social interactions (such as being misgendered). Not all trans people experience dysphoria but in order for a trans person to medically transition, they must be diagnosed with gender dysphoria.

Gay
Someone who is attracted to people of the same gender. A more modern and less medicalised version of homosexuality.

Gender affirming surgery
Any surgery a trans person might undergo to make their body feel more closely aligned with their internal understanding of their gender.

Gender reassignment surgery
An outdated term, now usually referred to as gender affirming surgery, because reassignment implies that trans peoples' bodies are wrong/need fixing.

Homosexual
A medicalised term for gay.

Hormone Blockers
A treatment which stops your body producing oestrogen or testosterone. Blockers are often prescribed to trans and gender questioning young people to pause puberty. They don't make any permanent changes but do give the young person time to decide what they need without having to go through the trauma of a puberty that may permanently change their bodies in ways that will make them incredibly dysphoric.

Hormone replacement therapy (HRT)
A treatment some trans people use to change the primary hormone in their body from testosterone to oestrogen or vice versa.

Intersex
"this is an umbrella term referring to conditions where sex-differentiation is not uniformly achieved, resulting in variation in their gendered physiology and/or anatomy" (Vincent, 2018, et al.).

Kinsey scale
A scale which ranks a person's sexual orientation on a scale from 0 (exclusively heterosexual) to 6 (exclusively homosexual) (The Kinsey Scale, n.d.).

Non-binary
Anyone who identifies outside of the traditional western binary idea of one's gender being exclusively male or female. Often used as an umbrella term.

Passing
When a trans person is perceived by others as the gender they identify as.

Phalloplasty
Surgical construction of a penis.

Sex change
Outdated term which refers to the medical steps a trans person may take to transition.

Sodomy
Anal sexual intercourse, historically associated with gay men.

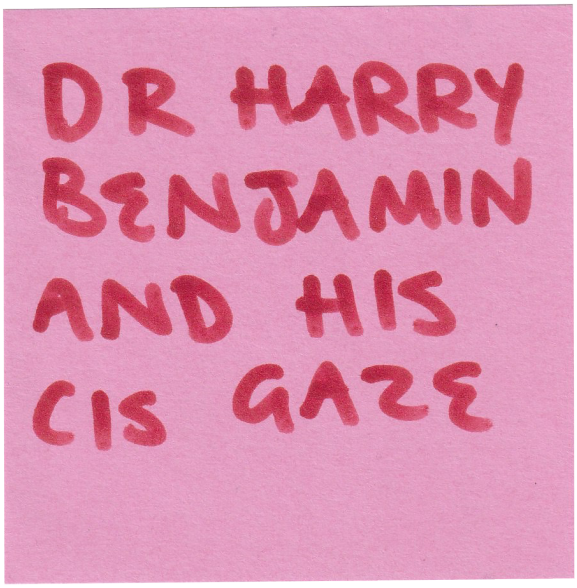
Top surgery
A surgery which reduces breast tissue to make a trans person's chest flatter.

Transition
The process a trans person goes through to live as the gender they identify as. This can be socially transitioning, like changing their name and wearing different clothes; or medically transitioning, which may involve treatments such as HRT, chest surgery, genital surgery, and facial feminisation/masculinisation surgery.

Transsexual
An outdated term that refers to someone who changes their sex.

Transvestite
An outdated term for someone who cross-dresses.

Vaginoplasty
Surgical construction of a Vagina.



In 1966, Dr Harry Benjamin published The Transsexual Phenomenon, within which he introduced his Sex Orientation Scale (later also known as the Benjamin Scale). The scale documents a spectrum from Pseudo Transvestite to High Intensity True Transsexual, essentially quantifying the varying levels of medical intervention needed by male-assigned gender-non-conforming and trans people. There are many obvious reasons, even in my brief description, as to why this scale has widely fallen out of favour, but I think it could actually be very useful - if updated appropriately - in the present.

Table 1. Sex Orientation Scale (S.O.S.)
Sex and Gender Role Disorientation and Indecision (Males)

	Group 1			Group 2	Group 3	
	Type I	Type II	Type III	Type IV	Type V	Type VI
Profile	TRANSVESTITE	TRANSVESTITE	TRANSVESTITE	TRANSSEXUAL	TRUE TRANSSEXUAL	TRUE TRANSSEXUAL
"GENDER FEELING"	Pseudo Masculine	Fetishistic Masculine	True Masculine (but with less conviction.)	Nonsurgical Undecided. Wavering between TV and TS.	Moderate intensity Feminine. ("Trapped in a male body".)	High intensity Feminine. Total psycho-sexual inversion.
DRESSING HABITS AND SOCIAL LIFE	Lives as man. Could get occasional "kick" out of "dressing." Not truly TV. Normal male life.	Lives as man. "Dresses" periodically or part of the time. "Dresses" underneath male clothes.	"Dresses" constantly or as often as possible. May live and be accepted as woman. May "dress" underneath male clothes, if no other chance.	"Dresses" as often as possible with insufficient relief of his gender discomfort. May live as a man or a woman; sometimes alternating.	Lives and works as woman if possible. Insufficient relief from "dressing."	May live and work as woman. "Dressing" gives insufficient relief. Gender discomfort intense.
SEX OBJECT CHOICE AND SEX LIFE	Hetero-, bi-, or homosexual. "Dressing" and "sexchange" may occur in masturbation fantasies mainly. May enjoy TV literature only.	Heterosexual. Rarely bisexual. Masturbation with fetish. Guilt feelings. "Purges" and relapses.	Heterosexual, except when "dressed." "Dressing" gives sexual satisfaction with relief of gender discomfort. May "purge" and relapse.	Libido often low. Asexual or auto-erotic. Could be bisexual. Could also be married and have children.	Libido low. Asexual, auto-erotic, or passive homosexual activity. May have been married and have children.	Intensely desires relations with normal male as "female," if young. Later, libido low. May have been married and have children, by using fantasies in intercourse.
KINSEY SCALE*	0-6	0-2	0-2	1-4	4-6	6
CONVERSION OPERATION	Not considered in reality.	Rejected.	Actually rejected, but idea can be attractive.	Attractive, but not requested or attraction not admitted.	Requested. Usually indicated.	Urgently requested and usually attained. Indicated.
ESTROGEN MEDICATION	Not interested. Not indicated.	Rarely interested. Occasionally usefull to reduce libido.	Attractive as an experiment. Can be helpful emotionally.	Needed for comfort and emotional ballance.	Needed as substitute for or preliminary to operation.	Required for partial relief.
PSYCHOTHERAPY	Not wanted. Unnecessary.	May be successfull. (In a favorable environment.)	If attempted usually is not successful as to cure.	Only as guidance; otherwise refused or unsuccessful.	Rejected. Useless as to cure. Permissive psychological guidance.	Psychological guidance or psychotherapy for symptomatic relief only.
REMARKS	Interest in "dressing" only sporadic.	May imitate double (masculine and feminine) personality with male and female names.	May assume double personality. Trend toward transsexualism.	Social life dependant upon circumstances.	Operation hoped for and worked for. Often attained.	Despises his male sex organs. Danger of suicide or self-mutilation, if too long frustrated.

*See explanation in the adjoining text.
Type 0: normal sex orientation and identification, heterosexual or homosexual. The idea of "dressing" or "sex change" foreign and unpleasant. Vast majority of all people.

(Benjamin, 1966)

At the time Benjamin devised it, the scale wasn't widely used (but neither was the knowledge that trans people deserve any sort of rights). On the surface, his use of the now very outdated terms transsexual and transvestite seem innapropriate, but

for him to differentiate the two was groundbreaking. Up until then, they had mostly been lumped into one homosexual, mentally ill, group. In his scale, Benjamin started to acknowledge the spectrum and sometimes fluid nature of gender. For example, in "Type III, Transvestite, True, Masculine (but with less conviction.)" (ibid.), he says that there could be a "Trend toward transsexualism" (ibid.) meaning a patient may come to him identifying as a transvestite, and then later come to identify as transsexual. In "Type IV" (ibid.) he also acknowledges trans people who may not medically transition, referring to them as "Transsexual, Nonsurgical" (ibid.).

It could be argued that the way he ranks people in terms of how trans they are is kinda yikes, with "Type 0" (ibid6) being cis people, "normal sex orientation and identification" (ibid.), and "Type VI" (ibid.) being "True Transsexual, High intensity" (ibid.). However, I would argue that he's actually ranking patients on their level of needs. The higher a patient's dysphoria is, the higher the number of their Type is. Obviously it's impossible to quantify dysphoria exactly, but Benjamin leaves space for patients to move around the scale.

One issue it certainly has is equating two entirely separate things. Cross-dressing doesn't require any medical or psychological assistance, it's a fetish and/or a hobby. Unfortunately, the early research which conflated the two, still has lasting effects in widespread misunderstandings of trans people to this day. If Benjamin had been able to separate sexual orientation and gender, maybe we wouldn't be fighting the perception that trans people are just dressing up in the present. However, Benjamin, like most of the first few doctors to research this, was a sexologist first, so he perceived all of his work through a sexologist lens.

The other issue I have with this scale is that it only deals with trans women. Maybe it's too much to expect him to include non-binary experiences (even though non-western cultures were using less binary systems of gender long before Benjamin's research). But this scale doesn't even acknowledge trans men. Benjamin devotes only one chapter in The Transsexual Phenomenon to "The Female Transsexual" (ibid.), by which he means those assigned female at birth. He argues however that "The proportion between male and female transsexuals in my series is approximately one to eight" (ibid.). He essentially has less to say about them because he's been far less able to research them. Contrastingly, "In 2017/18, 1,806 of the referrals [to the Gender Identity Development Service (GIDS)] were for young people assigned female at birth (AFAB), and 713 for those assigned male at birth [...] This continues the trend of an increase in AFAB referrals proportionately." (GIDS referrals increase in 2017/18, 2018, et al.).

Ultimately, one of the most exciting things about all of Benjamin's research was that he was one of the first doctors to suggest that transness couldn't be therapised out of us. At some points on the scale, he refers to psychotherapy as "Useless as to cure" (Benjamin, 1966) and "for symptomatic relief only" (ibid.). With these statements he is clearly saying that being trans isn't something that can be solved purely through therapy, but he also strongly suggests that therapy can still be helpful.

"In spite of their differing needs, right now all trans and non binary people are treated in the same way, they are referred to specialist services." (GenderGP, n.d.). Trans discourse has broadened exponentially since 1966, yet medical treatment for gender dysphoria has become more and more rigid. Although medical interventions may seem easier to access, there seems to be less space for a diversity of needs. An anonymous former psychologist at Tavistock and Portman NHS Trust said that "at the moment there's only one pathway through the service, it's a medical pathway, not a psychological one" (Sky News, 2019). Despite having spent nearly six years as a patient in these services, it still utterly baffles me that this is the case.

In all of my psychological assessments with both NHS and private doctors, I have always been assessed in a way that seems all too interested in appeasing transphobic opinions. I've answered the same questions over and over about regret and certainty and which male celebrity I most want to look like, yet the NHS system seems to favour medical transition over potentially less permanent or political interventions. I saw my first gender psychologist when I was 15, but I wasn't offered any form of therapy by the NHS gender identity services until I was 20, by which point, the vast majority of my trans-related trauma and dysphoria was directly caused by their services.

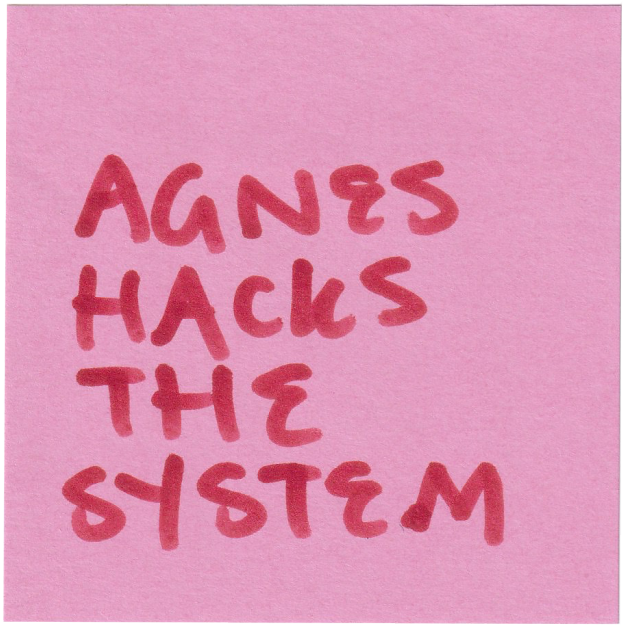
When Harry Benjamin published The Transsexual Phenomenon, where he was working in New York, sodomy would still be illegal for another fourteen years (Wikipedia, n.d.). No matter how they experienced their sexual orientation, all of Benjamin's patients would have had to tow a fine line between hereto- and homosexuality. He expected his trans patients to "in accordance with his female psychological sex, considers his sexual desire for a man to be heterosexual, that is, normal" (Benjamin, 1966). This meant that his patients would have to insist that they were attracted to men in order to prove their heterosexuality, but would have to deny having any sexual contact with men for fear of the legal ramifications of homosexuality. "The transsexual feels himself to be a woman ("trapped in a man's body") and is attracted to men. This makes him a homosexual provided his sex is diagnosed from the state of his body" (ibid.). The Kinsey Scale is an integral part

of the Benjamin Scale, with a patients gender identity being considered more valid, the more heterosexual they are.

Thankfully, compulsory heterosexuality is not something that has been preserved in present day NHS gender services. I personally found it easiest to tell my doctors that I identified as a gay man. This might have felt true when I was 15, but even then I wasn't ever quite sure of it, and it never really felt like anyone else's business. When I was 17, I used being gay as a reason not to freeze my eggs. My doctor insisted that if I met the right man then I might change my mind about not wanting to have kids. I explained to her that if I was a cis gay man, I wouldn't be able to biologically reproduce with a cis gay partner. This reasoning seemed to make more sense to a cisgender doctor than my real reason, which was the complex dysphoria I feel around the idea of reproduction and biological parenthood. In more recent years, I've used the label of gay (and its attached stereotypes) to explain away my slightly more feminine mannerisms. I haven't really identified as gay or been attracted to men in a very long time, but my sexual orientation doesn't really feel like anyone else's business. Plus, this lie felt pretty minor compared to all of the other lies I've told my doctors over the years, all of which were used as strategies to minimise the otherwise traumatic nature of the many psychological assessments I've received.

Clinical psychologist Gert Bakker said that trans people "know very well what to say and how to present to reach their goal" (Zembla: Transgender met spijt, 2018). From what I've found, there are no publicly available studies on how many trans people have lied to doctors. If that research was done, it would be found that a surprisingly large number of trans people have lied/exaggerated/stretched the truth to doctors. This research would totally upend the way healthcare is currently carried out for trans people in the UK. Right now, we're all - trans patients and their doctors - just living in this performative cycle, in which we tell them what they want to hear, and in turn they give us what we need. It's utterly ridiculous that everyone working in this system knows that it's all a sham, and yet no one has done anything to change it.

Ultimately, the reason why trans people have to lie is because the trans healthcare system is based on the cis gaze. "the majority of people working in the system are cis men, and the ideal that they aspire to achieve for us is through their lens as is the whole medical system. So you are walking into a room that is already in a framework of repair that is according to that normative standard and you have very little power to reframe that" (Scott, Trans Power, 2020). Trans people are expected to perform gender to cis standards. In this way, we are set up to fail.



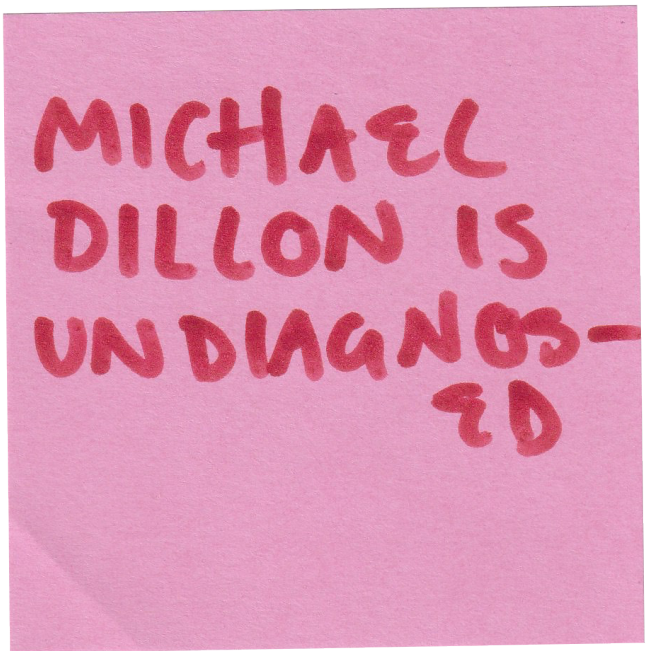
Through insights from trans people further into the system than me, when I first came out, I learned which parts of my transness were allowed by doctors and which weren't. Unfortunately, this mentality, taught to us by cis people who have qualifications in being experts on our lived experiences, bleeds into our communities in unhealthy ways. This celebration of cisnormativity and 'passing' that is normalised in certain corners of the trans community, combined with often debilitating dysphoria, can lead to really disgusting views being maintained by trans people. Being trans has been boiled down to a medical diagnosis. Being trans has been boiled down to the opinions of cisgender 'experts'. Trans people have been continually forced to conform to an understanding of gender that transness is in itself inherently opposed to.

In 1967, Harold Garfinkel published Studies in Ethnomenthodology, in which he described the case of a woman under the pseudonym Agnes. Agnes told Garfinkel, and his colleague Dr Robert J. Stoller, that she had been assigned male at birth but that "Secondary feminine sex characteristics developed at puberty" (Garfinkel, 1967). After nearly a year of weekly assessments, Agnes was eventually diagnosed with "testicular feminization syndrome" (ibid.), what would now be referred to as Androgen Insensitivity Disorder, an intersex condition (Vincent, 2018, et al.), and in March 1959, Agnes received vaginoplasty. "Not being considered a transsexual, her genitalia were surgically transformed so that she now had the penis and testes removed and an artificial vagina constructed from the skin of the penis." (Stoller, 1967). It wasn't until 1966 that Agnes disclosed to Stoller "that she had never had a biological defect that had feminized her but that she had been taking estrogens since age 12" (ibid.), stealing from her mother's prescription.

Stoller specified that Agnes was given surgery because they believed her to be intersex and not trans. Intersex bodies have, and continue to be, forced to conform to binary sex standards through medicalisation. A large majority of intersex people have been given surgeries without their consent (Intersexion, 2012, et al.). Intersex bodies have historically always been medicalised, but trans bodies were widely denied the surgery they needed until relatively recently. Agnes had no choice but to appropriate the medical insistence on 'normalising' intersex bodies, in order to received treatment that would have otherwise been denied to a trans person. I'm

bringing this up with the intention of highlighting the way trans people have historically had to cheat the systems in order to get what they need, not that trans people should be continuing to appropriate intersex experiences in the present. Intersex people have a shit enough time as it is.

Right now, we're still having to bend to the whims of cisgender doctors so as to receive the healthcare that we need. We're having to accept the shit bits in exchange for basic healthcare. "our surgeries are based on looking like them, having perfect 'functional' cocks and vaginas. I wonder if we disconnected from that normativity and thought much more about pleasure and shape. I wish we didn't feel so broken by not having normative genitals." (Roche, 2020). It wasn't until I actually met my top surgeon that I told any doctor what I actually wanted for my chest. I knew I wanted it flat, and that was cis-normative enough for medical professionals to understand. But he asked me if I wanted my "free nipple grafts", and I said "I don't think so" as if it were a question, when in fact I had been certain for a number of years. He was willing to do it but expressed to me that he really didn't understand why. Trying to explain to a cis man, whose day job is to make trans people look more cis, that I don't care for looking cis, is a precarious conversation to have. He didn't give me nipples but he did leave me with some remaining breast tissue. Just enough for it to look like a cis male chest.



In the 1930's, Dr George Foss started experimenting with giving testosterone to women with uninterrupted menstruation. When Michael Dillon (now widely considered the first person to have medically transitioned in the UK) came to him asking for hormones, he insisted on Dillon receiving a psychological assessment (Queer as Fact, 2017, et al.). It's unclear exactly what happened in this assessment, but it wouldn't have been as straight-forward as the kind of assessments trans people in the present day have to go through. Plus no one had devised the cheat sheets yet. Despite the assessment not going well, Foss still gave Dillon some testosterone pills to try out on his own (Dillon, 1946). It's unknown exactly where Dillon continued to get hormones from, but it's likely that he could just buy them over the counter as they were used by plenty of cis people for less gender related issues (Queer as Fact, 2017, et al.).

In 1942, Dillon was taken to hospital after fainting (ibid.). He had to out himself, and then a doctor just offered him a mastectomy (ibid.). No one knows who this doctor was, but, as far as I can tell, he did not expect Dillon to have a psychological assessment before operating (ibid.). This surgeon then introduced him to plastic surgeon Harold Gillies, who agreed to do phalloplasty on Dillon in 1946 (ibid.). Gillies had done a number of similar operations on cis men who had lost their penises in the world wars, and conceptualised Dillon's needs to be similar to any cis man without a penis (ibid.). I'm not saying that Michael Dillon had an easier time accessing healthcare than trans people in the present day, but there wasn't a precedent that doctors could follow. Maybe they acted on gut instinct, out of the kindness of their hearts. Maybe they didn't bother with psychological assessments because gender specialists didn't exist and mental health wasn't understood in the same way it is today. Maybe they could see how hard Dillon had fought just to exist.

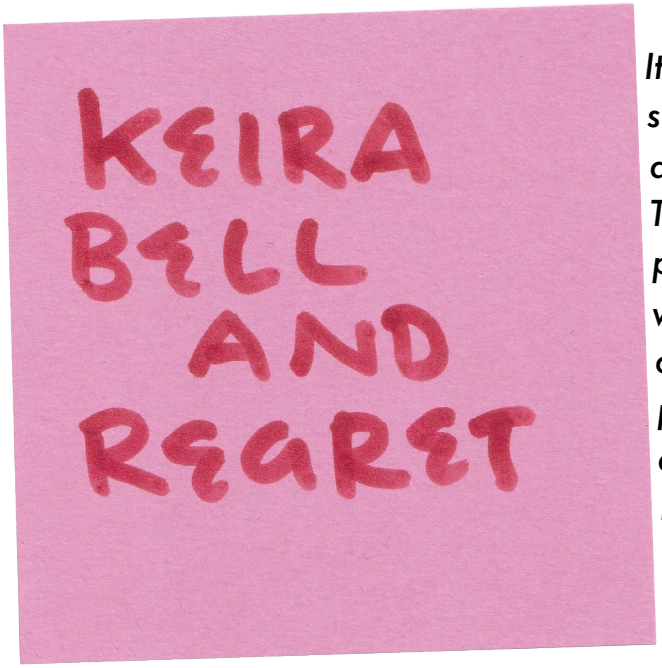
In the UK in the present, a specialist diagnosis of gender dysphoria (often with a second opinion) is needed to medically transition in any way (Vincent, 2018, et al.). I've had six different gender dysphoria diagnoses because the system doesn't actually always work the way it is intended to. When I was 15, I received a diagnosis despite not wanting anything the children's service could offer. When I was 17, I was privately diagnosed with dysphoria again so as to be prescribed

testosterone. When I was 19, I was given a diagnosis which made up half of a top surgery referral. I didn't get the other half of that referral for more than a year. To be clear: I had been asking the NHS for top surgery since the age of 15, and yet, they expected me to get a third NHS gender dysphoria diagnosis more than five years after the first one. I understand that you probably shouldn't be giving top surgery to a 15 year old, but the fact that I had to wait another year and a half for a third doctor to tell me that I was trans enough is utterly ridiculous. NHS Gender identity services could save a lot of their disappointingly small budget if they paid any attention to childhood diagnoses. Surely if I was diagnosed with something in my childhood, it should just be accepted that I still had that thing in adulthood unless my symptoms change?

In the World Health Organisation's most recent International Classification of Diseases (2018), all things trans were moved out of the chapter Mental and behavioural disorders and into Conditions related to sexual health. Although I agree with the argument that "trans-related and gender diverse identities are not conditions of mental ill health, and classifying them as such can cause enormous stigma" (WHO, n.d.), classifying them under sexual health feels like we're going back to a time when doctors like Harry Benjamin were conflating trans issues with sexuality. Although all of my doctors from past years have technically diagnosed me with gender dysphoria, the new official term is gender incongruence, which the World Health Organisation defines as "characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex" (World Health Organization, 2018). This wording is so incredibly vague that every individual doctor could take it to mean whatever they want it to and gender incongruence, through this definition, could be hugely misdiagnosed.

Arguably though, a diagnosis is inherently problematic. "Many patients [...] known exactly who they are and what they needed. A 'diagnosis' was unnecessary" (GenderGP, n.d.). Why should I have to go through a lengthy referral process to have my chest flattened but not have to have any psychological assessments for a breast reduction? "One day people will be able to go and chop their cocks off like having a haircut, just like having lip fillers or a facelift. We are just in a mis-place in history in which the world hasn't caught up" (Scott, 2020). Trans people know who they are and what they need. It's a ridiculous double standard for us to have to prove that to psychologists, when no one seeking plastic surgery has to. If I was a cis woman wanting a breast reduction, I could just book an appointment to see a surgeon but because I wanted rid of all my breast tissue, I had to tell my life story (or a more palatable version of my life story) to two psychologists. This all comes down to our societal obsession with conventional beauty. If a woman wants different tits, that has the potential (in the eyes of society)

to make her sexier, but for me to get mine chopped off means there must be something psychologically wrong with me! We've all spent years agonising over exactly how we need our bodies to look. We should be trusted to make informed decisions about our own bodies. I don't care about being sexy. I care about my body feeling like my body.



It seems like the whole system is deliberately shrouded in mystery so as to discourage anyone without the willpower to get through it. The waiting times are more of a test than the psychological assessments. Even as someone who has been through the system, stayed up to date with the medical experiences of other people in my community, and is now doing extensive research for the sake of this manifesto, I still feel like I have no idea what's going on. It doesn't seem like anyone - including the people who work in this system - has any idea what's going on and exactly how things are meant to work. The whole system needs to be turned upside down and started again from scratch, because the current procedures are out of date and weren't ever intended to be used by the huge influx of trans people currently trying to access healthcare.

My immediate response to the issue of waiting times is to just suggest that we need more gender clinics and clinicians. Although "There is substantial evidence that adding more resources will not necessarily improve accessibility and decrease queues" (Johannessen, K.A., Alexandersen, N., 2018), right now there is only one NHS clinic in the whole of the UK who cater to the medical needs of trans and gender-questioning young people. 77 young people were referred to the Gender Identity Development Service (GIDS) in 2009 but an overwhelming 2,590 were referred in 2018 (Sky News, 2019). "If demand exceeds capacity, queues would increase indefinitely" (Johannessen, K.A., Alexandersen, N., 2018). Even if "increasing resources as a sole solution is unsustainable" (ibid.), it should at least be the first step toward reducing such horrific waiting times. Cara English, Head of Public Engagement at Gendered Intelligence, said that waiting times "were already torturously long before the pandemic, and have stretched to ruinous heights. We need to increase capacity now" (I, 2020).

So many trans people are being failed purely because of these exceptionally long waiting times. For example, Sonja, who was interviewed by The I in August 2020, waited for so long for her first appointment that "By the time she was contacted by GIDS, she was told she was too old to be eligible for puberty blockers [...] Taking the puberty blockers will have halted the progression of biological puberty, such as the enlargement of the Adam's apple, the change in muscle density, overall bone structure, and bone growth. To alter from her neck upwards, Sonja said she will

need to undergo "around five facial feminisation surgeries". There's only one surgery, gender reassignment surgery, that is usually funded by the NHS." (Anderson, 2020). This is not fucking acceptable. These waiting times are causing permanent emotional and physical damage to trans people. These waiting times are wasting time and money for both the NHS and patients in the long run. We need easier access to our basic healthcare.

At the beginning of December 2020, a detransitioned woman and the mother of an autistic gender-questioning child won a court case over trans and gender-questioning young people's access to hormone blockers. (The Guardian, 2020 et al.) Heartbreakingly, GIDS subsequently "suspended new referrals for puberty blockers and cross-sex hormones for the under 16s" (ibid.). This feels like another in a long string of misrepresentations of hormone blockers. Hormone blockers don't do anything permanent (Vincent, 2018, et al.). They essentially just pause puberty, giving a young trans or gender-questioning person more time to consider their options (ibid.). That's it.

It's a big fucking deal to come out as trans, especially for a child. If they're sure enough about their gender that they feel able to verbalise it, then they should also be considered mature enough to be able to give informed consent about a non-permanent hormone treatment. Clinical psychologist, Diane Ehrensaft, says that "if we can facilitate a better life by offering these interventions, I weigh that against there might be a possibility that they'll change later, but they will be alive to change" (Louis Theroux: Transgender Kids, 2015). I would much rather have a few people who have detransitioned, than a bunch of people who wanted to transition but weren't allowed to (and so will be at a much higher risk of harming themselves (Yarbrough, 2018)).

This court case, which was seemingly based on one person's experience, has made sweeping generalisations about the needs of gender-questioning young people across the country. Keira Bell, the aforementioned detransitioned woman who won the court case, made decisions for herself that she now regrets, but that doesn't mean that other young people should be punished for someone else's irrelevant mistakes. Bell also only started taking blockers at 16, so why should this new ruling be making such huge decisions about gender questioning people under the age of 16?

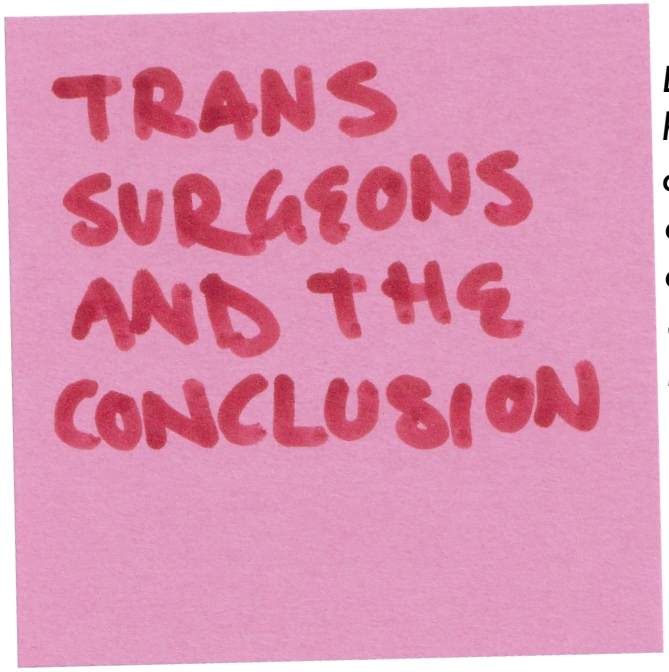
In the statement she gave after winning the case, Bell did say she wanted to "call on professionals and clinicians to create better mental health services and models to help those dealing with gender dysphoria" (Bell, 2020). I agree with this wholeheartedly. If someone regrets medically transitioning, that's because they

weren't given the appropriate mental health support before, during, and/or after transitioning. Being trans isn't a mental health issue in itself but trans people do disproportionately experience worse mental health than cis people, "39% of respondents experienced serious psychological distress in the month prior to completing the survey, compared with only 5% of the U.S. population." (U.S. Transgender Survey, 2015). However, Bell finishes her sentence by asking healthcare professionals to help gender-questioning young people "to reconcile with their sex" (Bell, 2020). Medical transition may not be the only way out of gender dysphoria, but neither is being forced into the sex you were assigned at birth.

The report of the 2015 US Transgender Survey found that, of the 27,715 people surveyed, only about 8% of people who medically transition go on to detransition. So, even if every young person who is given hormone blockers is then deciding to continue their medical transition, the vast majority of them won't go on to regret that decision. This is not to say that detransitioning/detransitioned people should be ignored because they're such a small minority. Our (both trans and cis people's) perceptions of detransition encompass only a very small part of what detransitioning can be. It's an unnecessarily taboo topic within the trans community because the experiences of a few detrans people (like Keira Bell) have been continually weaponized by transphobes to stop us transitioning. We need to be having new conversations about detransition in order to reframe it within and outside of our community. The same study also found that only 5% of that 8% detransitioned because they realised they were cis.

Only 0.4% of people who medically transition realise that they were cis all along.

Detransition and regret are not the same thing.



By the time I was seen by GIDS, I was 15 but had already gone though most of puberty so decided against hormone blockers. However, at the age of 17, I started HRT but stopped after about six months. I feel incredibly conflicted about sharing my complicated history with taking hormones at a young age, because I don't want my experiences to stop someone else being able to access the same thing at the same age. If I was to have the choice to go back and take testosterone all over again, I probably wouldn't bother. I don't think it relieved any more dysphoria than it caused. I don't think it was worth the hassle for me. I wouldn't describe my present feelings about this choice as regret though because I know it's what I needed at the time. I'm now at peace with the negative effects it had on me because I'm in a good place with my mental health and I'm in a supportive environment.

From my research into the experiences of those who do regret their medical transition, it often happens because they had separate mental health issues, and fell into toxic parts of the trans community that uphold the belief that medical transition is the only thing that can make you happy. Using transness as an excuse for self hatred is not always the same thing as genuine gender dysphoria.

Detransition also happens because sometimes gender can be fluid. Your gender right now shouldn't have to invalidate a previous gender. Changing your mind doesn't mean you aren't sure.

Being trans is a daily assault course and the medical professionals, who are meant to be helping us, are just making it harder. This is not to say that every psychologist at every gender clinic in the UK is inherently evil. I believe that every single one of the gender doctors I've met had the original intention of helping us out. They're having to give us a shit service because they're underfunded and they will ultimately never quite know what trans people really need unless they themselves are trans. "Imagine if trans people were the surgeons, the historians. This would be more than them finding solutions, this would be about dismantling dysfunctional systems on every level." (Scott, 2020). I'm not saying that replacing all of the psychologists with a bunch of unqualified trans people would solve all our

problems, but most trans people certainly find it way easier to discuss dysphoria and gender with other trans people.

I was lucky enough to grow up in Brighton, so when I first came out at 14, I started going to Allsorts Youth Project, a charity who "listens to, supports & connects children & young people under 26 who are lesbian, gay, bisexual, trans or unsure (LGBTU) of their sexual orientation and/or gender identity" (Allsorts Youth Project, n.d.). The first member of staff I met from Allsorts was trans, and seeing a fully grown trans adult was life-changing. Imagine if every person referred to a gender identity clinic got that experience...

You ask your GP for a referral to a gender identity clinic. You show up to your first appointment a few weeks later.

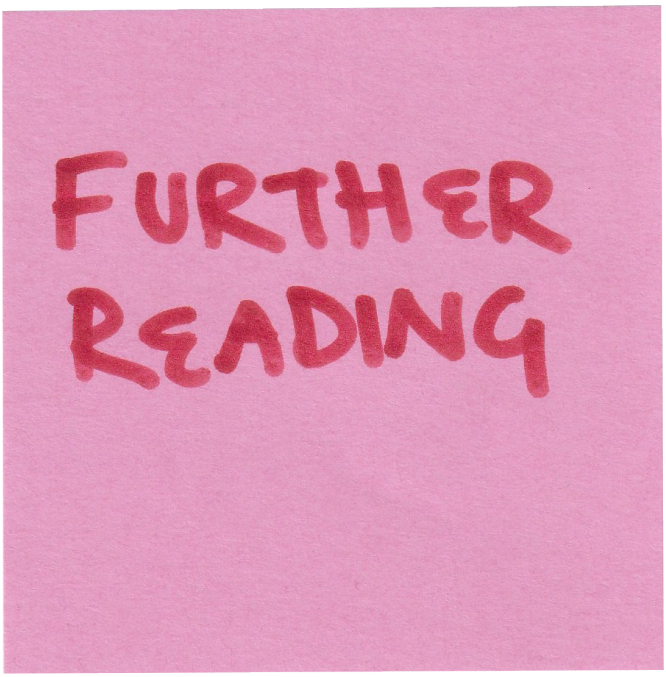
The psychologist is a lovely trans person who asks you about what you might want.
They talk you through all your options, the pros and cons.
They tell you that you're allowed to change your mind or not be sure about things, because you're here to figure out what you need, not pass any tests.
Together, you discuss where you feel you are on the scale.
The only thing they assess you for is whether you need more appointments and how often you need them.

You're able to come once a week to talk about whatever you need, because they have the resources and there's at least one gender identity clinic in every county, so you don't have to travel very far.

You get hormones and surgeries if and when you need them. The only requirement is that you have honest conversations with your psychologist about the pros and cons, as well as your hopes and fears about the procedure.

We need psychological help, not assessments. We need transparency and honesty. We need direct, sensible, helpful, knowledgeable advice about our options, not tests to pass or hoops to jump through. We need things to happen quicker.

We need healthcare and we need it now.



On trans rights in the UK: 'Coming Out As Trans - A Little Public Statement', Abigail Thorn, *https://youtu.be/FG-TrnwH4iQ*

On medically transitioning on the NHS (practical information): 'Transgender Health', Ben Vincent

On trans people accessing healthcare in the UK: 'Trans Health', Ruth Pearce

On taking testosterone in a different way: 'Tesco Junkie', Paul B. Preciado

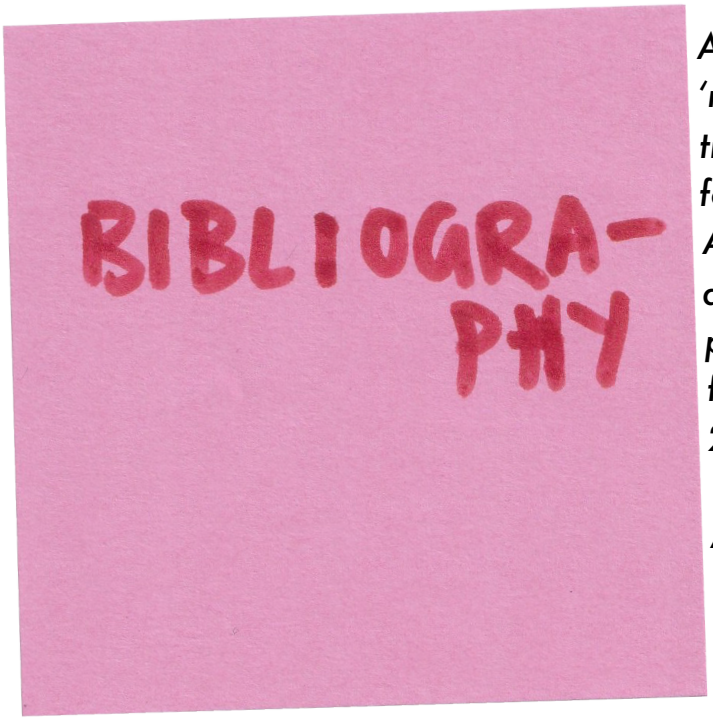
On rethinking the identity of trans: 'Trans Power', Juno Roche

On detransition: 'Stories Behind Reversing a Gender Transition', Mic *https://youtu.be/HbT_DQ0q3hs*

On intersex experiences: 'Intersexion', https://youtu.be/ugd31cXIYzk

On radical trans self love: 'titty tat', Ezra Michel, *https://vm.tiktok.com/ZSqKF3b2/*

On light relief after what may have used up a lot of emotional energy: https://www.colinlievens.com/pleaseclick



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