Four-year old Luke arrives for his first day at infant school. The children are divided into two groups according to gender.

‘But I’m a girl’, says Luke when he is guided towards the boys’ group.

Mrs. Parry, the head teacher, tells him: ‘Don’t be silly’.

‘But why am I a boy?’

‘Because God made you one’.

‘I think God made a mistake’.

Charity Norman, *The New Woman* (2015, pp. 84–85)

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**Continuum and Binary Approaches to Gender**

Heteronormativity, or the binary approach to gender, may assume a variety of beliefs. These can be summarised as follows:

- Gender identity is either masculine or feminine, and the two are or should be clearly differentiated, with hegemonic masculinity the norm for men.
- Anatomical males are or should be masculine in their gender identity while anatomical females are or should be feminine in their gender identity.
- Sexual identity, that is, sexual orientation, is or should be heterosexual. Sexual identity that is not heterosexual is abnormal.
- Marriage is an institution that should only be available to heterosexual males and females.
- It is appropriate to discriminate against those whose gender or sexual identity fails to meet these ‘normal’ standards.

Thus it can be seen that heteronormativity may be descriptive or prescriptive. It is a set of binary beliefs that tells us what gender and sexual identity are as well as what they should be.
In contrast, a spectrum or continuum approach to gender and sexual identity rejects all or most of these beliefs. Those opposed to heteronormativity and in favour of a spectrum approach to gender or sexuality are sometimes not clear whether they regard those men whose gender identity is strongly masculine and whose sexual identity is exclusively heterosexual as in some way flawed, but they do sometimes convey the impression that such men are missing an important ingredient that goes to make up a full life.

The advocacy of a continuum approach to gender identity has a long history. Edward Carpenter, a prominent gay poet and activist, wrote in the last decade of the 19th century, ‘It is beginning to be recognised that the sexes do not or should not normally form two groups hopelessly isolated in habit and feeling from each other, but that they rather represent the two poles of one group – which is the human race; so that while certainly the extreme specimens at either pole are vastly divergent, there are great numbers in the middle region who are by emotion and temperament very near to each other’ (Carpenter, 1984, p. 189). Many of the plays of George Bernard Shaw, written in late Victorian and early Edwardian England, can be seen as strongly opposed to what is now called heteronormativity, or the idea that only heterosexual gender and sexual identity are ‘normal’ (Graham, 2013), thus adumbrating so-called third-wave feminism.

Trans people have a variation of self-identity in which their gender identity is the opposite of their birth gender. The great majority of babies with anatomically male genitalia develop a clear masculine identity. Such an identity may be ‘traditionally’ or ‘hegemonically’ masculine, with beliefs that men should take the important decisions in life and that females should be subordinate and submissive. Such hegemonic masculinity remains widespread worldwide but has become a relatively small component part of the identity among some groups, for example, young heterosexual American males (Casey et al., 2016). Strongly masculine identity is also consistent with the view that women, although equal in status, are nevertheless different from men, not just anatomically but in, for example, their lifestyles, personalities and interests. A number of men do not experience their gender identity as strongly masculine but rather as at some point intermediate between male and female. A small minority, the trans population, see themselves as completely female. This self-perception can be seen as at one extreme of a continuum of agreement or consonance of gender identity with birth or anatomical gender (Clarke et al., 2010, p. 159).

Although the existence of trans people is sometimes seen as supportive of a spectrum or continuum approach to gender identity, this is by
no means necessarily the case. Indeed, the trans experience can be seen as categorically different from the clearly male or female gender identity of the majority of the population, which depends on the gender assigned at birth. The binary approach allows trans people to accept the fact that they are very different from the great majority of others in their gender identity. This means it is easier for them to realise there are others in the same predicament, with whom they can, if they wish, socialise, share and support each other when faced with the common experiences of prejudice and discrimination. Most transgender people themselves endorse a binary approach to gender identity, although if their attachment to this model is weak, they are more likely to show high self-esteem (Iantaffi & Bockting, 2011). It is notable that those opposed to a binary approach frequently quote findings from studies that would not have been possible without the identification of a categorically separate population of trans subjects. All the same, the use of a binary approach in research results in a failure to recognise the considerable complexities of the subject (Johnson & Repta, 2012). The binary approach has been criticised because it fails to recognise the fact that ‘many young people today experience their sexuality as fluid’ (Clarke, Ellis, Peel & Riggs, 2010, p. 152). This position is somewhat weakened by the empirical literature which suggests that, although bisexuality is common among men who have sex with men, it is consistency rather than fluidity that is characteristic of gender and sexual identity in adolescence as well as in adult life (Mock & Eibach, 2012; Savin-Williams et al., 2012; Dodge et al., 2016). Bisexuality is similarly consistent over time, at least in women (Diamond, 2008). This does not mean that the negative discrimination and stigmatisation shown towards those people whose gender and sexual identity does not meet heteronormative criteria is anything but highly objectionable and offensive.

The Development of Gender and Sexual Identity

As we saw in Chapter 2, the development of gender identity and sexual identity occurs sequentially and separately in childhood in two stages, the first from 2 to 3 years and the second, at adrenarche, from around 9 to 11 years (Herdt & McLintock, 2000). Thus the gender script is usually firmly established before the sexual script is formed. Although the concept of a stage approach is useful here, it has been criticised (Clarke et al., 2010, p. 156) because it has been thought to imply that the process of development is entirely innate and genetically determined. The extensive discussion of genetic and environmental influences on gender identity in Chapter 2 makes clear this is by no means necessarily the case.
As we saw in Chapter 2, gender is the first and then rapidly becomes the dominant feature of personal identity to be established in childhood. A small number of children question their gender from an early age. Such questions may only reflect fleeting uncertainties lasting a few weeks or months. Occasionally, however, over a period of several months, sometimes stretching into adolescence, these gender script uncertainties are reflected in cross-gender behaviour. Some boys, even as early as 2 to 3 years, consistently prefer to dress in girls’ clothing; to play with dolls rather than cars, toy soldiers and guns; and to chat with girls rather than play football with other boys. This sort of behaviour was shown by something like 1 in 20 American boys in the 1980s (Green, 1985). Its prevalence in the 21st century is higher probably because of greater acceptance of cross-gender behaviour, although its prevalence is uncertain (Olson-Kennedy et al., 2016). As boys move through primary or elementary school and into high school and adolescence, such cross-gender behaviour usually diminishes; they show more ‘gender-typical’ behaviour. There is, however, considerable continuity in sex-typed behaviour from childhood to early adolescence, from 3 to 13 years (Golombok et al., 2012).

A very much smaller number, currently perhaps 1 in 5,000 anatomical males will show what, until recently, was called ‘gender identity disorder’ and is now termed ‘gender dysphoria’, a term that denotes persistent discomfort with one’s biologic sex or assigned gender (Zucker, Lawrence, & Kreukels, 2016). These have a clear sense they are, in fact, female. They have a strong desire to live and be accepted as a member of the opposite sex, accompanied by a feeling of discomfort about their anatomical sex, especially the presence of male genitalia and the absence of breasts and female genitals. Their gender scripts tell them they are female; their bodies are a constant reminder that their script lacks appropriate evidence.

By mid-adolescence those boys, now presenting to specialist clinics in increasing although still relatively small numbers (Lyons, 2016), will be clearly different from others. Out of school, if not in school they will often dress as girls (transvestism), use makeup and have exaggerated feminine mannerisms. It is now appropriate to refer to them as being transgender. This is a more appropriate term than transsexual, as sexual preference in these individuals varies considerably and may well be heterosexual, homosexual, bisexual or asexual (Blanchard, 1985; Bancroft 2009). The behaviour of trans teenagers marks them out as different from their peers. Their schools, and later, if they enter higher education, their universities, may face problems over, for example, which lavatories they should use and whether to accept the girls’ names they wish to be known by. After school, such individuals may choose to follow occupations usually
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reserved for or with a predominance of women. This might be thought to present problems for prospective employers, and indeed many transgender women do have difficulties finding employment, but a number of commercial firms and public service employers are quite happy to employ transgender women (Jacques, 2010). The fact that they will not become pregnant and require maternity leave may be an attraction. Not infrequently a transgender identity is kept private, a secret that men may try to keep even from other family members. In adulthood such men may be married, although they may covertly dress in their wives’ clothes or have a separate set of female clothing they keep in a secret place. The drive to cross-dress may preoccupy such men to such an extent that their marriage ceases to be viable and breaks down. Most commonly their sexual orientation then becomes homosexual and indeed they may have been bisexual while in their marriages.

A qualitative study of growing up as a trans person has illuminated the lived experience involved (Clifford & Offord, 2007). From a ‘social power’ perspective, the trans child feels different to other children from quite an early age. This feeling of difference is uncomfortable and, throughout the school career, stimulates a number of coping strategies, many involving a combination of secrecy and openness (Clifford & Offord, 2007, p. 203). Eventually a triggering event such as watching a relevant television programme prompts a medical referral which, if sensitively handled, leads to greater self-understanding and the opportunity to exercise choice between a range of possible interventions. This results in a sense of relief as the individual concerned and his or her social circle become acclimatised to the new situation (Clifford & Offord, 2007, p. 209)

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As we saw in Chapter 2, the development of sexual desire at puberty (menarche in girls) is usually preceded by the development of sexual attraction when adrenarche occurs between the ages of 9 and 11 (Herdt & McLintock, 2000). This occurs several years after gender identity, usually firm, occasionally uncertain, is established.

At the age of 9 to 11 years, many trans boys on the threshold of physical adolescence develop feelings of sexual attraction towards other boys, other male adolescents or adult men. A significant minority do not – they have a sexual preference or orientation (see Chapter 2) for girls and women or have no particular preference; they will either be bisexual or asexual. Of 165 trans men studied by Blanchard (1985), 16 were heterosexual, 100 were homosexual, 35 were bisexual and 12 were asexual. Clearly transgender is only weakly associated with sexual preference.
Prevalence of Transgender

The size of the transgender population is small, and estimates of prevalence depend on the method used to identify ‘cases’. Largely based on American studies, it is estimated that there are about 5.8 per 100,000 males to females seeking treatment and about 2.5 per 100,000 females to males. On the other hand, as many as 100 to 700 people identify themselves as transgender on their own report (Collin, Reisner, Tângpricha, & Goodman, 2016). The fact remains, however, that in childhood, adolescence and adulthood the great majority of males see themselves as boys and then men and definitely not as girls and then women. Further, the content of their sexual scripts both in fantasy and in enactment overwhelmingly involves sexual attraction to and sexual desire for people of the opposite sex. While homosexuality and bisexuality are increasing in prevalence (see Chapter 7), the bulk of the population remains unequivocally heterosexual (Mock & Eibach, 2012).

Causation of Transgender

Increasing acceptance of and tolerance towards trans behaviour may be resulting in an increase in self-identification. A significant number of British primary schools now make it clear that if boys wish to wear skirts to school they are permitted to do so (Ramaswamy, 2016). This change in the scenario may bring about a change in the prevalence of this behaviour.

The reasons why some adolescents and boys perceive themselves to be of the opposite gender to their birth gender are unclear. Research has focused on biological influences, and there has been little investigation of psychosocial factors that might be causal (Olson-Kennedy et al., 2016). There is increasing evidence from behavioural genetic studies of identical and non-identical twins that there are genetic influences (Heylens et al., 2012), perhaps reflected in minor differences in brain structure (Guillamon, Junque, & Gomez-Gil, 2016). There may even be anatomical differences between trans men and men in the general population if studies of trans women are any guide. An imaging study found evidence of some degree of masculinisation of pelvic structure in female to male trans people (Sitek, Fijalkowska, Zadzinska, & Antoszewski, 2012). Clearly, however, if there is variation in the prevalence of self-identification as trans between societies or in the same society over time, social factors must be of major importance in determining prevalence.
Transgender and Mental Health Problems

Adolescent and adults with transgender identity are very likely to face incomprehension and then hostility from their parents as well as social exclusion from peer groups at school, university and in their place of employment. Consequently, it is not surprising that they have high rates of mental health problems, especially anxiety, depression and suicidality (Reisner, et al., 2015). Studies of high school seniors suggest that gender non-conformity is a much bigger risk for mental health problems than non-conformity in sexual preference (Rieger & Savin-Williams, 2012). The obvious visibility of gender non-conformity may well be responsible for this difference. Efforts to reduce discrimination and increase social support improve the quality of life of people with gender dysphoria and are likely to reduce their risk of suffering mental health problems (Basar, Öz, & Karakaya, 2016).

Hormonal and Surgical Interventions for People with Transgender

Some transgender adolescents and adult men wish to have their anatomy altered to fit their gender identity. They have an intense desire for their anatomy to tell the same story they tell themselves about their gender, their sense of being female, not male. This wish to look like a woman may also arise because of a strong awareness of a preference for sex with men accompanied by a feeling that sex with a man would feel more appropriate in the body of a woman. For whatever reason it is desired, the wish for surgical intervention raises many medical, psychological, hormonal, surgical and, at least as important as any of these, ethical issues.

The status of interventions to enable men who wish for anatomical change to fit their bodies to their sexual scripts is controversial and problematic. Before mid-puberty, the situation is reasonably clear-cut. If, before this age, only a fifth of boys who want to be girls retain this desire into late puberty, then it is clearly quite wrong to allow irreversible anatomical changes or perhaps even to allow reversible interventions with sex hormones. Once early adulthood is reached, numerous studies suggest it is very unlikely that a man who wants to transform into a woman is going to change his/her mind. The gender script is reasonably firmly fixed. Such men are now almost always referred to specialist clinics for people with ‘gender identity disorder’ or ‘gender dysphoria’. At such clinics it is likely they will undergo extensive physical
and psychological assessment (Sherer, Rosenthal, Ehrensaft, & Baum, 2012). Almost invariably it is found they are physiologically completely male and have no physical abnormalities to account for their wish to be women. Hormones and brain function give no clues to their anomalous sexual identity. They may well, however, have mental health problems such as depression or anxiety relating to their frustration at not having a woman’s body.

In these circumstances, most specialist clinics will suggest feminising hormone therapy in the first instance. Such hormones result in a moderate enlargement of the breasts, a reduction in facial hair and a redistribution of body fat to the hips and buttocks. Surgery to the vocal cords to raise its pitch is still at an experimental stage, although working on pitch production with a speech and language therapist can be helpful. These changes, together with the efforts the man makes to change appearance by dress and makeup will allow him to have a ‘real life’ as a woman. If, after a year or more living as a woman in real life has been successful, then she (for this is now the more appropriate personal pronoun) is usually referred for consideration of surgical treatment. Surgical reassignment can involve amputation of the penis, with the construction of a new orifice for the passage of urine, surgical removal of the scrotal sac and testicles, vaginoplasty (the construction of a vaginal opening), clitoroplasty and labioplasty, the creation of a realistically female appearance to the external genitalia. All these procedures may produce physical and psychological complications. Most women, however, feel pleased they have had the operation.

A year after hormone therapy, followed by surgical treatment by a highly specialist, multi-disciplinary team, gender dysphoria in trans people is improved, and they show no more psychological difficulties than others of the same age in the general population (de Vries et al., 2014). Longer-term follow-up studies are also encouraging, with good results in most male to female transgenders following sex reassignment 10 to 24 years after intervention. Most are in a job, partnered, and have a positive evaluation of their intervention (Ruppin & Pfafflin, 2015). The quality of the relationships the individual has had before operation may be considerably changed, however – sometimes strengthened, sometimes virtually destroyed. So such women may continue to need some form of counselling (de Vries et al., 2014).

A number of trans men who have previously had a sexual preference for women will, after operation, develop a preference for men (Daskalos, 1998). Lawrence (2003) found that prior to operation, 59% of trans men had sexual preferences for women, with only 9% towards
men. After operation, 25% were sexually attracted to women and 34% to men. This change in sexual preference may be attributed to emerging female gender identity or to the effect of exposure to female sex hormones.

**Gender and Sexual Scripts in People with Transgender**

Studies of the development of trans males therefore confirm the relative independence of gender and sexual scripts. It is sometimes assumed that gender identity, or gender script, determines sexual orientation or sexual preference, important components of the sexual script. Certainly, male appearance usually accompanied by a masculine gender identity brings with it social pressure from the self and others for a heterosexual script. The experience of attraction to people of the same sex may bring with it a sense of confusion. The wish to conform to social pressure will sometimes result in efforts to deny the direction of sexual attraction. Mostly such efforts will be at best temporarily successful (see Chapter 7). For trans adolescents, negative emotional experiences will be heightened by the fact that not only the sexual but also the gender script is dissonant to social and personal expectation. In the UK, the passage of the 2004 Gender Recognition Act has made a very significant improvement to the lives of such women by giving them the same legal rights as birth females.

**In Summary**

- People who are transgender, male or female, believe their ‘real’ gender is the opposite to their anatomical gender.
- This belief often, but by no means always starts between the ages of 3 and 6 years at the time of the development of gender identity.
- Some young people lose their trans beliefs in adolescence, but once adulthood is reached transgender identity is usually, but not always, fixed.
- The sexual scripts of trans people are very variable. Males who believe themselves to be female may prefer same-sex or opposite-sex intimate relationships, or they may be bisexual.
- Surgical treatment in adulthood transforming anatomy according to the wishes of the trans person is generally at least reasonably successful.
- After such male-to-female interventions, the preference for sex with men often increases.
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- Trans people often experience hostility, stigmatisation and abuse at home, school and/or in their place of employment.
- Consequently, they have a high rate of mental health problems.
- Appropriate counselling and the availability of supportive groups reduce the level of mental health problems.