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Gender Identity Disorder : A Misunderstood Diagnosis

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Gender Identity Disorder: A Misunderstood Diagnosis

**Thesis submitted to
The Graduate College of
Marshall University**

**In partial fulfillment of the
Requirements for the degree of
Master of Arts
Sociology**

by

Kristopher J. Cook

**Committee Members:
Dr. Richard Garnett, Committee Chairperson
Dr. Ken Ambrose
Dr. Elaine Baker**

Marshall University

2004

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Acknowledgments and Dedication

For Jill – The best sister, the best friend, and
the best support system anyone could ever have.

I love you.

To Mom and Dad – Thank you for making me the person I am,
and for shaping the person I have become.

I love you both.

To Mark – A true friend. My best friend. Thank you for
everything. I love you.

Bethany – There aren't enough words in the world
to describe how I feel about you.

Just know that I love you with all my

heart and soul.

Thanks for all your help.

This is dedicated to all transsexuals everywhere.

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Preface

I started researching this topic because I wanted to learn more about myself. This thesis started to be about my personal journey from a person I did not know at all into someone I longed to be, but something happened during my journey. Through school and through work, I met some extraordinary people. People that changed my life forever. It is because of these people I switched the focus from myself into helping out other individuals that are going through now what I went through so many years ago. I remember the confusion of not knowing who or what you are, the suicidal thoughts/attempts, the feelings of isolation; the list can go on and on. But unlike so many of the transgendered people I met through this journey, I was lucky enough to have a support system, the resources, and the education that, without them, I would not be here today. It took me ten years to complete my journey. It took me ten years to finally find peace. I only hope that this helps someone going through this journey the same way that so many people helped me through mine.

Abstract

“Gender Identity Disorder: A Misunderstood Diagnosis”

by Kristopher J. Cook

A transsexual is defined as a person who strongly identifies with the opposite sex. This is also known as gender identity disorder. The individual may identify with the opposite sex to the point of believing that he or she is, in fact, a member of the opposite sex who is trapped in the wrong body. This causes the person to experience serious discomfort with his or her own biological sex. A person with gender identity disorder may or may not know that they actually have a disorder. Not knowing they have this disorder, they can't explain the problems they experience in school, work, or even social settings. This research examines the history of transsexualism, the diagnostic criteria, and the theories behind gender identity disorder. It addresses the ever-present question of choice and it also explains why transsexuals, who are only striving to be happy with their true selves, are so easily misunderstood.

In the United States during the 1950's and 1960's, transsexuals were viewed by society as people who were mentally disturbed, weird, or immoral. They were thrown out of church communities and some were even shunned by their families and friends. The community as a whole did not understand the idea of transsexualism, nor did it condone the lifestyle of transsexualism. Transsexualism has come a long way from the stigmatism that it gained in the past, breaking through the old psychological treatments and giving definition to the idea of choice by using case studies to prove that transsexualism is treated by feeding the need.

What is a transsexual? A common answer is: "Someone who has the feeling that they are a different sex than the one that they were born – to some extent" (Stein, 1999). In fact, this is probably one of the hardest of all questions to answer because there are so many different meanings given to the word. The definition of transsexual that we have adopted comes from Ramsey (1996); it is as follows:

Transsexual: One who self-identifies opposite their birth sex.

Transsexuals often alter their bodies via surgery and/or hormones.

This includes those who go from male-to-female (MTF) and female-to-male (FTM). Consists of those yet to have surgery (Pre-Op) and those who have had reassignment surgery (Post-Op).

The word is really a way of grouping many different aspects of lifestyle. Gender identity, social behavior and even medical conditions are under an umbrella term known as transsexualism. That is how the word originated, and unfortunately, derivatives of the

word have been used in other ways such as “Transgenderist,” which refers to the individual, to something quite specific within the broader meaning of the word “transgender,” which refers to the groups classified under this term.

From my experience, one of the most difficult problems that the “transgendered community” has to address is that it is extremely difficult to get five transgendered people in one room to agree on what they mean in describing themselves. Because transgendered people are not usually seen in mainstream society, it is easy to misunderstand them as people. The usual image of a transgendered person that most people have is one of an actor, employed to stage a controversy on a US television chat show.

The reality is quite different. The overwhelming majority of transgendered people are intelligent, successful and worthwhile people who just happen to think differently from the other 95% of the world population (Stein, 1999) about who and what they are. While transgender does not imply sexual variation (gay, lesbian, bisexual, etc.), there are links between the way homosexuals were treated by the medical profession and legislators in the past and how transgendered people are considered now.

To understand the transsexual today, it is best to start by looking at how the transsexual was viewed in the past. Transsexualism has been recorded in history since the time of the Greeks and has been observed throughout Europe, Asia and the Americas. A number of studies about cultures that have been relatively untouched by Western civilization have identified transgendered behavior in these cultures. In many cases,

transgendered people in these cultures are fully accepted and often highly valued members of their community.

Bornstein (1994) starts with the classical and often cited cases: The Hijra of India, Berdaches amongst Native North Americans and some celebrated individual cases in Europe. It is interesting to note that while these groups exhibit strong variant behavior in their gender expression, they have often been claimed by the gay movement as validation of their sexuality as a persistent cross-cultural phenomenon.

The Gallae were people in ancient Greece, Rome, and Persia who displayed some kind of gender or sexual variance. The ancient mythology was replete with stories of those we now call transgendered people, which clearly indicates that transgender was something that was commonplace in those times (Bornstein, 1994). The Gallae were also represented as gifted and talented people throughout these legends. Some people, such as Tiresians, were credited with the power to change sex at will. Most people would know of the eunuchs of Rome and would probably have heard that several Roman emperors were cross-dressers or even more inclined towards being what we would now call a transsexual (Bornstein, 1994).

On the Indian sub-continent Hijra, where the people are viewed as a separate caste, have had a long tradition of being recognized as transgendered. They have been variously persecuted and revered, repeating the stories from elsewhere in the world. The major focus on the Hijra these days is to raise the world's consciousness about persecution of this minority. In some ways, this group is viewed as a third gender and in some they are viewed as a separate sub-culture. It is clear that the Hijra practiced

castration and have taken steps to change their bodies to a more female look (Bornstein, 1994).

The Berdache or Winkta of the Native North American nations are people who were born male or intersex and chose to live as women. The Navajo recognized a third sex, the Nadle, for those who did not fit either male or female. In these cultures the transgendered person was revered and usually played a major part in keeping the oral history of their people alive. A particularly painful method of self-castration was practiced; the person would ride an especially hardened saddle for days until the testicles were crushed (Bornstein, 1994).

The seventeenth, eighteenth, and nineteenth centuries in Europe provide hundreds of detailed accounts of both male and female transgendered people. Joan of Arc, King James I of England, Chevalier D'Eon, Edward Hyde, and many others are famous instances. There were even Popes who were known to be women (Bornstein, 1994).

The medical professions in the nineteenth and twentieth centuries chose to see transgendered people as “someone with a problem” because they did not conform to the social norms of the time. This parallels the way homosexual people were treated and many governments in the Victorian period passed legislation to make both homosexuality and impersonating a woman (or man) a crime (Bornstein, 1994). Bornstein also goes on to report that the evidence from before the middle-ages suggests that as in other cultures transgendered people were not only tolerated but also frequently held in honored company. In the past two hundred years, there have been many thousands of reports that showed a deceased man or woman having had a different set of genitalia than would have

been expected. These reports have been quite consistent during that time and have common characteristics where the person concerned lived a conventional life in the role of their own choosing and were rarely suspected of being otherwise than they presented. Transgender is identified in all cultures regardless of the level of acceptance within that culture. Fewer people are inclined to identify as transgendered in places where they may be socially ostracized or even imprisoned, but they still exist. This has been observed to remain the case over a long period of history.

Transgendered people of all types are evenly distributed across the social spectrum and across occupational groups as well (Ramsey, 1996). There seems to be no discrimination in nature against transgendered people. If anything transgendered people are likely to be above average in intelligence and social standing than the general community. The fact that transgendered behavior occurs in other primates seems to add considerable weight to the argument that this is simply a part of human nature. Once again there is a parallel with homosexuality, which is now widely recognized, as fundamental to the human condition (Stein, 1999).

How many transgendered people are there? This is difficult to say because there are no census data to confirm the estimates. Estimates of the ratio of male-to-female transsexuals in the United States are between 1:100,000 and 1:30,000. Corresponding estimates for female-to-male transsexuals are between 1:400,000 and 1:60,000. The estimates that have been made over the years have been progressively revised upwards and this trend is likely to continue (Sullivan, 1990).

The ratios for the number of male cross-dressers in the United States vary from 1:400 and up to 5% and somewhere between 1:1000 and 1:100 for females. This shows that cross-dressing is far more prevalent than transsexualism, but the figures for cross-dressing are even more difficult to verify because much cross-dressing behavior occurs in private. There are not even medical records that might be examined to get a better understanding of the true numbers (Sullivan, 1990). No discussion of transgender would be complete without a look at the differences and relationship between sex, gender identity and gender role. Sex is biologically determined and is nearly always unambiguous. Some intersexed people do exist who are frequently assigned an arbitrary sex at birth and are surgically modified to match that assignment, in the contemporary United States. We call people male or female and sometimes hermaphrodite for intersexed people (this is often a vexing issue for the people themselves).

The primary characteristics that identify males and females at birth are the genitals. It is worth noting that all embryos developing in the womb start off female and it is a complex interaction of hormones during certain critical weeks that ultimately determines the sex of the baby. The concept of gender develops as a child reaches the age of three. There they identify themselves and others as either a boy or girl. This is largely based on what they are told and it takes until the age of five or six before a child can properly connect gender identification with body characteristics. In most cases a child's gender identification corresponds with their anatomy, but not always (Volkan & Masri, 1998).

It is usually impractical to identify people's gender by inspecting their genitals (and young children find that they get into trouble for trying to do so), so children will identify gender by the clothes the other person wears and will start to develop the ability to pick gender from secondary characteristics such as the existence of breasts indicating that a person is a woman, or large muscles and a hairy body, indicating that the person is a man. At the age of seven or eight children start to understand gender roles. They identify clear cut concepts such as women have babies and develop this further to include family determined concepts as men mow the grass and women do the cooking. Such concepts become solidified during puberty and adolescence (Volkan & Masri, 1998).

So there is biological sex and there is gender. Gender is split into identity and role. Feinberg (1998) brings up three very important questions:

1. Are there only two sexes?
2. Are there only two genders?
3. Is the assumption, that a person's sex and gender must match in order for that person to be happy, actually true?

Feinberg (1998) states that there are many cultures in this world that see the need for three or more sexes to adequately explain the natural variation in the human body. The bipolar (male or female) model is not born by the reality that some people may both impregnate and be impregnated. There is ample evidence that there are more than just two genders recognized in many of the cultures in the world. Researchers see the need for five genders to adequately describe the naturally occurring gender identifications that are observed (male, female, and three kinds of intersex). It is clearly not true that a

person must have a gender that matches her/his sex. The existence of people who are clearly happy to have a gender identification and role that is different from their sex demonstrates otherwise. Also, it is not logically possible to have five genders and three sexes, in that case, as it has been suggested by several prominent researchers into gender (Feinberg, 1998). The reality is that there is a cultural norm in Western societies that says that gender and sex must correspond. It is believed that people who do not have that correspondence are intrinsically unhappy and must be treated to help achieve that correspondence. Research has shown that there is a large number of people who live in a gender role that does not correspond with their genitalia and that overall these people are quite happy with their lives on a long-term basis (Feinberg, 1998). In fact, these people are generally happier with their life than those who have sought surgical assistance to change their bodies to be more like the “opposite sex.” They are also at least as happy with their lives as those whose sex and gender correspond.

Because most members of society in their daily lives do not recognize transgendered people, transgender is not something that most of the population has direct experience with; this phenomenon is termed social invisibility (Sullivan, 1990). People who might identify with any of the diverse meanings of transgender are, for many reasons, not inclined to advertise their identity. The groups that are seen are almost exclusively the high profile transsexuals who make their lives public property (e.g. Renee Richards and Christine Jorgenson) and the “drag queens” that often make their living from theatrical shows where they focus on a glamorous image and frequently parody of women. Media representations on transgender are limited to a few films with a theme

that depicts a transgendered person and the “chat show” set-ups where actors play the role of a supposedly transgendered person. The chat shows only reinforce the common view that transgendered people are weird and have problems. This is the public image of transgender. The print media and news services do not pay much attention to transgendered people unless they are victims of violence or there is some kind of sex scandal. A very small number of people will have had contact with a person who they know has changed gender or is openly cross dressing in public. As a result of this lack of understanding of transgendered people as real people, the views of the conservative organizations, the medical professionals, and the chat shows prevail.

In the face of these views and the general feelings of guilt and social disapproval, most transgendered people keep any expression of their feelings private. At the most a few close friends and family members have any idea of their feelings. People who cross dress infrequently are particularly likely to wish to keep their activities secret. Even those transsexuals who have made the choice to live permanently in a different gender usually choose to remain invisible, rarely discussing their past. This is largely because they prefer to have a less complicated and stressful life and not make it difficult by emphasizing that they are transsexuals.

There is a gradually increasing knowledge of transgender as the greater number of people who are publicly visible as transsexuals transitioning in the workplace and films such as The Crying Game encourage transgendered people to talk to friends about their feelings. However, the vast majority of people who have gender variant feelings do not display them in public and make considerable efforts to keep them very private. This

makes it nearly impossible to accurately estimate the numbers of people with these feelings or even those who have a need to express them.

Social invisibility also makes it nearly impossible to conduct meaningful sociological and psychological surveys, which are inclusive of a broad cross-section of transgendered people. This contributes to the difficulties of finding a cause for transgenderism and properly understanding the interrelationship between the different forms of transgender feelings and behavior.

Why do males who can be easily accepted as a man put themselves through so much pain and social disapproval to appear to be a woman? And why do females who are very attractive as women, want to live as men? Why do these things? They feel that is right for them, usually after a great deal of soul-searching and self-analysis. It is not because these people are crazy or profoundly deluded.

Gender identity variance makes a mockery of prevailing community standards in many ways. Perhaps it is this threat to those standards that explains why so many people feel the need to attack people who express any gender variance. One of the ways in which people express gender variance is transsexualism.

The word transsexual was first used by Dr. Harry Benjamin to describe a particular type of cross-dresser who wanted to live life in an “opposite gender role” in the early 1950’s. This type of person was distinguished from the class of transvestite by having no apparent erotic stimulation from cross-dressing and this was considered a more “worthy” cause than the supposedly sexually “deviant” feelings of the transvestite (The Harry Benjamin International Gender Dysphoria Association [HBIGDA]).

Transsexuals are often viewed as a separate class of people by comparison with others with gender variance, but may also be seen as another form of expression of an underlying discomfort with the sex and gender assignment and roles they received in childhood. The one clearly distinguishable feature that identifies transsexuals is their desire to modify their bodies with hormones and usually surgical procedures to make their bodies more in line with what they want them to be.

Since transsexualism is the condition that is most intensively treated by the medical profession, the scientific literature contains more about this sub-group than any other. There have been many attempts to define this condition and to establish categories within the sub-group for the purposes of treatment modalities (that is, a script to follow for diagnosis and treatment). As a result, there is further fragmentation and there are value judgments made according to how a transsexual is classified. Diagnostic categories such as primary and secondary transsexual are evaluations at the time of diagnosis by a clinician that suggest the degree of “seriousness” of the condition and its root source (HBIGDA).

A primary transsexual is considered to be a person who has persistently, from an early age, believed him or her to be “in the wrong body.” A secondary transsexual is defined as one who comes to realize their “true nature” at a later age and usually does so via a path of cross-dressing (HBIGDA). A more practically based classification is male-to-female and female-to-male to identify what sex the person started as and what they seek to become. For the moment, we will not consider whether it is actually possible to

change sex rather than change gender roles and have one's body look and function concordantly (i.e. as the casual observer would expect).

Transsexuals are seen as following a defined path (HBIGDA):

1. Pre-operative where the person learns to live in their chosen gender and takes hormones to change the secondary sexual characteristics of her/his body.
2. Real life test where the person is evaluated for their ability to succeed in their chosen gender role.
3. Genital reconstruction or gender reassignment surgery (GRS/SRS) to adjust their sexual presentation.
4. Post-operative where the person lives in their gender role after surgery to "correct" their primary sexual characteristics.

Some of the more common things that a transsexual is likely to do to change their body are identified here. Male-to-female transsexuals and female-to-male transsexuals have differing needs and the options available are of differing effectiveness so they are listed separately.

Female-to-male

- Take testosterone (the male gonadal hormone) to suppress menstruation and estrogen production. This, over time, deepens the voice, causes facial hair to grow and increases density of body hair. Function of the genitals may change and the clitoris may grow. It does not alter bone structure.

- Mastectomy to remove inconvenient breasts.
- Hysterectomy to remove ovaries and uterus.
- Possible phalloplasty (GRS).

Male-to-female

- Take estrogen (the female gonadal hormone) and an anti-androgen (suppresses testosterone). This allows breast development to occur and a more feminine body shape to develop. It suppresses body hair but not facial hair. It does not alter voice pitch nor bone structure.
- Remove facial hair by electrolysis or laser treatment where necessary.
- Often, less than 40% of cases, breast augmentation is desired.
- Vaginoplasty and labioplasty (GRS).
- Other cosmetic surgery including facial surgery and liposuction.

Overall, the desirable effects of hormone treatment are more effective for female-to-male transsexuals but the surgical outcomes of GRS are much less effective. The cost of all the procedures identified above will often exceed \$35,000. People who identify themselves as transsexuals often seem to separate themselves from those who are not intending to permanently change their gender role or seek GRS/SRS. Many see themselves as driven to change their bodies to match their mind without compromise

while others seek an intermediate state of being that recognizes the balance they seek in their lives. Clearly, the changes that transsexuals seek to make to their bodies and how they live their lives are very challenging to most other people. This may be especially so for family and friends who see the person that they once knew change before their eyes and possibly become a stranger.

The following are some interesting things that have been noted about transgendered people (Transsexual Women's Resources):

- Transgendered people are, overall, more intelligent than the community average and display a higher degree of creativity. This is similar to findings that show that gay and lesbian people have higher intelligence, creativity, and earn more than average. Transgendered people are even more so. This may be partly because it takes more than average amount of personal resources to be openly (one cannot effectively measure anything on people who are unidentifiable) transsexual.
- Transsexuals (those who wish to change their bodies to match their gender identity) make up about 1 in 30,000 people in the community. This has changed from estimates of more than 1 in 100,000 in the 1950's as more people of all age groups have sought medical assistance to change their bodies (therefore identifying themselves).
- Estimates of the number of people who are transgendered vary from 1 to 2000 to as high as 5% of the population. More than 50% of the male population has probably cross-dressed at some time in their life.

There is little evidence that gender identification and sexuality are linked in any casual way or other way. There is a common misconception that they are but no link between the two has been found. The one link that is clear is that people with different gender expression and different sexuality are subjected to similar abuse and disapproval from certain sections of the population.

In the late nineteenth and twentieth centuries, it was believed that homosexuality and bisexuality were psychiatric disorders. What we might call transgendered behavior was considered a sub-set of sexual disorders. The view that transgender behavior is a psychiatric disorder has taken longer to disappear from literature. Many professionals still believe it to be a disorder and treat people accordingly.

A mental health professional makes a diagnosis of Gender Identity Disorder by taking a careful personal history from the client/patient. Upon finding that the patient does have this diagnosis they then must follow the Standards of Care for Gender Identity Disorders (see Appendix) to pursue treatment. No laboratory tests are required to make a diagnosis of Gender Identity Disorder. However, it is very important not to overlook a physical illness that might mimic or contribute to a psychological disorder. If there is any question that the individual might have a physical problem, the mental health professional should recommend a complete physical examination by a medical doctor. Laboratory tests might be necessary as a part of the physical workup.

Frequently, people with Gender Identity Disorder complain that they were born in the wrong sex. They describe their sexual organs as ugly and may refrain from touching

their genitalia. Although the genitalia of people with Gender Identity Disorder are normal, those with the disorder may show signs of trying to hide their secondary sex characteristics. For instance, males may try to shave off or pluck their body hair or take female hormones in an effort to enlarge their breasts. Females may try to hide their breasts by binding them close to their chest walls.

Before a diagnosis of Gender Identity Disorder can be assessed, one must first to attempt to define what a disorder is. This is not an easy subject on which to build a consensus. The most common definition used to describe and outline gender identity disorder is: A psychological condition characterized by “distress, disability and disadvantage.” Clearly, this is a standard by which Childhood Gender Identity Disorder could qualify as a disorder (American Psychiatric Association [APA], 1994).

The Diagnostic and Statistical Manual of Mental Disorders (forth edition), also know as the DSM-IV (APA, 1994) which is used to diagnose this disorder, defines Gender Identity Disorder as follows:

Gender Identity Disorder

Diagnosis and Prognosis

Definition

Gender identity disorder denotes a strong and persistent desire to be of the other sex (or the insistence that one is of the other sex), together with persistent

discomfort about one's own sex or a sense of inappropriateness in the role assigned to one's own sex.

Diagnostic criteria

DSM-IV criteria

The DSM-IV diagnostic criteria for gender identity disorder are divided into four criteria. The disorder is subdivided on the basis of age and on the basis of sexual attraction.

Criterion A

There must be a strong and persistent cross-sex identification (not merely a desire for a perceived cultural advantage of being of the other sex.)

In children, there must be at least four of the following features:

- A repeatedly stated desire to be of the other sex or an insistence that one is of the other sex;
- In boys, a preference for cross-dressing of simulating female clothing and attire;
- In girls, an insistence on wearing only stereotypical masculine clothing;
- Strong and repeated preferences for cross-sex roles in make-believe play or persistent fantasies of being of the other sex;

- An intense desire to participate in the stereotypical games and pastimes of the other sex;
- A strong preference for playmates of the other sex.

In adolescents and adults, the disorder is manifested by such symptoms as:

- A stated desire to be of the other sex;
- Frequent passing of oneself as being of the other sex;
- A desire to live as or be treated as the other sex;
- The conviction that one has the typical feelings and reaction of the other sex.

Criterion B

There must be persistent discomfort with one's own sex or a sense of inappropriateness in the role of one's own sex. In children, the disorder is manifested by any of the following symptoms:

- In boys, the assertion that the penis or testes are disgusting or will disappear; an assertion that it would be better not to have a penis; an aversion to 'rough-and-tumble' play; or a rejection of male stereotypical toys, games and activities;
- In girls, a rejection of urinating in the seated position; an assertion that she has a penis or will grow one; an assertion that she does not want to grow breasts or to menstruate; or a marked aversion to feminine clothes. In adolescents and adults, the disorder is manifested by such symptoms as:

- A preoccupation with getting rid of primary and secondary sex characteristics (e.g. requests for hormone treatment, surgery or other medical procedures to alter sex characteristics in order to simulate the other sex);
- A belief that one is of the wrong sex.

Criterion C

The disturbance must not be concurrent with a physical intersex condition.

Criterion D

The disturbance must cause significant distress or functional impairment.

Subtypes based on age

The disorder is coded on the basis of the current age of the patient:

- Gender identity disorder in children;
- Gender identity disorder in adolescents or adults.

Subtypes based on sexual attraction

In sexually mature patients, the disorder is divided into:

- Sexually attracted to males;
- Sexually attracted to females;
- Sexually attracted to both males and females;
- Sexually attracted to neither males nor females.

ICD-10 criteria

ICD-10 gives diagnostic criteria for three separate disorders under the category

‘Gender identity disorders’:

- Transsexualism;
 - Dual-role tranvestism;
 - Gender identity disorder of childhood.
-

Symptoms and signs

The principal symptoms are:

- A strong, persistent cross-sex identification – a desire to be or a feeling that one is of the other sex;
- A persistent discomfort about one’s own or a sense of inappropriateness in the role of that sex.

By definition, the disorder must cause significant distress or functional impairment.

Common behavior in male children

Common behavior in boys with gender identity disorder include:

- A preoccupation with traditionally feminine activities;
- Wearing girls’ clothes or simulating girls’ clothes if no clothes are available;

- A particular interest in female characters on television or videos;
- Playing with stereotypical girls' toys;
- Avoidance of stereotypical male activities (rough play and competitive sports);

- Little interest in stereotypical boys' toys;
- Sitting to urinate;
- Pretending not to have a penis;
- Expressing a wish to be a girl or a belief about growing up to be a woman.

Common behavior in female children

Common behavior in girls with gender identity disorder include:

- A preference for boys' clothing and short hair, a strong aversion to feminine attire;
- A preference for stereotypical male activities and rough-and-tumble play;
- An identification with powerful male figures in stories and television programs;
- Standing to urinate;
- Claiming to have a penis;
- Expressing a wish to be a boy or belief about growing up to be a man.

Common behavior in adults

Common behavior in adults with gender identity disorder include:

- A preoccupation with a desire to live as a member of the opposite sex;
- Adoption of behavior, dress, and mannerisms of the other sex (to

various extents).

Men may display breast enlargement, hair denuding, and other physical changes from hormone ingestion or depilation.

Women may have distorted breasts or breast rashes from wearing breast binders.

Common behavior in adolescents

Adolescents with gender identity disorder may display features that are usually seen in children or adults depending on the age and developmental level of the adolescent. Diagnosis in early adolescence in particular may be difficult.

Investigations

The diagnosis must be primarily based on the clinical history. A full physical examination must be performed.

No diagnosis tests are available, although psychological testing may provide evidence of identification with the other sex.

Karyotyping for sex chromosomes and sex hormone assays are usually not indicated if the physical examination is normal (unless hormonal or surgical sex reassignment is to be considered).

A routine electroencephalogram should be performed at least once in transsexual patients to rule out temporal lobe epilepsy.

Complications

Complications of gender identity disorder include:

- Social isolation, ostracism or ridicule, which may result in low self-esteem or dropping out of school (this is more common in males than females);
 - Impaired social relationships, in particular poor same-sex relationships with peers;
 - Family difficulties, difficulties relating to parents, marital problems;
 - Anxiety, depression and suicidality, which are common in children, adolescents and adults with the disorder;
 - Sexually transmitted diseases, especially in males, in whom prostitution is moderately common;
 - Substance misuse;
 - Legal problems, including increased criminality, difficulties with legal definitions of 'male' and 'female';
 - Medical problems, including infection, injury or death from self-inflicted body changes and self-prescribed hormones.
-

Differential diagnosis

The differential diagnosis of gender identity disorder includes:

- Non-conformity to stereotypical sex role behavior without any profound disturbance in sex identity (such as ‘tomboyish’ behavior in girls or ‘sissy’ behavior in boys);
 - Transvestic fetishism – cross-dressing for sexual excitement rather than from a feeling of being like a member of the other sex;
 - Schizophrenia or another psychotic disorder, in which the patient may have delusions of being of the opposite sex;
 - A physical intersex condition (e.g. androgen insensitivity syndrome, congenital adrenal hyperplasia) plus gender dysphoria (which would be diagnosed as a gender identity disorder not otherwise specified).
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Prognosis

Course in children

In children who come to medical attention, the onset typically occurs between the ages of 2 and 4 years. Presentation is typically at the time the child starts school.

It is rare for gender identity disorder to persist into adulthood; the cross-sex behaviors tend to diminish over time and in response to parental or medical intervention and peer pressures.

By late adolescence, about 75% of males who had a childhood history of gender identity disorder have a homosexual or bisexual orientation without features of gender identity disorder. The remaining 25% report a heterosexual orientation, again without features of gender identity disorder. (The corresponding figures for sexual orientation in females are not known.)

Course in adults

There are two distinct patterns of gender identity disorder in adults:

- A continuation of gender identity disorder that began in childhood or adolescence;
- An onset in early to mid-adulthood usually after or concurrent with transvestic fetishism.

Patients with childhood – or adolescence – onset gender identity disorder are more likely to request sex-reassignment surgery and more likely to be satisfied with the results of surgery.

Males with gender identity disorder who are sexually attracted to males tend to have a lifelong history of gender identity disorder and typically present for treatment earlier than others.

The course in adults tends to be chronic, with cyclical variations in many cases. Spontaneous remissions have been reported.

The majority of well-screened transsexuals who have had sex reassignment treatment report positive outcomes in terms of well being, happiness, and psychosocial adjustment.

Better surgical results predict better postoperative adjustment.

Treatment and outcome

Treatment aims

The aim of treatment in children is to develop social skills and comfort in the biological sex role.

The aim of treatment for non-sex-reassignment candidates is to encourage acceptance of the biologic sex and increased ability to function within it.

The aim of hormonal treatment in males is to increase the patient's physical resemblance to female norms (e.g. breast enlargement, feminization of body contour and skin texture, decrease in body hair and facial hair).

The aim of hormonal treatment in females is to increase the patient's physical resemblance to male norms (e.g. cessation of menses, increase in hair and muscle mass, clitoral growth, voice deepening).

The aim of treatment for transsexuals is achieve effective functioning in society as a member of the opposite sex.

Pharmacological treatment

No pharmacological treatments exist for children.

Pharmacological treatment has not been effective in reducing cross-sex desires in adults.

Hormonal treatment

Standards of care for hormonal treatment of gender identity disorder have been developed and should be followed.

The wearing of cross-sex clothing in daily life under psychiatric supervision for at least 1 year is advised before beginning hormone treatment.

Hormonal treatment for adults (estrogens** for men, androgens** for women) modifies physical sex characteristics to agree with the patient's sex identity (i.e. sex reassignment).

Hormonal treatment should ideally be accompanied by an ongoing psychotherapeutic relationship with the patient for a minimum of 3-12 months.

** off-label use

Many effects, such as deepening of the voice in women, may be irreversible.

Blood chemistry monitoring is required, including liver function tests, prolactin levels, and hormone status and serum lipids.

Standard dosage

Estrogens for men (may take 2 years or more to achieve maximal breast growth).

Androgens (testosterone) for women.

Contraindications

Estrogens are contraindicated in:

- Active or past thrombophlebitis, thrombosis or thromboembolic disorders;
- Known or suspected estrogen-dependent neoplasia.

Estrogens should be used with caution in:

- Asthma;
- Epilepsy;
- Migraine;
- Cardiac disease;
- Renal impairment;
- Hypercalcemia;
- Diabetes mellitus and glucose intolerance;
- Depression.

Androgens are contraindicated in:

- Coronary heart disease;
- Severe liver damage.

Main side effects

The main side effects of estrogens include:

- Elevated liver enzymes;
- Loss of libido;
- Mood disturbances;
- Hyperprolactinemia;
- Nausea and vomiting;
- Fluid retention;
- Hypertension;
- Thromboembolic events;
- Coronary heart disease;
- Malignant tumors.

The main side effects of androgens include:

- Acne;
- Elevation of cholesterol and triglyceride levels;
- Libido changes;
- Nausea;
- Jaundice;
- Alterations in liver function;
- Thromboembolic events;
- Sodium and fluid retention;

- Headache;
- Anxiety;
- Depression.

Main drug interactions

Androgens should be used with caution when given with anticoagulants, oxyphenbutazone or insulin.

Non-pharmacological treatment

Non-pharmacological treatments that have been used in gender identity disorder include:

- Psychotherapy, which may be helpful if aimed at helping patients to accept their biological sex and to function within it;
- Behavioral treatment, which can reduce cross-sex behavior in children;
- Supportive and skills-development psychotherapy, which is vital for candidates for hormonal or surgical sex reassignment;
- Sex reassignment surgery;
- Therapies that aim at changing the patient's disturbed sex identity structure (these therapies usually fail);
- The associated emotional and behavioral difficulties must be treated, particularly in adolescence. Treatment and prevention of the emotional and

behavioral problems are essential, even if the atypical gender development remains unchanged.

- Family therapy can include guidance to parents, involving them in individual and family therapy.

Follow-up and management

An ongoing therapeutic relationship is required for patients who are receiving psychotherapy.

After hormone or surgical sex reassignment, monitoring and optimizing of hormone levels are recommended. Psychotherapy should be focused on development and adaptation to new lifestyle.

Scientific background

Etiology

The etiology of gender identity disorder remains undetermined. The fundamental disturbance is possibly neurobiological in origin, involving sex differences in hypothalamic and adjacent brain regions.

Epidemiology

No recent epidemiological studies are available. However, the prevalence is estimated at 3% for boys in childhood and less than 1% for girls in childhood.

Approximately one adult male in 30,000 and one adult female in 100,000 request sex reassignment surgery.

Analysis of psychiatric settings indicates a male-to-female ratio of 5:1 in children and 2-3:1 in adults.

According to the DSM-IV definition, for a condition to be considered a disorder it must be shown that there is dysfunction in the individual. For Gender Identity Disorder to be considered a disorder, in accordance with the DSM-IV definition, it must be determined that cross-gender/cross-sex identification or behaviors both represent a behavioral, psychological, or biological dysfunction in the individual. The use of the term “dysfunction” causes confusion. The concept of dysfunction is open to interpretation, given that no definition is supplied for this nebulous term in the DSM-IV.

In recent studies, it has been argued that mental disorder should be conceptualized as harmful dysfunction. Dysfunction, according to these reports, refers to the “failure of a mechanism in a person to perform a natural function for which the mechanism was designed by natural selection” (Bartlett, Vasey, & Bukowski, 2000).

It is entirely inappropriate to use natural selection theory as a framework for determining whether discomfort with the prescribed gender role of one’s sex is, or is not, a dysfunction in the individual. The issue of whether discomfort with one’s biological

sex is a dysfunction in the individual is even more problematic. Outright repudiation of one's biological sex certainly seems dysfunctional, at least in the folk sense of the word. However, this sort of intuitive hunch is clearly an unacceptable foundation upon which to base a clinical diagnosis. In this context, it deserves to be noted that an entire industry has developed around cosmetic surgery, which involves modification or removal of body parts that individuals dislike or hate. Although these individuals are rarely, if ever, labeled as dysfunctional and in some cases are actively encouraged to pursue such behavior.

Another commonly asked question is Gender Identity Disorder simply a deviant behavior or a conflict between the individual and society? A limitation of an evaluation of Gender Identity Disorder as a deviant behavior is that there exists no agreed-upon definition of deviance. The latter is defined in the *Penguin Dictionary of Sociology* as, "Generally, any pattern of behavior that is markedly different from the accepted standards within a society. The connotation is always that moral or ethical issues are involved and, in use, the term is typically qualified to note the specific form, such as sexual deviance" (Abercrombie, Hill, & Turner, 1994).

According to recent reports, it seems unlikely that discomfort with one's biological sex per se represents a conflict between the individual and society. Discomfort with one's sex indicates an underlying unease with how an individual experiences his or her actual biological make-up. Such discomfort would probably exist regardless of the

degree of societal openness surrounding gender role expression. There are theories that therapists use as guidelines in dealing with patients who are diagnosed with Gender Identity Disorder. The following chapter deals with some of these theories.

What causes transsexualism? From my experience this is the most frequent question of any person or group. In short, nobody knows for sure what causes transgender. There are however, some theoretical frameworks that have been developed and tested over the past 40 years.

For better or for worse, the medical and psychology professions are the sources of the research findings on anything to do with transgender. They have used the term Gender Dysphoria to describe and define the condition seen in transgendered people. The underlying assumption is that the Gender Dysphoria causes the gender variant behavior of transgendered people. The concept of Gender Dysphoria has been successively refined over the past 20 years. The previously used term was Gender Identity Disorder, which was considered too pejorative due to its emphasis on treatment of a disorder (International Journal of Transgenderism [IJT]).

Transgendered people are a group of people who display behavior that is different from that which is “normally” expected for their birth sex. This highly diverse behavior is often invisible to the researcher and is certainly not fully understood. If there is a cause, and cause is assumed, it must be something that generates this behavior.

Gender Dysphoria is defined as a feeling that a person is not comfortable with the gender that corresponds with the sex with which they were born. This feeling may have different degrees resulting in differences in behavior. Persistence of this feeling is also seen to affect the behavior resulting from Gender Dysphoria. These variations in degree of Dysphoria are used to explain the observed behaviors of people who show variances in their gender expression from what is expected from their birth sex. These explanations

are frequently unconvincing, partly because the sub-groups they define and explain are largely arbitrary and are often attempting to justify a treatment perspective rather than to understand causation.

The research in transgenderism has primarily focused on transsexualism, which is intensely treated by the medical and psychology professions and data is relatively available for standard research methodologies. Other aspects of transgender have been largely ignored except for some attempts to categorize and define treatment approaches that are hotly debated.

Before we continue much further, it is important to note that when attempting to define a theory that is scientifically acceptable, it is important for the theory to (IJT):

1. Describe the observed facts well.
2. Adequately incorporate the observed variations.
3. Be repeatable under controlled conditions.
4. Be capable of predicting an outcome from a set of initial conditions.
5. Require as few assumptions as possible.

This means that a theory that attempts to explain a cause for gender dysphoria must explain what it is along with how, why, and when the cause exists as well as how the large number of variations in observed behavior and expressed feelings might be generated. It would also need to be testable and it should be possible to predict that, if certain initial conditions exist, certain outcomes will occur within certain statistical limits. The theory should also be free from counter-examples that are either not explained or are contradictory to the theory (IJT).

When all available hypotheses have been evaluated, the scientific method chooses the one that best meets the above criteria. A simpler explanation will be preferred over one that is complex or requires a leap of faith to accept.

Califia (1997) reports that three different schools of thought can be identified within the debate on Gender Dysphoria. These are not all that have been proposed over the years but these form the majority of the currently credible arguments.

First, the psychoanalytic approach based on innate bisexuality in humans has been proposed. This suggests that male-to-female transsexualism might result from a failure of a boy to separate himself from his mother in early boyhood. Instead of identifying with the father, the boy identifies with the mother. Such traditional analyses consider lack of a cohesive self, opposite gender envy and jealousy combined with positive reinforcement such as a parent encouraging opposite gender behavior as the driving force behind the feeling of discomfort or confusion with the persons' gender identification. A relatively high incidence of these factors has been observed in studies during supervised therapy for both male-to-female and female-to-male transsexuals (Califia, 1997).

The psychoanalytic theories, with many variants, present a hypothesis for a cause for Gender Dysphoria, but none of these theories has been investigated to see if the existence of these initial conditions correlate with resulting Gender Dysphoria. Studies of intra-family relationships, divorce rates, parental dominance, marital harmony, and many other factors have not revealed a common pattern that could account for Gender Dysphoria. In fact, the evidence is that stable and harmonious intra-family relations do not exclude a transsexual outcome of one or more children. This approach certainly does

not explain the significant numbers of people who display gender variant behavior and have not come from these kinds of family background.

The second school of thought is behaviorism, also known as Social Learning Theory. Gender identity development is viewed as the result of a learning process that is imposed on the developing gender identity of a child. Gender identity develops as the result of “imprinting” and “conditioning” processes (Califia, 1997). In gender dysphoric people the conditioning is different to that which would normally be expected. A typical example of this process would be a parental figure encouraging “tomboy” behavior for a child born as a female or encouraging a male child to dress up and behave like a girl.

This theory has been elaborated by introducing biological factors (by chemicals, hormones or by brain differences) and by introducing the concept of a “critical period” to account for the fact that many people have experienced periods where they were encouraged to behave outside “usual” gender roles and have not experienced Gender Dysphoria (Califia, 1997). In the critical periods, biological, psychodynamic, and environmental factors (in particular, the parents’ expectations and the way they rear their child) have an effect on the development of their gender identity. Prior and subsequent to this critical period, such an effect does not occur.

A prominent researcher, John Money, has drawn an analogy with the critical period of genital differentiation known to operate in the fetal period. Based on the result of his extensive research, he has hypothesized that the process of gender identity formation can be compared with the process of acquiring a language (Califia, 1997).

This school of thought is quite complex in the way it describes many special cases and variations in cause. It therefore becomes very difficult to test or to make predictions from a set of initial conditions. It does have the advantage of being quite descriptive. The whole process may, in fact, be quite complex and require complexity to adequately explain it.

The introduction of biological influences, known as the Biological Theory, at or prior to birth seem to be quite explanatory of many things observed in gender dysphoria, but they are difficult to test. For instance, the brain differences can only be discovered after a person dies by dissection. Prospective studies are hard to achieve in those circumstances. Monitoring of hormonal variations prior to birth is too intrusive to hope to perform a useful analytical test of this idea (Califia, 1997).

The third school of thought assumes that the development of gender identity is related to the maturation of cognitive development (Cognitive-Developmental Theory). At about eleven years of age, a child's gender identity starts to become consolidated or fixed as formal thought and abstract reasoning become possible. An abstract concept of gender identity develops rather than the concrete concept of boy or girl and this concept can be related to the rest of the world as a whole. This idea is in line with the work done by Piaget and others on childhood developmental processes. This school addresses some additional observations but has difficulty addressing all of the observations. It may possibly be a supplementary explanation (Califia, 1997).

All authors on gender identity development agree that a sense of gender identity termed core gender identity can be found in every child before 3 years of age. Core gender identity can be described as the child's recognition that he is a boy or she is a girl. Research shows that this concept proves to be highly resistant to change in later life.

On the basis of clinical evidence, it seems that there is a solid argument that the foundation of gender dysphoria is laid before the age of three. Further research of this period is needed in order to understand more about the origin of gender dysphoria (Califia, 1997). Gender may well be the most basic element that makes up human personality. In fact, gender is so basic to our identity that most people mistakenly assume our sense of being male or female is defined with absolute certainty by our anatomical sex. Contrary to popular belief, one's sense of gender and one's anatomical sex are two distinct elements each developing at different times in different parts of the body.

More theories surround what causes Gender Identity Disorder and where it originates. These theories are sub-categories in two very popular sociological theory bases, Social Constructionism and Essentialism (Stein, 1999).

Social Constructionism:

As the second wave of feminism grew in strength, criticism of discrimination against women led to a reaction to prescribed restrictive societal roles for the sexes. "Biology is not a destiny" became a rallying cry. What started out as a criticism of socially constructed roles developed into a theory of gender, which denied Essentialism

in every form, stating instead that society took the biological differences of procreation, and instilled in them an artificial behavioral difference. The theory denies that there is any natural basis for gender identity. Thus, it denies to transgender people any rational cause, while at the same time presenting no reason why not. To some authors this meant that transgender people were free to express themselves in any manner they chose since all gender expression is as valid as any other. Only societal convention stands in the way of such freedom. Such conventions can be modified by the society as is deemed desirable. To some, all such restrictions are to be avoided in a live and let live ethos.

Other authors, Janice Ramond and Germain Greer, being notable examples, saw male-to-female transgender people as exploitive of women, supporting the artificial sexist forms that oppress women. It is interesting that in this regard they exhibit a hidden Essentialism, one that focuses on the genitalia as defining classes of human beings. They decried the restrictions on one class, while despising those of the other class when they break those very restrictions (Califia, 1997).

Still the existence of transgender people poses a challenge to the social constructionist theory. One must explain both why gender identity exists, how it is perpetuated, enforced, and why some rare individuals chose to express a gender identity at odds with socially prescribed gender expression norms.

Performance Theory states that we are taught to perform gender, to act it out in the same way that we learn to act out social roles like teacher, student, friendly store

clerk, police officer, etc. One is said to “do gender” rather than “have a gender.” This is very similar in basics to the psychosocial theory of imprinting, save that there is no instinctual basis for having the ability to absorb a particular gender identity. We are taught a set of gender behaviors that become so ingrained as habit that we forget that we are merely acting them out (Stein, 1999).

Transgender people are explained as having been improperly instructed. Even among those inclined toward psychosocial models, as one would expect physicians to be, one finds this theory in currency. It is the model used in justifying Behavioral Modification Therapy to treat Gender Identity Disorder in children. Under the assumption that even though gender identity is arbitrarily socially constructed and taught to children, one should not allow children to express gender behavior different than the norm. Some rationalize it on the basis of wanting the children to fit in, experience less rejection, and bullying. Others are simply moralists who insist that God has ordained that we should all behave in a certain prescribed manner (Stein, 1999).

One Post-Modern philosophical theory, one that has a striking resemblance to the psychosocial theory that transgendered people are simply crazy, is that transgendered people are suffering under a “false consciousness”; that they are not really experiencing a gender at all, but an alienation from their social and biological reality. This theory is perhaps the most transphobic of all theories in that it denies what is called in Post-Modern cant, “agency,” the characteristic of experiencing and expressing their existence and very real psychic pain (Stein, 1999).

Oppression Theory starts from the assumption that transgendered people are very much in command of their faculties and have made a rational decision to avoid societal restrictions on desires they experience. The usual script is that an ambitious woman noting that she is unable to succeed in a man's world wears men's clothes, assumes a fictitious identity as a man, in order to achieve career success. These "passing women" are the darlings of the feminist historian because they are revered as daring pioneers for women's liberation, or they are held as examples, proof, of how horrible conditions were in some past epoch. To the feminist historian, modern FTM transsexuals are an embarrassing disproof of the theory. Similarly, Oppression Theory is used to explain modern MTF transgendered people as being examples of internalized homophobia in gay men, too ashamed to live openly, and so have to "pretend" to be women in order to express their desire for same sex relations. To such gay male chauvinists, the fact that half of transgendered people identify as lesbian or gay male after transition, are an equally embarrassing disproof of the theory (Stein, 1999).

Social Constructionist Theories fail to note that ethnobiological studies of sexually dimorphic behavior in animals are not socially constructed for non-humans. Nor does it explain the cross-cultural similarity and temporal stability of core gender identity throughout history around the world.

Essentialism:

Essentialism posits that men and women are "made that way." It is a deceptively self-evident fact that most everyone accepts since for over 99% of the population there is

a clear-cut correlation between genital morphology and gender identity. It is easy for the average person to ignore the disquieting cases of intersex that cast doubt on the simplistic assumption of binary sex assignment. The question of which sex an intersex person “really is” demonstrates the essentialist bias through much of Western Society for the past two centuries. Historically, Essentialism divided on which of two somatic characteristics was indicative of the “real sex” of an individual, genitalia or gonads. For most people the genitalia, the presence or absence of a penis was the overriding feature. As medical science grew more sophisticated in the nineteenth century, the gonads came to be the indicative feature. But early in the twentieth century the newly discovered chromosomes, specifically the presence or absence of the “Y” chromosome, became the newly crowned final arbiter of “real” sex. The faith in microscopic examination to “scientifically” determine one’s sex was unquestioned (Califia, 1997).

In 1968 the International Olympic Committee instituted chromosomal karyotyping for all female athletes. Any person that did not have the required 46, XX chromosome karyotype were disqualified from competition and informed that scientifically speaking, they were not women. The demonstrable fact that they had female genitalia had lived, as female all their lives not knowing that they did not have the officially approved karyotype for women, did not enter into the unfeeling officials minds. Reductionist Essentialism had no room for intersexed people. They were counseled to fake an injury and slink away into silence to keep their shame of being “not female” from becoming known (IJT).

In 1970, the Corbett vs. Corbet decision to nullify the marriage of a MTF transsexual to a non-transsexual man used karyotyping as the “scientific” marker for sex and gender that the law was henceforth to follow in the United Kingdom, throwing the legal status of transsexual and many intersexed people into limbo, neither male nor female (IJT).

Although Essentialism has often been used as a philosophy to ‘prove’ that transsexuals and transgendered people do not have a valid claim to their identity, Essentialism still has explanatory power. If the locus of gender is found, not in the genitals or chromosomes, but elsewhere, transsexuals could be rationally described as “men trapped in women’s bodies” or “women trapped in men’s bodies.” There are several loci that are, or have been proposed as the Essential Seat of Gender, but they come down to two main categories, “Brain Sex” and “The Soul” (Stein, 1999).

Many religions have a concept of an essential self that is separate from the body. In Judeo-Christian-Moslem belief systems one’s soul separates from the body after death. This soul retains the sense of self, including gender identity. Some religious thought includes the concept of the soul entering the body at some point in becoming a living being and therefore must become or always have been a gendered self. For religions that included the concept of reincarnation, the notion that a being always returns to the same sex body suggested an explanation for transgendered identity. Once in a while, a soul finds itself in the wrong sexed body. This idea was openly discussed in newsletters published in the sixties and seventies by the Erickson Education Foundation. This was the personal belief of Reed Erickson, the Foundations benefactor. The Church of

Latterday Saints (Mormon) debated the issue of pre-born souls finding themselves in the wrong body with Kristi Independence Kelly in 1980 at her excommunication. The Church held that, though the pre-born souls did have a gender before birth, God did not make mistakes: “There is no such thing as a man in a woman’s body or a woman in a man’s body” was declared, excathedra by the leader of the Mormon faith. Apparently, intersexed people must have also intersexed souls (Bornstein, 1994).

Some non-Judeo-Christian-Moslem cultures held that transgendered people were indeed gendered souls in the wrong body. Some believed that this juxtaposition gives the transgendered person a special status with the spirits of nature or the powers. In ancient times in the Mediterranean culture, MTF transsexual women became priestesses, Galla, of the goddess, Cebele. The Hopi Nation held that a transgendered spirit, or Katchina, sent visions to transgendered people. In India, the Hijra, transgendered and intersexed people are both reviled and revered, given varying circumstances. Mystical Essentialism has played an important role in various cultures, including our own (Bornstein, 1994).

The early twentieth century European researchers and medical practitioners believed that gender and sexual behavior in general are the result of a sexually dimorphic brain. That is to say that the brain itself has a sex. This sex usually conforms to the chromosomal and the genital sex. However, just as there can be chromosomal and genital intersex conditions, the brain might also exhibit intersex morphology leading to behavior and that elusive personal experience, gender identity, at odds with either somatic or chromosomal sex. Magnus Hirschfeld, a leading early researcher described the entire spectrum of what today we would call Queer expression, gay, lesbian, bisexual,

transgender, transsexual, as forms of “Sexual Intermediates,” or intersex. This was not a metaphor or a rationalization. Instead, it was a theory based on careful observation and scientific generalization, based on the lack of neurological science at that time.

Hirschfeld and his colleague, Harry Benjamin, believed that as our understanding of the brain grew we would discover just where and how the brain was organized to produce sexual orientation and gender identity. For Hirschfeld, there was no major divide between non-conforming sexual orientation and gender identity, they were simply different forms that intersex could take. Thus for Hirschfeld, the late twentieth century division between the concepts of gender identity and sexual orientation, the great political divide between the gay and lesbians and the transgender community would be meaningless. To Hirschfeld, we are all transgendered, gay, and transsexual alike (IJT).

In the first decades of the twentieth century, experiments with cross sex gonadal implants in animals suggested that there was a connection between hormones and gender specific behavior. This led to horrific experiments in humans during the Nazi era and beyond as hormones became available as a common pharmaceutical. Testosterone was administered to gay men and MTF transgendered people in an attempt to cure them. The hormone treatments had no effect on the sexuality or gender identity of the victims of such experiments. No lasting harm was done to the gay men. But the supermasculinizing effects on the transgendered victims was severely traumatizing (Stein, 1999).

In the later decades of the century, neuroscientists found significant sexual dimorphism in microstructures in the brains of animals and humans. Experiments on rats

indicated that hormone levels during a period in late gestation and early post-natal development to be critical to the development of these structures and subsequent behavior. Gorby was able to create what he described as a laboratory model of transsexuality in rats. He demonstrated this in both MTF and FTM cases. When he introduced them to each other, the FTM rats mounted the receptive MTF rats (Stein, 1999).

Using human children to explore gender identity and sexual orientation would be extremely unethical in the laboratory, but science often uses “experiments of opportunity.” Simon La Vey used autopsy material from straight and gay men who had died from AIDS to find that a small microstructure of the brain differed in the two populations, suggestive of a sexual orientation controlling microstructure. The same technique of using autopsy was performed by Swaab to discover a different structure associated with gender identity. Shaffer, in an as yet unpublished study, used MRI data from a large pool of controls, MTF and FTM transsexuals to demonstrate that the corpus collosum showed sexually dimorphic structures that, on a statistical basis, correlated with gender identity. Both Swaab’s and Shaffer’s work ruled out effects of hormones in adulthood (Stein, 1999).

The early data, on humans, agree with laboratory findings using animals. However, it is also known that experience can shape the brain. The lack of sensory stimulus and a chance to work out problems leads to dramatically less brain development in infantile rats. In humans there is a suggestion that early musical training affects the shape of the corpus collosum, building greater connectivity between the two hemispheres

of the brain. These early experiences suggest that early gender experiences could also lead to sexual dimorphism in the human brain by a similar mechanism. This would agree with Dr. Money's imprinting hypothesis, but would be at odds with Gorby's work with rats and the results of the case of "John/Joan," where an infant boy whose penis was 'accidentally' cut off during a routine circumcision, underwent gender reassignment surgery. Science could very well demonstrate that the seat of sexual orientation and gender identity is located in the brain. How that arises developmentally is still open for further research (IJT).

No matter what theory one adopts, for most children, whose sex and gendermap are congruent, this insight typically goes unnoticed. However, if there is a sex/gendermap incongruency, the child is left perplexed about his or her gender status and begins a lifelong, often compulsive search for resolution of the discrepancy.

All children naturally comply with the demands of their internal sense of gender. Boys generally express male behavior and girls generally express female behavior even when raised in closely monitored gender-neutral conditions. If there is any confusion in the child, he or she quickly learns from adults and peers that certain gender-expression behaviors are inappropriate for that individual. This is true even of gender dysphoric children. Some gender dysphoric children internalize their dilemma and make heroic efforts to display the gender behavior expected of them, while expressing their internal sense of gender through secret play, cross-dressing, and cross-gender fantasies. Others may continue to struggle by insisting that they be allowed to openly express maleness or

femaleness irrespective of their assigned sex. Either way, the problem becomes subsumed into the child's personality (Stein, 1999).

The arrival of adolescence increases the difficulties for people who are gender dysphoric. Without fail, the sub-sequent development of secondary sex characteristics counter to the individual's desires increases anxiety. Often, frustration sets in, and a determination to finally resolve the problem becomes the individual's driving force in life. This is especially true for gender dysphoric males. Since the obvious first effort is to accept the physical evidence of their genitalia as reality, it is very common to see many of these people push through these early years of adulthood by engaging in stereotypical, even supermale activities. Since outward behavior has no permanent influences on internal gender understanding, these activities serve only to complicate the individual's social involvement, resulting in anxiety about expressing his true felt gender (Stein, 1999).

This anxiety state is characterized by feelings of confusion, shame, guilt, and fear. These individuals are confused over an inability to handle their gender identity problem in the same way they readily handle other problems in life. They feel shame over an inability to control what they believe society considers being sexually perverse activities. Even though cross-dressing and cross-gender fantasies provide much-needed temporary relief, these activities often leave the individual profoundly ashamed of what she or he has done. Closely associated with shame is guilt over being dishonest by hiding secret needs and desires from family, friends, and society. For example, people commonly get married and have children without telling their spouse of their gender dysphoria before

making the commitment. Typically, it is kept secret because they have the mistaken conviction that participation in marriage and parenting will in itself erase their gender dysphoria. All of this then leads to fear of being discovered. With some justification, gender dysphoric people fear being called sick, uncaring, selfish, and even being left alone by the people they love the most (Feinberg, 1998).

To sum things up, Gender Identity Disorder is a real and serious problem. Although we don't know all of what may be the cause or causes of the feeling that these individuals have toward their assigned sex, we can be reasonably certain that it is connected with either a congenital irregularity or an irregularity that occurs in the first few years of childhood, or some combination of the two. We also know that every individual's sense of gender, once established, is unchangeable over the individual's lifetime. Men do not suddenly think they are women and women do not suddenly think they are men. This is true for transsexuals as well as those whose sense of gender does correspond to their genitalia; most transsexuals report being aware of their condition from the age of four to seven. The only variable is the individual's ability to tolerate the anxiety of feeling missexed. If the individual's gender dysphoria is a relatively minor one, cross-gender lifestyle changes in periodic dressing and behaviors may be all that is necessary to ease the anxiety. However, if the individual's dysphoria is profound, a lifestyle change may be insufficient. In this latter case, gender expression moves from a lifestyle problem to a life-threatening problem.

Do Transsexuals Have A Choice?

Is being transsexual a choice or not? Why did I include a chapter just on this question? Although I examined the history and theories associated with transgenderism, the question still remains whether or not people choose to be transsexual. This chapter examines sexual orientation, which is associated with being transsexual, and choice.

There are two positions about sexual orientation and choice: voluntarism about sexual orientation, the view that people choose their sexual orientations, and determinism about sexual orientation, the view that people do not choose their sexual orientations (this view is not to be confused with determinism, a traditional metaphysical view that says all events are determined). There are various reasons why many people favor determinism about sexual orientation over voluntarism about sexual orientation. Lets look at some examples (Brevard, 2001).

I begin with the various reasons for believing that people do not choose their sexual orientations. Most significantly, there is introspective evidence that sexual orientations are not chosen. Think about your own sexual orientation. Insofar as you are clear as to what your sexual orientation is, do you recall having chosen it? You have probably made lots of decisions that relate (in various ways) to your sexual orientation; such as whether to engage in certain sexual behaviors and whether and in what contexts to identify yourself as having a particular sexual orientation, but these decisions are different from choosing your sexual orientation. Consider the following observation. On a particular occasion, you might decide to have sex with a person of the same sex/gender. Doing so does not in itself constitute deciding to become a homosexual.

You might do it for money. You might do so as a favor to the other person involved. These examples involve deciding to have sex with someone of the same sex/gender, but they do not involve choosing to be a homosexual. Similarly, you might decide to say that you are a heterosexual. Doing so does not, however, constitute deciding to become a heterosexual. You might say you are a heterosexual because you do not want to lose your job. You might do so because you think you are a heterosexual, when in fact you are not. These cases involve choosing to identify as heterosexual, but they do not involve choosing to become a heterosexual. To have a sexual orientation, roughly, is to find certain sorts of people sexually attractive by virtue of, to some extent, their sex/gender and to be disposed, all else being equal, to want to have sex with such people. The introspective evidence against voluntarism about sexual orientation is the feeling, shared by most men and some women in this culture, that one did not choose one's sexual orientation or one's sexual desires and dispositions. In some Western countries, however, many women and some men feel their sexual orientations are fluid and that some conscious choice is involved in the development of sexual orientation (Stein, 1999).

There is also observational evidence that suggests that sexual orientations are not chosen, that is, scientific, clinical, psychological, and testimonial evidence that a person cannot change his or her sexual orientation. Countless numbers of gay men and lesbians have attempted to change their sexual orientation through one or another kind of treatment. Attempted treatments have included lengthy psychoanalysis, prayer, hormonal injections, and electric shock treatment to name just a few. All such treatments have

been dramatic failures. That most people who have tried to change their sexual orientations have failed seems to count against voluntarism about sexual orientation. Further, in places where there are no positive representations of lesbians and gay men, where homosexuals are violently repressed and severely punished, and in which social pressures push an individual to be heterosexual, there are still people who are sexually attracted to people of the same sex/gender. It seems that at least some of these people living under such conditions would chose to be heterosexuals if they could. Since they are not in fact heterosexuals, this suggests that they do not have a choice in the matter.

There is additional introspective evidence that coheres with this observational evidence. Imagine trying to change your own sexual orientation. In doing so, I am not asking you to imagine trying to have sex with a person of a sex/gender other than the one to which you are primarily attracted or to imagine trying to identify as having a sexual orientation different from the one you have. Instead, I am asking whether you could change your underlying desires with respect to the sex/gender to which you are sexually attracted and whether you could make yourself disposed to have sex with people with whom you are not disposed to have sex. If you think it would be basically impossible to do this, then this seems to provide evidence for the view that voluntarism about sexual orientation is false (Califia, 1997).

There is another reason why voluntarism about sexual orientation is implausible. Both nativist and experiential theories of sexual orientation and both primarily biological and primarily psychological theories of sexual orientation seem to argue against voluntarism. The thought is that whichever sort of theory is true, or if there are multiple

origins to sexual orientations, a person does not choose his or her sexual orientation, genetic makeup. Environmental conditions could also play a role in the development of ones sexual orientation. However a person's sexual orientation develops, choice is not involved.

The American Psychological Association issued a summary statement on homosexuality in July of 1994. They said,

The research on homosexuality is very clear. Homosexuality is neither mental illness nor moral depravity. It is simply the way a minority of our population expresses human love and sexuality. Study after study documents the mental health of gay men and lesbians. Studies of judgment, stability, reliability, and social/vocational skills all show that gay men and lesbians function every bit as well as heterosexuals. Nor is homosexuality a matter of individual choice.

Research suggests that the homosexual orientation is in place very early in the life cycle, possibly even before birth. It is found in about ten percent of the population, a figure that is surprisingly constant across cultures, irrespective of the different moral values and standards of a particular culture. Contrary to what some imply, the incidence of homosexuality in a population does not appear to change with new moral codes or social mores. Research findings suggest that efforts to repair homosexuals are nothing more than social prejudice garbed in psychological accouterments (IJT).

I believe that we have no choice about being born with a predisposition to transgender, no choice to be transsexual or whatever other word you use to describe it,

but we choose what we do about it. The notion of choice and of taking responsibility for that choice, is crucial to our being able to become the best we can be in this world. To be able to choose is to be empowered in this world. Many transsexuals argue that they have no choice but to have surgery, that they have no choice over the chain of events that leads them to surgery. For some, this fundamental tenet of faith is so strong that they feel (if a person feels they have choice over gender reassignment surgery), for transsexuals have no choice. This is a key part of their history and many get distressed when anyone talks about the choices a transsexual person has to make in this world.

Where do choices end for transsexuals? They choose where they go for surgery. They choose when to have surgery. They choose how to pay for surgery. They choose to have a graft or not. They choose where to transition, choose how and what to tell their friends and family. They even choose what they wear to and from the hospital. They choose all these things, but they insist they don't actually choose to gendershift and have surgery. You may wonder what they would have done if surgery was not an option, as it wasn't until about 40 years ago. Life is about the cycle of death and rebirth, and we all choose to die in some way and be reborn, though the death of the physical body is the ultimate choice.

Rational Choices

I actually had one interviewee argue that no rational person would choose to gendershift and have surgery, so therefore it can't be a rational choice. Is it a rational

choice for a cross-dresser to put on a dress and go to the mall? The rationality of decisions is very much about the way you view the options.

This culture wants to convince us that no rational person would do either, and enforces that decision with stigma. Who would choose to take the pain that one has in telling their mother, their kids, or their wife that they choose to change gender and/or sex. Heterosexism requires the separation of men and women, and works hard to tell us that to cross that line is a horrible and bizarre thing. But it isn't, or at least that is the message of the transgender paradigm.

The difference seems to be as simple as the difference between “I had no other choice but to have surgery,” and, “I felt I had no other choice but to have surgery.” The first statement denies any possibility of other choices, while the second affirms that we saw surgery as the right choice for us, whatever the drawbacks.

I do understand that many transsexual people who have chosen gendershift and surgery do feel they had no other choice; that they exhausted their other options, but that is not unique to transsexuals. The ability to relinquish responsibility for our actions because we saw no other choice than to drink, leave, kill, (or any other action) opens up an excuse for all. This makes me very uncomfortable.

I believe that transsexual people who choose surgery make the best choice they can under the circumstances, but actually going through with gendershift and surgery has been made to seem so selfish and harebrained that they choose to claim no choice in the matter. “I didn’t want to do it! I had to! My nature forced me into it!”

Gendershift and surgery are fine and honorable choices, not selfish or hare-brained. They are often the best choice that we can make to get on with our lives. I applaud and admire their choice, for a transgendered and a transsexual person to bring their gender, role, and body into harmony.

Stigma and The Closet

If it were easier to make the choice to gendershift, we would not have so many transgendered people twisted by the closet, torn apart by being impaled on the horns of the dilemma of which way to turn. We wouldn't have to wait until everything else in our life is gone before we chose to walk through the wall of gender. Much of the pain of living with stigma would be lessened and we could get on with our lives and our contributions to the world.

But there is a model that says that transsexualism is a disease, a birth defect that it is something to run from and deny, or something not to be proud of. I know many cross-dressers who longed to be transsexual, because that was explainable; it took you out of the range of making a choice to change clothes. But today even many transsexuals reject that illness model.

A patient was talking to a psychologist at an American Psychological Association Convention. When he told the doctor that he was talking about transgender, transsexuality, the psychologist replied, "I don't think God makes mistakes," he simply answered, "Neither do I." We are not mistakes, just humans with special gifts and

challenges, like any other human. We can choose to see our transgendered nature as a curse, or simply another way humans are born (personal communication).

This is a big deal. Do we actually have choice over how we live our lives, even if we don't have choice over who we are? Are we slaves to the world or do we control our destiny by the choices we make?

What Is Choice?

Much of this discussion rides on how we define choice. It is clear that choices are based both on biological predisposition and on a wide range of other environmental factors and it is possible to argue that humans are merely victims of their genetic and cultural programming, and have no true choice. You can argue that humans are so limited by their history that free choice or free will is not an option; we are just meat puppets.

But to make that argument is to take away our responsibility for change, for transformation. If we are only slaves to our past, then we have no personal responsibility or personal freedom. We become only a part of the collective, not individuals. Robert Schuller preaches on the fact that this century has been one of collectivism, of serving the machine, but the pendulum is swinging back in the next century to the individual. He reminds us of our individual responsibility and choice, "If it is to be, it is up to me."

Transgendered people make individual choices. It is clear that well over 90% of people in this culture don't have massive discomfort at living in the socially expected gender role. Transgendered people don't ask for the ability to change the role of everyone,

but the ability of individuals to define their own role, either crossing the sex/gender line permanently or exploring the turf around it. We don't choose for the culture as a whole, but we do claim the right to choose for ourselves, to not simply take what is issued at birth.

Not every choice is for something, we often choose against something. We choose not to be women, but does that mean we choose to be men? For some of us we do, but for others the choice is more complex. Many of us choose not to choose, but let the world push us where it will. Does that mean we haven't made a choice? We always make the best choice we can, even if we don't understand why we made the choice. Even when we make choices that appear self destructive, we are choosing to destroy something that is haunting us. We often choose to paint ourselves into a corner so that the only choice left to us is the one we want, or the one that we think we deserve, and so we get it without seeming to make a choice. This is especially true of choices that carry such stigma as transgender and sexual orientation. We are so afraid of being shunned, isolated, or separated for simply doing what will satisfy us that we try to abdicate the choice.

The Fear Of Choice

Erica Jong notes that one reason people are so afraid of choice is because it seems so easy to make the wrong one. It's so easy, especially in a culture where choice is frowned on, one that socializes us to serve the machine, to become homogenized. People club us about our choices – “If you really love me, you would never hurt me this way!” –

when our choices are not about hurting them but rather about finding what we need. We become gun-shy and afraid of losing love and connection, so we try to find ways to not be isolated, to not have to take the responsibility and consequences of our choices. We need to believe we are lovable for who we are, not just because we choose to do what others want us to (Transsexual women's resources).

We also recognize that taking responsibility for our choices now means we always had responsibility for our choices and then we have to forgive ourselves for our past transgressions, which is hard for anyone. Learning to love ourselves unconditionally, not just for what we did or didn't do but also simply for what we are, is the basis of learning to love others that way.

More Choices Than Ever

As others have noted, the range of choice that is open to us is expanding geometrically. We have choices of communication, of travel, of medical treatments, of lives that were unknown just a few years ago and the possibilities that are just over the horizon are even more boggling. We are not living in a world that is getting simpler, but one that is getting vastly more complex, where the range of choice will allow any individual to become who they want to be.

The simple fact that we have so much more information available to us opens up our choices immensely. We now see options we would not have known existed before. To be prepared to handle this range, we have to start teaching kids to make intelligent choices, not merely to follow role patterns. We can't simply crave going back to a

simpler time; it just isn't going to happen. Those simple times weren't really all that much fun because we were chastised, stigmatized, humiliated and declared criminal for the choices we made that seemed anti-social. The drug problem is a good example. While some people tried to have kids "just say no," those in recovery found that they couldn't kick the habit until they took responsibility for their own choices, and trusted, rather than fought, the callings of their higher power.

Society has an interest in making the choice to be transgendered, or to live as a gay person, or lots of other choices as difficult as possible. The easier the choice, the more people will take it and that may be seen as a destabilizing force. If people thought they could choose to change without stigma, they would and where would we be then? There are reasons that the hurdles for gender reassignment surgery are so high, reasons the gatekeepers fight so hard, and that we become whom they expect us to be in order to get what we want and what we need.

Taking Responsibility For Choices

I watched Martine Rothblatt confront an interviewer on local TV. As the interviewer tried to get the "no choice" phrase out of her, she simply said she had lived as a man and had always wanted to live as a woman. Her wife and kids thought it was OK, so she did. The interviewer looked stymied, not understanding how anyone would gendershift just because they chose to. Gendershift is so drastic, so irreversible, so weird, so isolating; why would anyone choose to do this? But Martine knows that she made a

choice for change. It was her time and her way. She was born transgendered, and she chose to gendershift.

We have no choice in the gender we are assigned by our parents, no choice in what they expect us to wear, to do. For them it is a simple process of only looking at what is between our legs, not what is in our hearts. Some children like red shirts, others blue ones, do we look for a cause in these choices? Could we find one if we did? But when some children with penises prefer dresses and some children with vaginas prefer no dresses, we look for a cause. Why are these choices different? Because the world says they are, that's all.

The Pressure To Make the "Right" Choice

I know the enormous pressure that exists when a person grows up gender queer, transgendered, or even transsexual in this culture. To know what is expected of you was somehow contrary to your nature. I understand that for many, the pressure is so intense that choosing surgery is the only choice they see for happiness and that many of us were in so much pain that they saw the choice between surgery and death as the only choice at all.

But taking responsibility for your choices in no way diminishes the pain and suffering you felt. In fact, taking responsibility confirms your ability to do something about your pain and suffering.

By choosing to gendershift, have gender reassignment surgery or transgress gender in other ways, you cease to be a victim to the pressure the outside world puts on

you to conform to gender standards. We are shaped by peer pressure whether we resist it or conform to it, but by choosing our own path we become not merely followers or reactionaries, but actively responsible for shaping our own life and future.

Choices and Power

Declaring the ability to choose the shape and direction of our life gives us the power to transcend our history, to become more than slaves to our predisposition and our environment. Our choices will be shaped by whom we are and where we have been I have a role that I wouldn't have chosen for myself given the stigmas of this culture, but somehow it feels like the absolutely right choice. This is the dilemma of humans.

Think of the people who moan, "I have no choice but to go to work because of the bills!" But you can reduce the bills, choose to live more simply, choose other work. You do have choices, even if some of them require you to do unpleasant things, to renounce something you want now in order to get something you want more later. When you choose to work for long-term happiness, you have stopped being a victim, and that means you are in control.

The point is that, whatever limits we have to free will, in the long run it is our choices that determine the ultimate direction of our life, and determines our ultimate happiness. It only takes a little bit of choice to make a big difference to any human life. We can transcend our history; we are humans.

If we want to stop being victims, we must take responsibility for our choices, even those choices that are almost unfathomable to most in this heterosexist culture. We must

be able to satisfy ourselves, to become congruent and whole, even if some people think we are just plain nuts.

Even if we simply say, “I didn’t choose to kill myself and put an end to other’s embarrassment with me, rather I chose to live in a way that I could be happy and effective.” We need to take pride in our choices.

To paraphrase what JoAnn Roberts often reminds us, in the words of John Steakley, “You are what you choose to do when it counts.” Once we have control of and responsibility for our own lives, and we don't simply give in to nature or the culture, then we can start to become full and complete individuals. And to me, that choice is worth working very, very hard for (TWR).

1) Transitioning is always a choice.

2) If you are transsexual you're always forced... at least to make a choice.

Having waded through the murky waters of medical research into gender dysphoria, it is probably useful to have a look at what transgender means to the people who experience it.

The idea that a transgendered person is ill is a community perception based on outdated psychotherapeutic ideas and the people themselves rarely consider themselves to be ill once they overcome feelings of guilt and the results of shame.

There is a perception amongst communities that a transgendered person is ill in some way. This stems from the thinking of psychiatrists in the early part of this century who believed that anyone who was not happy with their sex or wished to, in any way, behave like the “opposite” sex was mentally ill. This view focused on the assumption that these people “must be” deluded or psychotic because they held a false reality to be true. It was only from the post Second World War period that the medical profession started to understand that no amount of behavior modification or drug treatment seemed to be able to change the mind of the majority of people who had a persistent sense of being the wrong gender (TWR).

There were and still are a few cases where people do have delusions about their gender but this is due to a readily diagnosed psychosis and these cases are a tiny minority. Transgendered people do not “think they are Napoleon” and there is no credible research that suggests so.

There are illnesses that may be associated with people who have a strong sense that they are “living in the wrong body.” This includes depression and even feeling suicidal. Part of the reason for this is the social pressure that is placed on transgendered

people using shame to force them to conform to expectations. This often results in large doses of guilt that can be difficult to resolve in later life.

The association of childhood and adolescent cross-dressing with fetish and illicit sexual experience also contributes to the shame and guilt feelings for many people and these feelings carry into adulthood.

Living with guilt and the need to suppress an important part of one's self-image (gender identity) can result in other problems in life such as low self-esteem and even problems with employment, relationships and life skills.

Only a few transgendered people see themselves as ill. They may see the need to address the guilt and shame aspects of their lives, but feelings that they need to "be cured" usually do not last beyond the time that they address the underlying guilt feelings. Of those who do see themselves as ill, most believe that the cure for their illness is to change their body to the sex that they believe it should be. Many others who do not see themselves as ill also seek to change their bodies to more accurately reflect their gender identity.

There are some transgendered people who do have a psychiatric illness but this is at a rate that is consistent with the rate of psychiatric illness in the general population and is quite independent of gender identity.

The vast majority of transgendered people lead very productive and healthy lives and, at some point, successfully integrate their gender identity into their daily lives and that of their families and friends. The single biggest factor that assists with this integration is acceptance of self and that is assisted in turn by the acceptance of others.

Some people may see being transgendered as a misfortune. It is expressed in terms of “You poor person. How can you possibly be cured?” After some consideration, a transgendered person might well reply, “That’s OK I would never have it any other way.”

Yes, there are significant negatives to being transgendered but there are many things that are positive about it too (Sullivan, 1990).

Negatives:

If a transgendered person is unable to come to terms with themselves then there is a reasonably high likelihood of being affected by:

- Social disapproval
- Increased risk of depression and suicide
- Potential poverty trap as a result of the above
- Potential loss of friends and family support
- For transsexuals, a dependence on the services of the medical profession

Positives

If a transgendered person is able to integrate their nature into their life and the lives of those they usually have:

- The ability to put all the negatives behind and enjoy life to the maximum
- A broader outlook on life and all it has to offer

- The potential to experience more than most people could ever hope for from life
- Lasting and trusting relationships
- The ability to tap a reserve of creativity and strength beyond what is usual in the general population.

Being transgendered is not a sentence to a miserable, poverty-ridden life devoid of friends. Nor is it easy to come to terms with oneself against the misinformation and opprobrium directed towards people who are “different” or challenge the accepted cultural norms.

There is some good evidence available to suggest that those people who have managed to come to terms with their differences are emotionally stronger and happier people than the general population (Ramsey, 1999).

Lets look at some examples of individuals who experience Gender Identity Disorder, whom I interviewed especially for this thesis:

CASE ONE

A 30-year-old biological female diagnosed with Gender Identity Disorder. In the process of starting gender reassignment surgery (currently has been on hormone therapy for several months and has name changed to a male name). Has worked in social services for six years. Comes from an average middle class family from rural West Virginia. Family very strict concerning religious beliefs. No criminal activity but admitted to substance abuse (alcohol only) in the past, now only drinks 'occasionally' depending on situation. Raised with father since she was five-years-old. Stated that, "I knew I was born in the wrong body since high school." Dated both girls and boys in high school (due to wanting to be 'normal'), but only dated girls after graduating. Joined Marine Corps, which only reinforced wanting gender reassignment surgery. Well educated, possessing a bachelors' and masters' degree. Dresses in masculine cloths, conveys almost consistently male mannerism, and reports being accepted as a male in all personal and professional domains of her life. Has been living in the male role for six years. Currently in a "heterosexual" relationship with a female.

In an interview with this respondent about how it feels to be transsexual, the respondent replied:

Imagine the worst Halloween costume you ever had to dress up in your life. Now imagine the one person on the planet you really don't want to see. Then imagine how you would feel wearing this costume everyday and not being able to get out

of it and at the same time always seeing this person you can't stand to see. That's the way I felt for twenty-some years. It's a feeling that you never forget or get over. Since I went through my transition, I am more accepted. People treat me with a lot more respect, because they don't know I was once a woman, and I have come out of a shell I never thought I could. For the first time in my life I am comfortable with who and want I am. For the first time in my life, I am happy.

When asked about what it was like growing up as a transsexual the respondent replied:

No one can possibly know what we [transsexuals] go through unless you're going through it too. When I was a teenager, I never knew what I was going through. I didn't even hear the word transsexual until I was in college. I can't even count how many times I tried suicide. It was a constant struggle. A struggle between who you are, what you are, what you feel, what you're suppose to be like, what you're suppose to act like, I can go on and on. I felt very alone. I didn't have anybody to turn to. My friends would've freaked out, and my family was too religious to even help. All I heard for being who I was, was turn to God. Don't get me wrong, I strongly believe in God, but I also believe in being happy. I still don't know any transsexuals that are going through surgery, or even thinking about it, and I'm thirty-one. People think that transsexuals are freaks, but if given the opportunity to change something they want without being labeled, how many people do you think would? Before my transition, when I went out in public,

people just assumed that I was a male because of the way I looked. It was after they found out that I wasn't they started to label me and treat me different. Now I just fit the part.

CASE TWO

An 18-year-old biological female diagnosed with Gender Identity Disorder. She is a recent high school graduate who identified herself as female all her life. She began wearing male clothing and shortened her hair into a male cut during her senior year in high school. Stated that she wants to enter her freshman year at college with a male identity. Currently lives and has grown up with both parents and two younger sisters, whom has shown no signs of being transgendered. Family accepts her wanting to be masculine in appearance, but refuses to accept gender reassignment surgery as an alternative. Her family states that they would have “nothing else to do with her” if she went through with her plans. Family is from an upper-middle class background from an urban part of Ohio. No criminal activities or substance abuse are found.

During an interview the respondent was asked when and how she realized she was transsexual, she replied,

It’s not something that you realize, it’s not something that you choose, it’s just something that you are. When you find something that makes you comfortable you want to stay with it. I found what makes me comfortable; I just wish that everybody could be this lucky. It’s not about wanting to physically be a man or wanting to have sex with someone as a man. It’s more like wanting that appearance. You want people to see you on the outside like you are on the inside. I’m looking forward to going to college as a man. I only hope that in time if I

chose to go through with the surgery my parents will accept that. Right now they're just getting over the shock of me being 'gay' and trying to deal with the fact that I want to look like this. I believe that they will come around eventually. I have faith. Right now I'm just happy with this part of the process.

CASE THREE

A 19-year-old biological female college student diagnosed with Gender Identity Disorder. A very intelligent, resilient individual with many strengths and the capacity to succeed in her life. She is a successful student and played leadership roles in several school organizations. Reported that she had a large social peer group in which she was referred to with her preferred male name. No signs of criminal activity or substance abuse. Raised alone by mother in rural Kentucky, who is very understanding and acceptable of her being a 'lesbian' but refuses to accept her undergoing gender reassignment surgery and would result in losing contact with her if she does. Due to this, she decided not to go through with the surgery stating that her family was too important to lose. After the initial interview, I talked again with this individual only to find out that she became very unstable with signs of substance abuse (alcohol only) arising because of severe depression. When asked about the current situation, the only statement she made was, "I don't know who I am. I'm not a woman and I'm not a man. I want to see if I can learn how to be comfortable in this body." She is currently in therapy, still going to college getting ready to graduate.

When asked how she was feeling about the situation, the respondent replied,

I don't think anyone can understand what someone like me is going through. It's even an added stress having between your family and something you've wanted all your life. Think of it this way, if you had to choose between someone you

love (someone whom you want to be a part of your life), and having your dream come true, what would you chose? It's not fair. I love my mom. I don't want to lose her, but at the same time my dream is right in front of me. A dream I have for as long as I can remember. It is within reach and I can't do anything about it. I cry a lot over what to do. I do consider myself suicidal. I guess I'll be like this until my mom passes away or until I die because I don't see myself doing anything about it right now. It's a no win situation.

CASE FOUR

A 35-year-old biological born male who has undergone gender reassignment surgery, currently living as female. Happily married and currently a very successful hairdresser. Raised with both parents from urban West Virginia. Family background is middle class with alcohol and drug abuse present. No criminal activities, but signs of abuse are present. Knew she was transgendered in high school. Dated only males. Dropped out of high school and left home at an early age because of disapproval and lack of support from family. Family disowned her and presently they have no contact with each other. Lived basically in poverty, working in the sex industry, bars, and doing drag shows, while saving up for gender reassignment surgery, and still abusing alcohol and drugs. Got clean before surgery and is currently still sober.

During the interview she stated that,

After a year and a half doing drag shows, I remained the only blemish on an otherwise perfectly charming existence. In spite of the sparkling, protective veneer I'd learned to apply to my face and my professional persona, inside I was still the frightened, insecure kid I'd always been. I was still the problem. Offstage, I didn't belong. I was applauded by gay society, but they didn't accept me as one of their own. I was too feminine to be attractive to most gay men. "If I wanted a woman, I'd find one" was a familiar phrase. I didn't belong in straight society either. Society was apparently divided into two distinct sexual groupings,

and I didn't fit in either one. It was as though one foot was forever wedged into a sequined, spiked heel while the other was firmly planted in a dingy sneaker. I spent my evenings in designer gowns, but during the day, society demanded I live as a man. It was a confusing way to live. In public, I generally wore jeans and lumberjack shirts and prayed I would pass as a lesbian. Life isn't perfect, and in reality, the product is never finished – it's a work in progress. For me, there will probably always remain dark shadows from a transgendered past to haunt me. Still, I'm more at peace with my total person than I ever thought possible. Over the years it has become less important that I be considered 150 percent female. I am what I am. It is more important that I accept and value that person. Universal acceptance would be nice, but it is not necessary – and will never happen! Rejection does still hurt. These days, it just doesn't hurt as much, or for as long.

CASE FIVE

A 36-year-old biological female with one child. Got pregnant by a 'one night stand' with a best friend just to 'see what it was like' to have sex with a man. Knew she was transgendered as long as she can remember and always dated only women. Appearance was very masculine and served as a 'male' role to her daughter. Only dates 'feminine' women who serve as a 'female' role to her daughter. Family background is of lower middle class, which explains why individual is not pursuing gender reassignment surgery (too expensive). Currently the individual and her daughter reside in an urban area of West Virginia. Individual stated that she was comfortable being female, and that she receives during sex as well as gives. Also states that she would not become a man if she could because of her feelings of hating men to the point where she can't 'stand' them. Individual has a long history of criminal activities and substance abuse (both alcohol and drug), as well as the daughter. She has been prison and the daughter has a history of placement in states custody. Both mother and daughter show signs of past abuse. Won't talk about family, states it's only "the two of them" now and wants to keep it that way.

During the interview, this respondent stated,

I have been in trouble with the law for as long as I can remember. I have always been masculine and had looks like a man. I don't mind being considered a man when I go out in public; it actually makes me feel good because people let you get by with more when they think you are a man. I like the appearance of being a

man but I don't think I would ever go through with surgery even though I have thought about it. Most of the women I have been with consider themselves lesbians. If I'm not a woman then I wouldn't be considered a lesbian. I like lesbians too much. Maybe it's because I'm institutionalized, or maybe it's because I just hate men, but I don't think I would have the surgery even if I could.

Do you consider yourself transsexual?

I consider myself transsexual because in public I am a man. For the appearance of my daughter, my girlfriend, and myself I am a man. That's what I want and that makes me happy. I don't have to have surgery to consider myself a man. I don't have to go through with the surgery for my girlfriend, or my daughter to accept me as a man. I'm happy with the things like they are now. The ones who are most important in my life know who and what I am. That's all that counts. That's all that makes me happy.

CASE SIX

A 20-year-old biological female. This individual is a severe drug and alcohol addict due to deep depression and it being provided by father. High school drop out and currently not pursuing a GED or job. Living from place to place with family and friends. Has a long history of criminal activity and is currently in trouble with the law. Family is from lower class, on social security, with both of the parents working 'odd' jobs for extra money. Family is from urban Kentucky, but not highly functional. Not fully educated about Gender Identity Disorder, only knows that she wants to be a man. Appearance is very masculine, with both cloths and mannerisms of a man. Family is aware of the individual being 'gay' and tolerates it, but gives little to no support in helping her. This individual has only dated and will only date women. Depression comes from the fact that she wants to be a man, but can't. Currently this individual is very suicidal, but refuses to get help. Also there is a history of severe abuse from parents. Father also abuses mother of the individual.

This individual will not attend school or work under a female name. She will not let her partners touch her during sexual encounters. This individual assumes the male role and will only date women that will accept that. During the initial interview she stated that,

The only thing that will make me happy, and the only thing I want is to be a man. I can't do anything about it right now until I get the money I need to get surgery done. That's why I'm in trouble all the time. I do these things to get money, and

I'm trying to save, but it gets frustrating and then I want the pain to go away so I get high or go and do something stupid. It's a never-ending cycle. Sometimes I don't want to live, especially as a woman.

CASE SEVEN

A 19-year-old biological female. This individual is a severe drug and alcohol addict who is currently in a rehab program. Dropped out of high school but is presently attending GED classes in preparation to take the test within a month. She is currently working at a fast food restaurant and is about to be promoted to manager. This individual also does not understand Gender Identity Disorder, but shows all signs of this diagnosis. This case is the younger sibling of case number six with all family background information the same. This individual is somewhat masculine with clothes being of male gender, but mannerisms being a cross between masculine and feminine. Wants to be a man, but has come to accept her biological sex because of her inability of getting surgery. Has dated men in the past, but prefers women. Currently will only date women.

In response to the question, “What makes you think that you are transsexual?” the respondent replied,

I think I’m transsexual because of the fact that that is all I think about. I want to be a man. I want to make love to a woman as a man. I want to touch them, and let them be able to touch me as a man. I think that is the only way I would let a woman touch me. That is if I was a man. I would like it better if my work thought I was a man. I only accept being a girl now because I have to. I know what I have to do to get surgery, and that’s what I’m working toward. My girlfriend treats me like a man, and that helps a lot. I get that feeling that I have to

be a man at some time in my life just to stay sane, and she gives that to me. I don't know what I would do without her. I swear sometimes it's like a hungry feeling you get and you have to feed the feeling to satisfy it so it will go away. Who would want to wish that on themselves? It's being an addict at something you can't do anything about. At least with drugs or alcohol, you can get treatment. With this, without the money or resources, you're just sort of hung out to dry. It's worse than going through withdraws.

CASE EIGHT

An 18-year-old biological female. This individual is the youngest sibling of case number six and case number seven. Currently a senior in high school but has plans to drop out. Also a severe drug and alcohol addict, but states she only uses when available. This individual, unlike her sisters, resides at home with the parents all the time. Currently this individual is diagnosed with depression, bi-polar disorder, and multiple personality disorder due to severe sexual, mental and physical abuse. This individual is also very suicidal and a habitual runaway. Appearance and mannerisms of this individual are feminine, with clothes being that of both female and male persuasion. They've had reports of this individual 'experimenting' with other girls, but this individual denies the reports. She states that lesbianism is 'gross' and she would never do it. Also this individual states that she is currently not dating – neither male nor female. She has never heard of Gender Identity Disorder and knows nothing about it. Won't talk about her sexual orientation. States that she would like to be a man because life would be much easier.

I included this case study, not because of this individual being a 'true' transsexual, but because this individual wants to be a man because of the 'power' issue a lot of people view when considering the transition. A wrong reason for pursuing transition but it happens. When asked about why this individual wanted to be a man, the respondent replied,

Because I think my life would be a lot easier if I was a man. I wouldn't be scared of relationships. I would be a person people actually liked. I don't like myself for who or what I am. I just want people to like me for who and what I am. I think my dad wanted a boy, so I want to be a boy to make him happy.

What about what makes you happy?

I don't think I can be happy. I've never been happy in my life. I'm not sure I even know what that means. I want to be happy. I try to be happy, but it never works. Like I said, I don't think I can be. I don't think I can. Sometimes I wonder if it even exists. Is anybody ever really happy?

A couple of months after this interview this individual committed suicide by an overdose of drugs, a suicide that may have been prevented by giving more education on sexuality, and how to deal with it. A source revealed that this individual was gay but could not accept it.

It can be a different challenging experience to have the girl you've been going steady with shift into a new, masculine person before your eyes. Statistics predict doom for most relationships in which one partner undergoes any serious life change, and it's true that most initially lesbian relationships don't survive the transition into this new, nameless territory. For Tracy, a twenty-seven-year-old self-proclaimed 'dyke,' the decision to leave her marriage came after years of witnessing the erosion of her solidly lesbian relationship into something that felt disorientingly "straight."

Tracy, who identifies "femme. Not high, not low, just femme," noticed a shift in her skirt-wearing, face painting girlfriend a year into their relationship. An accidental short haircut set into motion a series of slow but obvious changes. "Boy clothes were worn, her hair was eventually all off or incredibly short, the gym routine changed from running to weights." Eventually, her partner made the full transition to a male identity.

Recounts Tracy, "We fell into these roles of husband and wife, and it was simply that. He fixed the cars, did all the household fixer-uppers, and wore suits to work. I cooked and cleaned, took care of our daughter and wore skirts." Finding herself enmeshed in roles that many bonafide straight ladies would balk at, Tracy "began to panic. We both did."

The four-year relationship ended two months after the couple got married. After busting back into the dating world "on a dyke rampage," Tracy has settled into a more serious relationship, and finds herself a bit culture-shocked from the roles she'd grown accustomed to. "I'm dating someone who needs the same kind of princess attention I was

used to receiving, not giving. I feel like I'm basically relearning how to be a lesbian, as weird as that sounds."

Not all such relationships end tragically, or end at all. Twenty-five year old Tina had a relatively easy time coping with her partner's transition. There were challenges says Tina, "I was afraid of folks questioning my queerness, since I already get that shit as a femme. I was afraid of becoming invisible." But the couple worked through it by "Sticking together. Having total respect for one another and our identities."

Such mutual respect in no doubt largely responsible for the longevity of their seven-year romance. "My partner does not want me to become 'straight' to be in this relationship," she explains, "but really respects my queer identity." It's a respect that goes both ways. Tina says she's privileged to "be in love with a strong, brilliant person who is willing to question gender and its meaning in society."

Whether or not a relationship can survive a gender transition involves many factors: the reality of biology, attachment to identity, assumptions about gender roles, true love, commitment, and social stigmas – or the sudden, disturbing lack of them. When asked for a bit of insight for ladies whose sweethearts are considering hopping the gender fence, Tina quips, "It's not about you! This is a time when we, as allies and as partners, need to get over ourselves." While it may be a lot to ask someone to transcend the heartache and take the high road of understanding, Tina maintains it is crucial. "Our partners should be able to count on our support for their choices around gender, whatever they are. Whether or not we stay in the relationship, our support for their transition shouldn't be conditional" (Tea, 2003).

Having looked at the history, definitions, theories, whether transsexualism is a choice or not and examples of gender dysphoria; each has its areas where even its proponents feel there is a need for further work to prove or disprove certain hypothesis. There appear to be too many unknowns involved to be sure of much at all. This is mainly because we rely on “accidents of birth” in the population to provide us with data. It would be quite unethical to establish controlled experiments like the ones that are carried out on rats and other animals on human children to get a definitive answer.

Given the fact that most of the funding and impetus for research on gender dysphoria comes from the need for the medical profession to treat a particular group of individuals (transsexuals), the majority of research is undertaken on this group. Findings for this group are then often used to extrapolate to other groupings within the overall classification of gender dysphoria.

One of the difficulties faced by those who try to classify gender dysphoric people is that it is not possible to generate classifications based on cause, because the cause(s) are not understood. The standard diagnosis tools such as the DSM III and IV to focus on the need for a clinical diagnosis for treatment of patients. This results in a bias towards the classification of gender dysphoric people into categories of “illness” which, in most cases, is not a true reflection of that group’s circumstances.

Professor L. Gooren of Amsterdam states in his paper, “Transsexualism, Introduction & General Aspects of Treatment,” “Gender identity, a typical human attribute, is not likely to be explained exclusively by either hormones or rearing; but

science is still far away from a solid theoretical model that unifies and explains the many expressions of gender dysphoria encountered in clinical medicine” (Transsexual women’s resources).

There is an undoubted need for transgendered people to find their “true selves” and to be proud of who and what we are. Merely accepting the orthodoxy of churches and the media will not help transgendered people very much. It is well known that those people who have had feelings that are described as transgendered for any length of time will almost never cease to have these feelings, regardless of the amount of psychotherapy they might receive to achieve a “cure” (TWR). The best thing for a transgendered person to do, by far, is to work on the acceptance of himself or herself as a worthwhile person who has the ability to achieve their full potential. Effort spent on correcting the damage that low self-esteem may have done to their outlook on life is rarely misspent.

It is not necessary for a transgendered person to be treated as a sick person. They can be thought of as someone who has discovered that a traumatic experience in their life has caused a long period of suppressed grief and anger to surface. Helping them through a time of crisis will produce future rewards in a happier and more capable person.

Do transgendered individuals have a right to exist? Why do we need to examine this question? Surely there is no need to look at such a fundamental issue that seems to be covered by anti-discrimination legislation? Unfortunately, there are quite a few people and organizations who seem to get a lot of column space and air time from the media to tell us why people who do not conform to their expectations should not be allowed to do so in public and even in extreme cases, not be allowed to exist at all. These

people range from the American “moral majority” through the various conservative organizations of the “rural rump” to the Rev. Fred Nile.

They give a lot of different messages but they are asserting that anyone who expresses variant behavior in gender or sexuality should be prevented from doing so. Their arguments are based on the idea that it is wrong, evil, or a bad influence on others.

Well then, do transgendered people have the right to exist? The answer has to be yes! They have existed for most of human history and the evidence suggests that it is the only since Judean-Christian-Muslim monotheism that transgender has been frowned upon (based on the close association of transgendered people with the old religions).

None of the arguments put forward by the anti-diversity groups seems to be born out by any evidence and the moral judgments do not stand up to any scrutiny either. Here are some of the accusations (TWR):

- Transgendered people are perverts
- They are a danger to children
- They are an anathema to God
- It is not natural
- It is unhealthy
- It will ruin the lives of your children

Are transgendered people perverts? Studies have shown that this is not true. There is actually a lower incidence of sexual abuse and aberrant behavior within those people who are transgendered (TWR).

Are they a danger to children? Far less than other sectors of the community in fact. There is a much lower incidence of child molestation than in the general community. It is usually the most upright and solid citizens who are a danger to children in this way. Transgendered people are usually very loving parents and favored uncles and aunts (TWR).

Does God really hate transgendered people? Most people understand their God to be a loving being that “cares for even the tiniest bird in the sky” and forgives all people. Why should transgendered people be excluded from this? Religious arguments can become tortured affairs with quote and counter quote from scriptures but the principles of all religions hold. Everyone is included and there is no discrimination according to sex, race or anything other than adherence to the principles of the religion. A large proportion of transgendered people are active and welcome members of their church (TWR).

Is being transgendered unnatural? If we look at the fact that transgender is evident across cultural boundaries and has clearly been in existence for many centuries, it is hard to see why it could be unnatural. It seems to be entirely natural, although different to the norms of Western culture; it is fully accepted in many cultures in the world (TWR).

Is it unhealthy? Being transgendered is not, in itself, unhealthy. Some of the consequences of it can be. It is not very healthy to be depressed because of the need to suppress genuine feelings of identifying with a gender that does not conform to your birth sex. Nor is it healthy to be attacked (physically or verbally) by others for expressing your feelings in a positive way (TWR).

Will the children of transsexuals have ruined lives? They only published information on this shows that, in the group studied, NO children were subject to a greater level of teasing at school nor were they likely to experience any gender identity problems as a result of being children of transsexuals. The big issue was the divorce of their parents and the unpleasantness that is often associated with one parent denigrating the other. Divorce is not so much caused by one partner being transgendered but it often precipitates other problems in the marriage, which lead to divorce (TWR).

Why are we interested in understanding human sexual behaviors and desires? Attempting to understand human sexual behavior is a legitimate part of the quest to understand human sexual nature (that is, to understand universal features of human biology and psychology). However, social factors have a significant effect on what questions get the most attention and how research gets framed. Most notably, scientists doing research on sexual orientation are almost always concerned with how and why people become homosexual, or transsexual, not how and why people become heterosexual. It is important to weed out cultural presumptions about sexual orientation, especially those that infiltrate scientific research and its metaphysical foundations. Once we have done so, the character and shape of scientific research (as well as social scientific and humanistic research) and our general thinking about sexual orientation will be dramatically changed for the better.

I want to end with an essay from a transsexual, who has fought being who they truly are all their life, but recently came to terms with it and now embraces the new life that now makes them whole. This is how they expressed how they feel.

Because being transsexual is often so hurtful, so filled with sadness and longing, with shame, and loss of self, it is easy to come to the conclusion that the whole thing is utterly a curse, perhaps inflicted by arcane and evil ancient gods. Oh, probably. But there is an upside too.

Most human lives are utterly mundane, devoid of any real uniqueness; the average person somnambulates through an existence devoted to filling the roles expected of them. But to be a transsexual is a magical, wondrous thing.

We are given many gifts in compensation for the terrible loss of our childhood as ourselves, and for the pain we endure. We are by some as yet unknown mechanism statistically far more intelligent, as a class, than perhaps any other kind of people. We are almost universally more creative, and we often possess incredible levels of courage and self-determination, demonstrated by our very survival, and ultimate attainment of our goal. We are rare as miracles, and in our own way, as magical, or so has been the belief of all ancient cultures on the earth.

We are given awareness that others would never experience, understanding of gender, of the human condition, of society and the roles and hidden rules unquestioned within it. We are given a window into the lives of both sexes, and cannot help but be, to some degree, beyond either. From this we have a rare opportunity: to choose our own life, outside predetermined and unquestioned definition or role. We can do new things, original things, only because our experience is so unique.

We get to be true shapeshifters, and experience the sheer wonder of melty-wax flesh and a real rebirth into the world. Our brains and bodies gain benefit from having

been bathed in and altered by the hormones of both sexes. We appear to retain our visible youthfulness where others wrinkle, and for years longer. We possess neural advantages from both sexes, such as the language advantages of the feminized brain, and the spatial abilities of the masculinized brain both. We are shocked into waking up; if we allow it, to a life we created for ourselves... we are not automatically doomed to sleepwalk through life.

After our transformation and the full-moon lycanthropic miracle that the modern age affords us, we can live lives of success, love, and genuine specialness if we choose. If we can get past our upbringing, past the programming, the bigotry, the messages of disgust from the culture around us, if we can stand as ourselves in freedom, then our special gifts grant us a heritage of wondrous power.

We have a proud and marvelous history. In ancient days we were magic incarnate. We were Nadle, Winkte, Two-souls, Shamans and healers and magical beings to our communities. We possessed the ability to give the blessings of the gods and spirits, and were prized as companions, lovers, and teachers.

We were the prize gift of ancient tribes, entertainers, designers and dreamers. Sometimes we were the rulers of empires, and the consorts of emperors. We were champions and warriors too, who were feared for our unique gifts turned to inevitable victory.

Know that it is only in recent centuries, with the rise of the single minded, monolithic and monotheistic desert religions, filled with harsh single gods and twisted,

narrow morals, that our kind have become reviled, the objects of scorn. Once, we were the kin of the gods.

To be transsexual is not easy and it is not a birth that could be envied, but neither is it damnation. It was once considered a rare wonder, a faery gift that cuts as it blesses.

And in the modern age, of hormones and surgery, we are the first generations of our kind to finally know the joy of complete transformation, of truly gaining our rightful bodies. No other transsexuals in history have been so fortunate.

I say that we are unicorns, rare and wondrous, with still a touch of ancient magic and the kinship of the gods. Though it is agony, beyond the fire we have the opportunity to become alchemic gold.

We have much to add to the world and to give ourselves and to those who love us. We have always been, we are still the prizes of the tribe, for only the world around us has changed, the desert harshness branding us vile. We are still the same.

Our compensations are real, and our lives are special. We have but to grasp the gifts born of our sufferings. When I look around me at the mundane lives, there are times I think that maybe I am glad I was born transsexual, for I would never have been what I have become without that curse. I cannot help but be grateful for my uniqueness, so I am brought to a strange revelation, deep down I cherish having been born a transsexual.

Be a unicorn with me, and cherish it too (personal communication).

Epilogue:

Depression and Suicide Among Transsexuals

Transsexuals are confronted by myriad frustrating, contradictory and depressing situations and experiences, and therefore should be depressed. I would argue that if they were not depressed, they would most certainly not be displaying a normal transsexual pattern. Often, it is depression and anger that help transsexuals maintain their focus and, in time, attain a positive resolution of their dysphoria.

Because suicidal thoughts and actions often accompany deep and persistent depressions, suicidal variables may appear more frequently in the backgrounds of transsexuals than of the general public. When I talk with a transsexual with a history of suicidal impulses or gestures, I explore with them the reasons for their thoughts and actions. If depression, anger and suicidal variables are related to gender dysphoria, they will most likely abate as the transsexual moves along the treatment path. Suicidal intentions tend to dissipate as people come to believe that a positive outcome is likely.

In my experience, once a transsexual has dealt with these issues, he is no more or less inclined to depression or suicide than anyone else. The problem is they have to deal with the issues, and to do that you have to admit to them. If you are, or know someone, who is transsexual, and need help or just someone to talk to, please contact one of the following agencies or a local professional who specializes in the area of sexuality.

Remember, you are not alone.

Hotlines

The American Boyz (410) 620-2161

FTM International (FTMI) (415) 553-5987

The International Foundation for Gender Education (IFGE) (781) 899-2212

The National Youth Advocacy Coalition (NYAC) (202) 319-7596

CrossPort (513) 919-4850

National Suicide Hotline 1-800-SUICIDE (1-800-784-2433)

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Appendix

Appendix

The Harry Benjamin International Gender Dysphoria Association's Standards of Care for
Gender Identity Disorders, Sixth Version.

The Harry Benjamin International Gender Dysphoria Association's

Standards of Care for Gender Identity Disorders, Sixth Version

February, 2001

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This is the sixth version of the Standards of Care since the original 1979 document. Previous revisions were in 1980, 1981, 1990, and 1998.

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I. Introductory Concepts

The Purpose of the Standards of Care. The major purpose of the Standards of Care (SOC) is to articulate this international organization's professional consensus about the psychiatric,

psychological, medical, and surgical management of gender identity disorders. Professionals may use this document to understand the parameters within which they may offer assistance to those with these conditions. Persons with gender identity disorders, their families, and social institutions may use the SOC to understand the current thinking of professionals. All readers should be aware of the limitations of knowledge in this area and of the hope that some of the clinical uncertainties will be resolved in the future through scientific investigation.

The Overarching Treatment Goal. The general goal of psychotherapeutic, endocrine, or surgical therapy for persons with gender identity disorders is lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment.

The Standards of Care Are Clinical Guidelines. The SOC are intended to provide flexible directions for the treatment of persons with gender identity disorders. When eligibility requirements are stated they are meant to be minimum requirements. Individual professionals and organized programs may modify them. Clinical departures from these guidelines may come about because of a patient's unique anatomic, social, or psychological situation, an experienced professional's evolving method of handling a common situation, or a research protocol. These departures should be recognized as such, explained to the patient, and documented both for legal protection and so that the short and long term results can be retrieved to help the field to evolve.

The Clinical Threshold. A clinical threshold is passed when concerns, uncertainties, and questions about gender identity persist during a person's development, become so intense as to seem to be the most important aspect of a person's life, or prevent the

establishment of a relatively unconflicted gender identity. The person's struggles are then variously informally referred to as a gender identity problem, gender dysphoria, a gender problem, a gender concern, gender distress, gender conflict, or transsexualism. Such struggles are known to occur from the preschool years to old age and have many alternate forms. These reflect various degrees of personal dissatisfaction with sexual identity, sex and gender demarcating body characteristics, gender roles, gender identity, and the perceptions of others. When dissatisfied individuals meet specified criteria in one of two official nomenclatures--the International Classification of Diseases-10 (ICD-10) or the Diagnostic and Statistical Manual of Mental Disorders--Fourth Edition (DSM-IV)--they are formally designated as suffering from a gender identity disorder (GID). Some persons with GID exceed another threshold--they persistently possess a wish for surgical transformation of their bodies.

Two Primary Populations with GID Exist -- Biological Males and Biological Females. The sex of a patient always is a significant factor in the management of GID. Clinicians need to separately consider the biologic, social, psychological, and economic dilemmas of each sex. All patients, however, should follow the SOC.

II. Epidemiological Considerations

Prevalence. When the gender identity disorders first came to professional attention, clinical perspectives were largely focused on how to identify candidates for sex reassignment surgery. As the field matured, professionals recognized that some persons with bona fide gender identity disorders neither desired nor were candidates for sex reassignment surgery. The earliest estimates of

prevalence for transsexualism in adults were 1 in 37,000 males and 1 in 107,000 females. The most recent prevalence information from the Netherlands for the transsexual end of the gender identity disorder spectrum is 1 in 11,900 males and 1 in 30,400 females. Four observations, not yet firmly supported by systematic study, increase the likelihood of an even higher prevalence: 1) unrecognized gender problems are occasionally diagnosed when patients are seen with anxiety, depression, bipolar disorder, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, other sexual disorders and intersexed conditions; 2) some nonpatient male transvestites, female impersonators, transgender people, and male and female homosexuals may have a form of gender identity disorder; 3) the intensity of some persons' gender identity disorders fluctuates below and above a clinical threshold; 4) gender variance among female-bodied individuals tends to be relatively invisible to the culture, particularly to mental health professionals and scientists.

Natural History of Gender Identity Disorders. Ideally, prospective data about the natural history of gender identity struggles would inform all treatment decisions. These are lacking, except for the demonstration that, without therapy, most boys and girls with gender identity disorders outgrow their wish to change sex and gender. After the diagnosis of GID is made the therapeutic approach usually includes three elements or phases (sometimes labeled triadic therapy): a real-life experience in the desired role, hormones of the desired gender, and surgery to change the genitalia and other sex characteristics. Five less firmly scientifically established observations prevent clinicians from prescribing the triadic therapy based on diagnosis alone: 1) some carefully diagnosed persons spontaneously change their aspirations; 2)

others make more comfortable accommodations to their gender identities without medical interventions; 3) others give up their wish to follow the triadic sequence during psychotherapy; 4) some gender identity clinics have an unexplained high drop out rate; and 5) the percentage of persons who are not benefited from the triadic therapy varies significantly from study to study. Many persons with GID will desire all three elements of triadic therapy. Typically, triadic therapy takes place in the order of hormones ==> real-life experience ==> surgery, or sometimes: real-life experience ==> hormones ==> surgery. For some biologic females, the preferred sequence may be hormones ==> breast surgery ==> real-life experience. However, the diagnosis of GID invites the consideration of a variety of therapeutic options, only one of which is the complete therapeutic triad. Clinicians have increasingly become aware that not all persons with gender identity disorders need or want all three elements of triadic therapy.

Cultural Differences in Gender Identity Variance throughout the World. Even if epidemiological studies established that a similar base rate of gender identity disorders existed all over the world, it is likely that cultural differences from one country to another would alter the behavioral expressions of these conditions. Moreover, access to treatment, cost of treatment, the therapies offered and the social attitudes towards gender variant people and the professionals who deliver care differ broadly from place to place. While in most countries, crossing gender boundaries usually generates moral censure rather than compassion, there are striking examples in certain cultures of cross-gendered behaviors (e.g., in spiritual leaders) that are not stigmatized.

III. Diagnostic Nomenclature

The Five Elements of Clinical Work. Professional involvement with patients with gender identity disorders involves any of the following: diagnostic assessment, psychotherapy, real-life experience, hormone therapy, and surgical therapy. This section provides a background on diagnostic assessment.

The Development of a Nomenclature. The term *transexual* emerged into professional and public usage in the 1950s as a means of designating a person who aspired to or actually lived in the anatomically contrary gender role, whether or not hormones had been administered or surgery had been performed. During the 1960s and 1970s, clinicians used the term *true transsexual*. The true transsexual was thought to be a person with a characteristic path of atypical gender identity development that predicted an improved life from a treatment sequence that culminated in genital surgery. True transsexuals were thought to have: 1) cross-gender identifications that were consistently expressed behaviorally in childhood, adolescence, and adulthood; 2) minimal or no sexual arousal to cross-dressing; and 3) no heterosexual interest, relative to their anatomic sex. True transsexuals could be of either sex. True transsexual males were distinguished from males who arrived at the desire to change sex and gender via a reasonably masculine behavioral developmental pathway. Belief in the true transsexual concept for males dissipated when it was realized that such patients were rarely encountered, and that some of the original true transsexuals had falsified their histories to make their stories match the earliest theories about the disorder. The concept of true transsexual females never created diagnostic uncertainties, largely because patient histories were relatively consistent and gender

variant behaviors such as female cross-dressing remained unseen by clinicians. The term "gender dysphoria syndrome" was later adopted to designate the presence of a gender problem in either sex until psychiatry developed an official nomenclature.

The diagnosis of Transsexualism was introduced in the DSM-III in 1980 for gender dysphoric individuals who demonstrated at least two years of continuous interest in transforming the sex of their bodies and their social gender status. Others with gender dysphoria could be diagnosed as Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type; or Gender Identity Disorder Not Otherwise Specified (GIDNOS). These diagnostic terms were usually ignored by the media, which used the term transsexual for any person who wanted to change his/her sex and gender.

The DSM-IV. In 1994, the DSM-IV committee replaced the diagnosis of Transsexualism with Gender Identity Disorder.

Depending on their age, those with a strong and persistent cross-gender identification and a persistent discomfort with their sex or a sense of inappropriateness in the gender role of that sex were to be diagnosed as Gender Identity Disorder of Childhood (302.6), Adolescence, or Adulthood (302.85). For persons who did not meet these criteria, Gender Identity Disorder Not Otherwise Specified (GIDNOS)(302.6) was to be used. This category included a variety of individuals, including those who desired only castration or penectomy without a desire to develop breasts, those who wished hormone therapy and mastectomy without genital reconstruction, those with a congenital intersex condition, those with transient stress-related cross-dressing, and those with considerable ambivalence about giving up their gender status. Patients diagnosed with GID and GIDNOS were to be subclassified according to the sexual orientation: attracted to males; attracted to

females; attracted to both; or attracted to neither. This subclassification was intended to assist in determining, over time, whether individuals of one sexual orientation or another experienced better outcomes using particular therapeutic approaches; it was **not** intended to guide treatment decisions. Between the publication of DSM-III and DSM-IV, the term "transgender" began to be used in various ways. Some employed it to refer to those with unusual gender identities in a value-free manner -- that is, without a connotation of psychopathology. Some people informally used the term to refer to any person with any type of gender identity issues. Transgender is not a formal diagnosis, but many professionals and members of the public found it easier to use informally than GIDNOS, which is a formal diagnosis.

The ICD-10. The ICD-10 now provides five diagnoses for the gender identity disorders (F64):

Transsexualism (F64.0) has three criteria:

1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment;
2. The transsexual identity has been present persistently for at least two years;
3. The disorder is not a symptom of another mental disorder or a chromosomal abnormality.

Dual-role Transvestism (F64.1) has three criteria:

4. The individual wears clothes of the opposite sex in order to experience temporary membership in the opposite sex;
5. There is no sexual motivation for the cross-dressing;
6. The individual has no desire for a permanent change to the opposite sex.

Gender Identity Disorder of Childhood (64.2) has separate criteria for girls and for boys.

For girls:

7. The individual shows persistent and intense distress about being a girl, and has a stated desire to be a boy (not merely a desire for any perceived cultural advantages to being a boy) or insists that she is a boy;
8. Either of the following must be present:
 - a. Persistent marked aversion to normative feminine clothing and insistence on wearing stereotypical masculine clothing;
 - b. Persistent repudiation of female anatomical structures, as evidenced by at least one of the following:
 1. An assertion that she has, or will grow, a penis;
 2. Rejection of urination in a sitting position;
 3. Assertion that she does not want to grow breasts or menstruate.
9. The girl has not yet reached puberty;
10. The disorder must have been present for at least 6 months.

For boys:

11. The individual shows persistent and intense distress about being a boy, and has a desire to be a girl, or, more rarely, insists that he is a girl.
12. Either of the following must be present:
 - a. Preoccupation with stereotypic female activities, as shown by a preference for either cross-dressing or simulating female attire, or by an intense desire to participate in the games and pastimes of girls and rejection of stereotypical male toys, games, and activities;
 - b. Persistent repudiation of male anatomical structures, as evidenced by at least one of the following repeated assertions:
 1. That he will grow up to become a woman (not merely in the role);
 2. That his penis or testes are disgusting or will disappear;
 3. That it would be better not to have a penis or testes.

13. The boy has not yet reached puberty;
14. The disorder must have been present for at least 6 months.

Other Gender Identity Disorders (F64.8) has no specific criteria.

Gender Identity Disorder, Unspecified has no specific criteria.

Either of the previous two diagnoses could be used for those with an intersexed condition.

The purpose of the DSM-IV and ICD-10 is to guide treatment and research. Different professional groups created these nomenclatures through consensus processes at different times.

There is an expectation that the differences between the systems will be eliminated in the future. At this point, the specific diagnoses are based more on clinical reasoning than on scientific investigation.

Are Gender Identity Disorders Mental Disorders? To qualify as a mental disorder, a behavioral pattern must result in a significant adaptive disadvantage to the person or cause personal mental suffering. The DSM-IV and ICD-10 have defined hundreds of mental disorders which vary in onset, duration, pathogenesis, functional disability, and treatability. The designation of gender identity disorders as mental disorders is not a license for stigmatization, or for the deprivation of gender patients' civil rights. The use of a formal diagnosis is often important in offering relief, providing health insurance coverage, and guiding research to provide more effective future treatments.

IV. The Mental Health Professional

The Ten Tasks of the Mental Health Professional. Mental health professionals (MHPs) who work with individuals with gender identity disorders may be regularly called upon to carry out many of these responsibilities:

14. To accurately diagnose the individual's gender disorder;
15. To accurately diagnose any co-morbid psychiatric conditions and see to their appropriate treatment;
16. To counsel the individual about the range of treatment options and their implications;
17. To engage in psychotherapy;
18. To ascertain eligibility and readiness for hormone and surgical therapy;
19. To make formal recommendations to medical and surgical colleagues;
20. To document their patient's relevant history in a letter of recommendation;
21. To be a colleague on a team of professionals with an interest in the gender identity disorders;
22. To educate family members, employers, and institutions about gender identity disorders;
23. To be available for follow-up of previously seen gender patients.

The Adult-Specialist. The education of the mental health professional who specializes in adult gender identity disorders rests upon basic general clinical competence in diagnosis and treatment of mental or emotional disorders. Clinical training may occur within any formally credentialing discipline -- for example, psychology, psychiatry, social work, counseling, or nursing. The following are the recommended minimal credentials for special competence with the gender identity disorders:

24. A master's degree or its equivalent in a clinical behavioral science field. This or a more advanced degree should be granted by an institution accredited by a recognized national or regional accrediting board. The mental health professional should have

documented credentials from a proper training facility and a licensing board.

25. Specialized training and competence in the assessment of the DSM-IV/ICD-10 Sexual Disorders (not simply gender identity disorders).
26. Documented supervised training and competence in psychotherapy.
27. Continuing education in the treatment of gender identity disorders, which may include attendance at professional meetings, workshops, or seminars or participating in research related to gender identity issues.

The Child-Specialist. The professional who evaluates and offers therapy for a child or early adolescent with GID should have been trained in childhood and adolescent developmental psychopathology. The professional should be competent in diagnosing and treating the ordinary problems of children and adolescents. These requirements are in addition to the adult-specialist requirement.

The Differences between Eligibility and Readiness. The SOC provide recommendations for eligibility requirements for hormones and surgery. Without first meeting these recommended eligibility requirements, the patient and the therapist should not request hormones or surgery. An example of an eligibility requirement is: a person must live full time in the preferred gender for twelve months prior to genital surgery. To meet this criterion, the professional needs to document that the real-life experience has occurred for this duration. Meeting readiness criteria -- further consolidation of the evolving gender identity or improving mental health in the new or confirmed gender role -- is more complicated, because it rests upon the clinician's and the patient's judgment.

The Mental Health Professional's Relationship to the Prescribing Physician and Surgeon. Mental health professionals who

recommend hormonal and surgical therapy share the legal and ethical responsibility for that decision with the physician who undertakes the treatment. Hormonal treatment can often alleviate anxiety and depression in people without the use of additional psychotropic medications. Some individuals, however, need psychotropic medication prior to, or concurrent with, taking hormones or having surgery. The mental health professional is expected to make this assessment, and see that the appropriate psychotropic medications are offered to the patient. The presence of psychiatric co-morbidities does not necessarily preclude hormonal or surgical treatment, but some diagnoses pose difficult treatment dilemmas and may delay or preclude the use of either treatment.

The Mental Health Professional's Documentation Letter for Hormone Therapy or Surgery Should Succinctly Specify:

28. The patient's general identifying characteristics;
29. The initial and evolving gender, sexual, and other psychiatric diagnoses;
30. The duration of their professional relationship including the type of psychotherapy or evaluation that the patient underwent;
31. The eligibility criteria that have been met and the mental health professional's rationale for hormone therapy or surgery;
32. The degree to which the patient has followed the Standards of Care to date and the likelihood of future compliance;
33. Whether the author of the report is part of a gender team;
34. That the sender welcomes a phone call to verify the fact that the mental health professional actually wrote the letter as described in this document.

The organization and completeness of these letters provide the hormone-prescribing physician and the surgeon an important degree of assurance that mental health professional is knowledgeable and competent concerning gender identity disorders.

One Letter is Required for Instituting Hormone Therapy, or for Breast Surgery. One letter from a mental health professional, including the above seven points, written to the physician who will be responsible for the patient's medical treatment, is sufficient for instituting hormone therapy or for a referral for breast surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty).

Two Letters are Generally Required for Genital Surgery. Genital surgery for biologic males may include orchiectomy, penectomy, clitoroplasty, labiaplasty or creation of a neovagina; for biologic females it may include hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, or creation of a neophallus.

It is ideal if mental health professionals conduct their tasks and periodically report on these processes as part of a team of other mental health professionals and nonpsychiatric physicians. One letter to the physician performing genital surgery will generally suffice as long as two mental health professionals sign it.

More commonly, however, letters of recommendation are from mental health professionals who work alone without colleagues experienced with gender identity disorders. Because professionals working independently may not have the benefit of ongoing professional consultation on gender cases, two letters of recommendation are required prior to initiating genital surgery. If the first letter is from a person with a master's degree, the second letter should be from a psychiatrist or a Ph.D. clinical psychologist, who can be expected to adequately evaluate co-morbid psychiatric conditions. If the first letter is from the patient's psychotherapist, the second letter should be from a person who has only played an evaluative role for the patient. Each letter, however, is expected to cover the same topics. At least one of the letters should be an

extensive report. The second letter writer, having read the first letter, may choose to offer a briefer summary and an agreement with the recommendation.

V. Assessment and Treatment of Children and Adolescents

Phenomenology. Gender identity disorders in children and adolescents are different from those seen in adults, in that a rapid and dramatic developmental process (physical, psychological and sexual) is involved. Gender identity disorders in children and adolescents are complex conditions. The young person may experience his or her phenotype sex as inconsistent with his or her own sense of gender identity. Intense distress is often experienced, particularly in adolescence, and there are frequently associated emotional and behavioral difficulties. There is greater fluidity and variability in outcomes, especially in pre-pubertal children. Only a few gender variant youths become transsexual, although many eventually develop a homosexual orientation.

Commonly seen features of gender identity conflicts in children and adolescents include a stated desire to be the other sex; cross dressing; play with games and toys usually associated with the gender with which the child identifies; avoidance of the clothing, demeanor and play normally associated with the child's sex and gender of assignment; preference for playmates or friends of the sex and gender with which the child identifies; and dislike of bodily sex characteristics and functions. Gender identity disorders are more often diagnosed in boys.

Phenomenologically, there is a qualitative difference between the way children and adolescents present their sex and gender predicaments, from and the presentation of delusions or other psychotic symptoms. Delusional beliefs about their body or gender

can occur in psychotic conditions but they can be distinguished from the phenomenon of a gender identity disorder. Gender identity disorders in childhood are not equivalent to those in adulthood and the former do not inevitably lead to the latter. The younger the child the less certain and perhaps more malleable the outcome.

Psychological and Social Interventions. The task of the child-specialist mental health professional is to provide assessment and treatment that broadly conforms to the following guidelines:

35. The professional should recognize and accept the gender identity problem. Acceptance and removal of secrecy can bring considerable relief.
36. The assessment should explore the nature and characteristics of the child's or adolescent's gender identity. A complete psychodiagnostic and psychiatric assessment should be performed. A complete assessment should include a family evaluation, because other emotional and behavioral problems are very common, and unresolved issues in the child's environment are often present.
37. Therapy should focus on ameliorating any comorbid problems in the child's life, and on reducing distress the child experiences from his or her gender identity problem and other difficulties. The child and family should be supported in making difficult decisions regarding the extent to which to allow the child to assume a gender role consistent with his or her gender identity. This includes issues of whether to inform others of the child's situation, and how others in the child's life should respond; for example, whether the child should attend school using a name and clothing opposite to his or her sex of assignment. They should also be supported in tolerating uncertainty and anxiety in relation to the child's gender expression and how best to manage it. Professional network meetings can be very useful in finding appropriate solutions to these problems.

Physical Interventions. Before any physical intervention is considered, extensive exploration of psychological, family and social issues should be undertaken. Physical interventions should be addressed in the context of adolescent development. Adolescents' gender identity development can rapidly and

unexpectedly evolve. An adolescent shift toward gender conformity can occur primarily to please the family, and may not persist or reflect a permanent change in gender identity. Identity beliefs in adolescents may become firmly held and strongly expressed, giving a false impression of irreversibility; more fluidity may return at a later stage. For these reasons, irreversible physical interventions should be delayed as long as is clinically appropriate. Pressure for physical interventions because of an adolescent's level of distress can be great and in such circumstances a referral to a child and adolescent multi-disciplinary specialty service should be considered, in locations where these exist.

Physical interventions fall into three categories or stages:

38. Fully reversible interventions. These involve the use of LHRH agonists or medroxyprogesterone to suppress estrogen or testosterone production, and consequently to delay the physical changes of puberty.
39. Partially reversible interventions. These include hormonal interventions that masculinize or feminize the body, such as administration of testosterone to biologic females and estrogen to biologic males. Reversal may involve surgical intervention.
40. Irreversible interventions. These are surgical procedures.

A staged process is recommended to keep options open through the first two stages. Moving from one state to another should not occur until there has been adequate time for the young person and his/her family to assimilate fully the effects of earlier interventions.

Fully Reversible Interventions. Adolescents may be eligible for puberty-delaying hormones as soon as pubertal changes have begun. In order for the adolescent and his or her parents to make an informed decision about pubertal delay, it is recommended that the adolescent experience the onset of puberty in his or her biologic sex, at least to Tanner Stage Two. If for clinical reasons it is thought to be in the patient's interest to intervene earlier, this must

be managed with pediatric endocrinological advice and more than one psychiatric opinion.

Two goals justify this intervention: a) to gain time to further explore the gender identity and other developmental issues in psychotherapy; and b) to make passing easier if the adolescent continues to pursue sex and gender change. In order to provide puberty delaying hormones to an adolescent, the following criteria must be met:

41. throughout childhood the adolescent has demonstrated an intense pattern of cross-sex and cross-gender identity and aversion to expected gender role behaviors;
42. sex and gender discomfort has significantly increased with the onset of puberty;
43. the family consents and participates in the therapy.

Biologic males should be treated with LHRH agonists (which stop LH secretion and therefore testosterone secretion), or with progestins or antiandrogens (which block testosterone secretion or neutralize testosterone action). Biologic females should be treated with LHRH agonists or with sufficient progestins (which stop the production of estrogens and progesterone) to stop menstruation.

Partially Reversible Interventions. Adolescents may be eligible to begin masculinizing or feminizing hormone therapy, as early as age 16, preferably with parental consent. In many countries 16-year olds are legal adults for medical decision making, and do not require parental consent.

Mental health professional involvement is an eligibility requirement for triadic therapy during adolescence. For the implementation of the real-life experience or hormone therapy, the mental health professional should be involved with the patient and family for a minimum of six months. While the number of sessions during this six-month period rests upon the clinician's judgment, the intent is

that hormones and the real-life experience be thoughtfully and recurrently considered over time. In those patients who have already begun the real-life experience prior to being seen, the professional should work closely with them and their families with the thoughtful recurrent consideration of what is happening over time.

Irreversible Interventions. Any surgical intervention should not be carried out prior to adulthood, or prior to a real-life experience of at least two years in the gender role of the sex with which the adolescent identifies. The threshold of 18 should be seen as an eligibility criterion and not an indication in itself for active intervention.

VI. Psychotherapy with Adults

A Basic Observation. Many adults with gender identity disorder find comfortable, effective ways of living that do not involve all the components of the triadic treatment sequence. While some individuals manage to do this on their own, psychotherapy can be very helpful in bringing about the discovery and maturational processes that enable self-comfort.

Psychotherapy is Not an Absolute Requirement for Triadic Therapy. Not every adult gender patient requires psychotherapy in order to proceed with hormone therapy, the real-life experience, hormones, or surgery. Individual programs vary to the extent that they perceive a need for psychotherapy. When the mental health professional's initial assessment leads to a recommendation for psychotherapy, the clinician should specify the goals of treatment, and estimate its frequency and duration. There is no required minimum number of psychotherapy sessions prior to hormone therapy, the real-life experience, or surgery, for three reasons: 1)

patients differ widely in their abilities to attain similar goals in a specified time; 2) a minimum number of sessions tends to be construed as a hurdle, which discourages the genuine opportunity for personal growth; 3) the mental health professional can be an important support to the patient throughout all phases of gender transition. Individual programs may set eligibility criteria to some minimum number of sessions or months of psychotherapy.

The mental health professional who conducts the initial evaluation need not be the psychotherapist. If members of a gender team do not do psychotherapy, the psychotherapist should be informed that a letter describing the patient's therapy might be requested so the patient can proceed with the next phase of treatment.

Goals of Psychotherapy. Psychotherapy often provides education about a range of options not previously seriously considered by the patient. It emphasizes the need to set realistic life goals for work and relationships, and it seeks to define and alleviate the patient's conflicts that may have undermined a stable lifestyle.

The Therapeutic Relationship. The establishment of a reliable trusting relationship with the patient is the first step toward successful work as a mental health professional. This is usually accomplished by competent nonjudgmental exploration of the gender issues with the patient during the initial diagnostic evaluation. Other issues may be better dealt with later, after the person feels that the clinician is interested in and understands their gender identity concerns. Ideally, the clinician's work is with the whole of the person's complexity. The goals of therapy are to help the person to live more comfortably within a gender identity and to deal effectively with non-gender issues. The clinician often attempts to facilitate the capacity to work and to establish or maintain supportive relationships. Even when these initial goals are attained,

mental health professionals should discuss the likelihood that no educational, psychotherapeutic, medical, or surgical therapy can permanently eradicate all vestiges of the person's original sex assignment and previous gendered experience.

Processes of Psychotherapy. Psychotherapy is a series of interactive communications between a therapist who is knowledgeable about how people suffer emotionally and how this may be alleviated, and a patient who is experiencing distress. Typically, psychotherapy consists of regularly held 50 minute sessions. The psychotherapy sessions initiate a developmental process. They enable the patient's history to be appreciated current dilemmas to be understood, and unrealistic ideas and maladaptive behaviors to be identified. Psychotherapy is not intended to cure the gender identity disorder. Its usual goal is a long-term stable life style with realistic chances for success in relationships, education, work, and gender identity expression. Gender distress often intensifies relationship, work, and educational dilemmas. The therapist should make clear that it is the patient's right to choose among many options. The patient can experiment over time with alternative approaches. Ideally, psychotherapy is a collaborative effort. The therapist must be certain that the patient understands the concepts of eligibility and readiness, because the therapist and patient must cooperate in defining the patient's problems, and in assessing progress in dealing with them. Collaboration can prevent a stalemate between a therapist who seems needlessly withholding of a recommendation, and a patient who seems too profoundly distrusting to freely share thoughts, feelings, events, and relationships. Patients may benefit from psychotherapy at every stage of gender evolution. This includes the post-surgical period, when the

anatomic obstacles to gender comfort have been removed, but the person may continue to feel a lack of genuine comfort and skill in living in the new gender role.

Options for Gender Adaptation. The activities and processes that are listed below have, in various combinations, helped people to find more personal comfort. These adaptations may evolve spontaneously and during psychotherapy. Finding new gender adaptations does not mean that the person may not in the future elect to pursue hormone therapy, the real-life experience, or genital surgery.

Activities:

Biological Males:

1. Cross-dressing: unobtrusively with undergarments; unisexually; or in a feminine fashion;
2. Changing the body through: hair removal through electrolysis or body waxing; minor plastic cosmetic surgical procedures;
3. Increasing grooming, wardrobe, and vocal expression skills.

Biological Females:

4. Cross-dressing: unobtrusively with undergarments, unisexually, or in a masculine fashion;
5. Changing the body through breast binding, weight lifting, applying theatrical facial hair;
6. Padding underpants or wearing a penile prosthesis.

Both Genders:

7. Learning about transgender phenomena from: support groups and gender networks, communication with peers via the Internet, studying these Standards of Care, relevant lay and professional literatures about legal rights pertaining to work, relationships, and public cross-dressing;
8. Involvement in recreational activities of the desired gender;
9. Episodic cross-gender living.

Processes:

- Acceptance of personal homosexual or bisexual fantasies and behaviors (orientation) as distinct from gender identity and gender role aspirations;
- Acceptance of the need to maintain a job, provide for the emotional needs of children, honor a spousal commitment, or not to distress a family member as currently having a higher priority than the personal wish for constant cross-gender expression;
- Integration of male and female gender awareness into daily living;
- Identification of the triggers for increased cross-gender yearnings and effectively attending to them; for instance, developing better self-protective, self-assertive, and vocational skills to advance at work and resolve interpersonal struggles to strengthen key relationships.

VII. Requirements for Hormone Therapy for Adults

Reasons for Hormone Therapy. Cross-sex hormonal treatments play an important role in the anatomical and psychological gender transition process for properly selected adults with gender identity disorders. Hormones are often medically necessary for successful living in the new gender. They improve the quality of life and limit psychiatric co-morbidity, which often accompanies lack of treatment. When physicians administer androgens to biologic females and estrogens, progesterone, and testosterone-blocking agents to biologic males, patients feel and appear more like members of their preferred gender.

Eligibility Criteria. The administration of hormones is not to be lightly undertaken because of their medical and social risks. Three criteria exist.

- Age 18 years;
- Demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks;

- Either:
 - a documented real-life experience of at least three months prior to the administration of hormones; or
 - a period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months).

In selected circumstances, it can be acceptable to provide hormones to patients who have not fulfilled criterion 3 - for example, to facilitate the provision of monitored therapy using hormones of known quality, as an alternative to black-market or unsupervised hormone use.

Readiness Criteria. Three criteria exist:

- The patient has had further consolidation of gender identity during the real-life experience or psychotherapy;
- The patient has made some progress in mastering other identified problems leading to improving or continuing stable mental health (this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis and suicidality);
- The patient is likely to take hormones in a responsible manner.

Can Hormones Be Given To Those Who Do Not Want Surgery or a Real-life Experience? Yes, but after diagnosis and psychotherapy with a qualified mental health professional following minimal standards listed above. Hormone therapy can provide significant comfort to gender patients who do not wish to cross live or undergo surgery, or who are unable to do so. In some patients, hormone therapy alone may provide sufficient symptomatic relief to obviate the need for cross living or surgery.

Hormone Therapy and Medical Care for Incarcerated Persons.

Persons who are receiving treatment for gender identity disorders should continue to receive appropriate treatment following these Standards of Care after incarceration. For example, those who are receiving psychotherapy and/or cross-sex hormonal treatments

should be allowed to continue this medically necessary treatment to prevent or limit emotional lability, undesired regression of hormonally-induced physical effects and the sense of desperation that may lead to depression, anxiety and suicidality. Prisoners who are subject to rapid withdrawal of cross- sex hormones are particularly at risk for psychiatric symptoms and self- injurious behaviors. Medical monitoring of hormonal treatment as described in these Standards should also be provided. Housing for transgendered prisoners should take into account their transition status and their personal safety.

VIII. Effects of Hormone Therapy in Adults

The maximum physical effects of hormones may not be evident until two years of continuous treatment. Heredity limits the tissue response to hormones and this cannot be overcome by increasing dosage. The degree of effects actually attained varies from patient to patient.

Desired Effects of Hormones. Biologic males treated with estrogens can realistically expect treatment to result in: breast growth, some redistribution of body fat to approximate a female body habitus, decreased upper body strength, softening of skin, decrease in body hair, slowing or stopping the loss of scalp hair, decreased fertility and testicular size, and less frequent, less firm erections. Most of these changes are reversible, although breast enlargement will not completely reverse after discontinuation of treatment.

Biologic females treated with testosterone can expect the following permanent changes: a deepening of the voice, clitoral enlargement, mild breast atrophy, increased facial and body hair and male pattern baldness. Reversible changes include increased upper

body strength, weight gain, increased social and sexual interest and arousability, and decreased hip fat.

Potential Negative Medical Side Effects. Patients with medical problems or otherwise at risk for cardiovascular disease may be more likely to experience serious or fatal consequences of cross-sex hormonal treatments. For example, cigarette smoking, obesity, advanced age, heart disease, hypertension, clotting abnormalities, malignancy, and some endocrine abnormalities may increase side effects and risks for hormonal treatment. Therefore, some patients may not be able to tolerate cross-sex hormones. However, hormones can provide health benefits as well as risks. Risk-benefit ratios should be considered collaboratively by the patient and prescribing physician.

Side effects in biologic males treated with estrogens and progestins may include increased propensity to blood clotting (venous thrombosis with a risk of fatal pulmonary embolism), development of benign pituitary prolactinomas, infertility, weight gain, emotional lability, liver disease, gallstone formation, somnolence, hypertension, and diabetes mellitus.

Side effects in biologic females treated with testosterone may include infertility, acne, emotional lability, increases in sexual desire, shift of lipid profiles to male patterns which increase the risk of cardiovascular disease, and the potential to develop benign and malignant liver tumors and hepatic dysfunction.

The Prescribing Physician's Responsibilities. Hormones are to be prescribed by a physician, and should not be administered without adequate psychological and medical assessment before and during treatment. Patients who do not understand the eligibility and readiness requirements and who are unaware of the SOC should be informed of them. This may be a good indication for a referral to

a mental health professional experienced with gender identity disorders.

The physician providing hormonal treatment and medical monitoring need not be a specialist in endocrinology, but should become well-versed in the relevant medical and psychological aspects of treating persons with gender identity disorders.

After a thorough medical history, physical examination, and laboratory examination, the physician should again review the likely effects and side effects of hormone treatment, including the potential for serious, life-threatening consequences. The patient must have the capacity to appreciate the risks and benefits of treatment, have his/her questions answered, and agree to medical monitoring of treatment. The medical record must contain a written informed consent document reflecting a discussion of the risks and benefits of hormone therapy.

Physicians have a wide latitude in what hormone preparations they may prescribe and what routes of administration they may select for individual patients. Viable options include oral, injectable, and transdermal delivery systems. The use of transdermal estrogen patches should be considered for males over 40 years of age or those with clotting abnormalities or a history of venous thrombosis. Transdermal testosterone is useful in females who do not want to take injections. In the absence of any other medical, surgical, or psychiatric conditions, basic medical monitoring should include: serial physical examinations relevant to treatment effects and side effects, vital sign measurements before and during treatment, weight measurements, and laboratory assessment. Gender patients, whether on hormones or not, should be screened for pelvic malignancies as are other persons.

For those receiving estrogens, the minimum laboratory assessment should consist of a pretreatment free testosterone level, fasting glucose, liver function tests, and complete blood count with reassessment at 6 and 12 months and annually thereafter. A pretreatment prolactin level should be obtained and repeated at 1, 2, and 3 years. If hyperprolactemia does not occur during this time, no further measurements are necessary. Biologic males undergoing estrogen treatment should be monitored for breast cancer and encouraged to engage in routine self-examination. As they age, they should be monitored for prostatic cancer.

For those receiving androgens, the minimum laboratory assessment should consist of pretreatment liver function tests and complete blood count with reassessment at 6 months, 12 months, and yearly thereafter. Yearly palpation of the liver should be considered. Females who have undergone mastectomies and who have a family history of breast cancer should be monitored for this disease.

Physicians may provide their patients with a brief written statement indicating that the person is under medical supervision, which includes cross- sex hormone therapy. During the early phases of hormone treatment, the patient may be encouraged to carry this statement at all times to help prevent difficulties with the police and other authorities.

Reductions in Hormone Doses After Gonadectomy. Estrogen doses in post-orchietomy patients can often be reduced by 1/3 to 1/2 and still maintain feminization. Reductions in testosterone doses post-oophorectomy should be considered, taking into account the risks of osteoporosis. Lifelong maintenance treatment is usually required in all gender patients.

The Misuse of Hormones. Some individuals obtain hormones without prescription from friends, family members, and pharmacies in other countries. Medically unmonitored hormone use can expose the person to greater medical risk. Persons taking medically monitored hormones have been known to take additional doses of illicitly obtained hormones without their physician's knowledge. Mental health professionals and prescribing physicians should make an effort to encourage compliance with recommended dosages, in order to limit morbidity. It is ethical for physicians to discontinue treatment of patients who do not comply with prescribed treatment regimens.

Other Potential Benefits of Hormones. Hormonal treatment, when medically tolerated, should precede any genital surgical interventions. Satisfaction with the hormone's effects consolidates the person's identity as a member of the preferred sex and gender and further adds to the conviction to proceed. Dissatisfaction with hormonal effects may signal ambivalence about proceeding to surgical interventions. In biologic males, hormones alone often generate adequate breast development, precluding the need for augmentation mammoplasty. Some patients who receive hormonal treatment will not desire genital or other surgical interventions.

The Use of Antiandrogens and Sequential Therapy. Antiandrogens can be used as adjunctive treatments in biologic males receiving estrogens, though they are not always necessary to achieve feminization. In some patients, antiandrogens may more profoundly suppress the production of testosterone, enabling a lower dose of estrogen to be used when adverse estrogen side effects are anticipated.

Feminization does not require sequential therapy. Attempts to mimic the menstrual cycle by prescribing interrupted estrogen

therapy or substituting progesterone for estrogen during part of the month are not necessary to achieve feminization.

Informed Consent. Hormonal treatment should be provided only to those who are legally able to provide informed consent. This includes persons who have been declared by a court to be emancipated minors and incarcerated persons who are considered competent to participate in their medical decisions. For adolescents, informed consent needs to include the minor patient's assent and the written informed consent of a parent or legal guardian.

Reproductive Options. Informed consent implies that the patient understands that hormone administration limits fertility and that the removal of sexual organs prevents the capacity to reproduce. Cases are known of persons who have received hormone therapy and sex reassignment surgery who later regretted their inability to parent genetically related children. The mental health professional recommending hormone therapy, and the physician prescribing such therapy, should discuss reproductive options with the patient prior to starting hormone therapy. Biologic males, especially those who have not already reproduced, should be informed about sperm preservation options, and encouraged to consider banking sperm prior to hormone therapy. Biologic females do not presently have readily available options for gamete preservation, other than cryopreservation of fertilized embryos. However, they should be informed about reproductive issues, including this option. As other options become available, these should be presented.

IX. The Real-Life Experience

The act of fully adopting a new or evolving gender role or gender presentation in everyday life is known as the real-life experience.

The real-life experience is essential to the transition to the gender role that is congruent with the patient's gender identity. Since changing one's gender presentation has immediate profound personal and social consequences, the decision to do so should be preceded by an awareness of what the familial, vocational, interpersonal, educational, economic, and legal consequences are likely to be. Professionals have a responsibility to discuss these predictable consequences with their patients. Change of gender role and presentation can be an important factor in employment discrimination, divorce, marital problems, and the restriction or loss of visitation rights with children. These represent external reality issues that must be confronted for success in the new gender presentation. These consequences may be quite different from what the patient imagined prior to undertaking the real-life experiences. However, not all changes are negative.

Parameters of the Real-Life Experience. When clinicians assess the quality of a person's real-life experience in the desired gender, the following abilities are reviewed:

- To maintain full or part-time employment;
- To function as a student;
- To function in community-based volunteer activity;
- To undertake some combination of items 1-3;
- To acquire a (legal) gender-identity-appropriate first name;
- To provide documentation that persons other than the therapist know that the patient functions in the desired gender role.

Real-Life Experience versus Real-Life Test. Although professionals may recommend living in the desired gender, the decision as to when and how to begin the real-life experience remains the person's responsibility. Some begin the real-life experience and decide that this often imagined life direction is not in their best interest. Professionals sometimes construe the real-life experience

as the real-life test of the ultimate diagnosis. If patients prosper in the preferred gender, they are confirmed as "transsexual," but if they decided against continuing, they "must not have been." This reasoning is a confusion of the forces that enable successful adaptation with the presence of a gender identity disorder. The real-life experience tests the person's resolve, the capacity to function in the preferred gender, and the adequacy of social, economic, and psychological supports. It assists both the patient and the mental health professional in their judgments about how to proceed. Diagnosis, although always open for reconsideration, precedes a recommendation for patients to embark on the real-life experience. When the patient is successful in the real-life experience, both the mental health professional and the patient gain confidence about undertaking further steps.

Removal of Beard and other Unwanted Hair for the Male to Female Patient. Beard density is not significantly slowed by cross-sex hormone administration. Facial hair removal via electrolysis is a generally safe, time-consuming process that often facilitates the real-life experience for biologic males. Side effects include discomfort during and immediately after the procedure and less frequently hypo- or hyper-pigmentation, scarring, and folliculitis. Formal medical approval for hair removal is not necessary; electrolysis may be begun whenever the patient deems it prudent. It is usually recommended prior to commencing the real-life experience, because the beard must grow out to visible lengths to be removed. Many patients will require two years of regular treatments to effectively eradicate their facial hair. Hair removal by laser is a new alternative approach, but experience with it is limited.

X. Surgery

Sex Reassignment is Effective and Medically Indicated in Severe GID. In persons diagnosed with transsexualism or profound GID, sex reassignment surgery, along with hormone therapy and real-life experience, is a treatment that has proven to be effective. Such a therapeutic regimen, when prescribed or recommended by qualified practitioners, is medically indicated and medically necessary. Sex reassignment is not "experimental," "investigational," "elective," "cosmetic," or optional in any meaningful sense. It constitutes very effective and appropriate treatment for transsexualism or profound GID.

How to Deal with Ethical Questions Concerning Sex Reassignment Surgery. Many persons, including some medical professionals, object on ethical grounds to surgery for GID. In ordinary surgical practice, pathological tissues are removed in order to restore disturbed functions, or alterations are made to body features to improve the patient's self image. Among those who object to sex reassignment surgery, these conditions are not thought to present when surgery is performed for persons with gender identity disorders. It is important that professionals dealing with patients with gender identity disorders feel comfortable about altering anatomically normal structures. In order to understand how surgery can alleviate the psychological discomfort of patients diagnosed with gender identity disorders, professionals need to listen to these patients discuss their life histories, and dilemmas. The resistance against performing surgery on the ethical basis of "above all do no harm" should be respected, discussed, and met with the opportunity to learn from patients themselves about the psychological distress of having profound gender identity disorder.

It is unethical to deny availability or eligibility for sex reassignment surgeries or hormone therapy solely on the basis of blood seropositivity for blood-borne infections such as HIV, or hepatitis B or C, etc.

The Surgeon's Relationship with the Physician Prescribing Hormones and the Mental Health Professional. The surgeon is not merely a technician hired to perform a procedure. The surgeon is part of the team of clinicians participating in a long-term treatment process. The patient often feels an immense positive regard for the surgeon, which ideally will enable long-term follow-up care. Because of his or her responsibility to the patient, the surgeon must understand the diagnosis that has led to the recommendation for genital surgery. Surgeons should have a chance to speak at length with their patients to satisfy themselves that the patient is likely to benefit from the procedures. Ideally, the surgeon should have a close working relationship with the other professionals who have been actively involved in the patient's psychological and medical care. This is best accomplished by belonging to an interdisciplinary team of professionals who specialize in gender identity disorders. Such gender teams do not exist everywhere, however. At the very least, the surgeon needs to be assured that the mental health professional and physician prescribing hormones are reputable professionals with specialized experience with gender identity disorders. This is often reflected in the quality of the documentation letters. Since fictitious and falsified letters have occasionally been presented, surgeons should personally communicate with at least one of the mental health professionals to verify the authenticity of their letters.

Prior to performing any surgical procedures, the surgeon should have all medical conditions appropriately monitored and the effects

of the hormonal treatment upon the liver and other organ systems investigated. This can be done alone or in conjunction with medical colleagues. Since pre-existing conditions may complicate genital reconstructive surgeries, surgeons must also be competent in urological diagnosis. The medical record should contain written informed consent for the particular surgery to be performed.

XI. Breast Surgery

Breast augmentation and removal are common operations, easily obtainable by the general public for a variety of indications. Reasons for these operations range from cosmetic indications to cancer. Although breast appearance is definitely important as a secondary sex characteristic, breast size or presence are not involved in the legal definitions of sex and gender and are not important for reproduction. The performance of breast operations should be considered with the same reservations as beginning hormonal therapy. Both produce relatively irreversible changes to the body.

The approach for male-to-female patients is different than for female-to-male patients. For female-to-male patients, a mastectomy procedure is usually the first surgery performed for success in gender presentation as a man; and for some patients it is the only surgery undertaken. When the amount of breast tissue removed requires skin removal, a scar will result and the patient should be so informed. Female-to-male patients might have surgery at the same time they begin hormones. For male-to-female patients, augmentation mammoplasty may be performed if the physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social gender role.

XII. Genital Surgery

Eligibility Criteria. These minimum eligibility criteria for various genital surgeries equally apply to biologic males and females seeking genital surgery. They are:

- Legal age of majority in the patient's nation;
- Usually 12 months of continuous hormonal therapy for those without a medical contraindication (see below, "Can Surgery Be Performed Without Hormones and the Real-life Experience");
- 12 months of successful continuous full time real-life experience. Periods of returning to the original gender may indicate ambivalence about proceeding and generally should not be used to fulfill this criterion;
- If required by the mental health professional, regular responsible participation in psychotherapy throughout the real-life experience at a frequency determined jointly by the patient and the mental health professional. Psychotherapy per se is not an absolute eligibility criterion for surgery;
- Demonstrable knowledge of the cost, required lengths of hospitalizations, likely complications, and post surgical rehabilitation requirements of various surgical approaches;
- Awareness of different competent surgeons.

Readiness Criteria. The readiness criteria include:

- Demonstrable progress in consolidating one's gender identity;
- Demonstrable progress in dealing with work, family, and interpersonal issues resulting in a significantly better state of mental health (this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis, suicidality, for instance).

Can Surgery Be Provided Without Hormones and the Real-Life Experience? Individuals cannot receive genital surgery without meeting the eligibility criteria. Genital surgery is a treatment for a diagnosed gender identity disorder, and should undertaken only after careful evaluation. Genital surgery is not a right that must be granted upon request. The SOC provide for an individual approach

for every patient; but this does not mean that the general guidelines, which specify treatment consisting of diagnostic evaluation, possible psychotherapy, hormones, and real-life experience, can be ignored. However, if a person has lived convincingly as a member of the preferred gender for a long period of time and is assessed to be a psychologically healthy after a requisite period of psychotherapy, there is no inherent reason that he or she must take hormones prior to genital surgery.

Conditions under which Surgery May Occur. Genital surgical treatments for persons with a diagnosis of gender identity disorder are not merely another set of elective procedures. Typical elective procedures only involve a private mutually consenting contract between a patient and a surgeon. Genital surgeries for individuals diagnosed as having GID are to be undertaken only after a comprehensive evaluation by a qualified mental health professional. Genital surgery may be performed once written documentation that a comprehensive evaluation has occurred and that the person has met the eligibility and readiness criteria. By following this procedure, the mental health professional, the surgeon and the patient share responsibility of the decision to make irreversible changes to the body.

Requirements for the Surgeon Performing Genital Reconstruction. The surgeon should be a urologist, gynecologist, plastic surgeon or general surgeon, and Board-Certified as such by a nationally known and reputable association. The surgeon should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. Even experienced surgeons in this field must be willing to have their therapeutic skills reviewed by their peers.

Surgeons should attend professional meetings where new techniques are presented.

Ideally, the surgeon should be knowledgeable about more than one of the surgical techniques for genital reconstruction so that he or she, in consultation with the patient, will be able to choose the ideal technique for the individual patient. When surgeons are skilled in a single technique, they should so inform their patients and refer those who do not want or are unsuitable for this procedure to another surgeon.

Genital Surgery for the Male-to-Female Patient. Genital surgical procedures may include orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty. These procedures require skilled surgery and postoperative care. Techniques include penile skin inversion, pedicled rectosigmoid transplant, or free skin graft to line the neovagina. Sexual sensation is an important objective in vaginoplasty, along with creation of a functional vagina and acceptable cosmesis.

Other Surgery for the Male-to-Female Patient. Other surgeries that may be performed to assist feminization include reduction thyroid chondroplasty, suction-assisted lipoplasty of the waist, rhinoplasty, facial bone reduction, face-lift, and blepharoplasty. These do not require letters of recommendation from mental health professionals. There are concerns about the safety and effectiveness of voice modification surgery and more follow-up research should be done prior to widespread use of this procedure. In order to protect their vocal cords, patients who elect this procedure should do so after all other surgeries requiring general anesthesia with intubation are completed.

Genital Surgery for the Female-to-Male Patient. Genital surgical procedures may include hysterectomy, salpingo-oophorectomy,

vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty. Current operative techniques for phalloplasty are varied. The choice of techniques may be restricted by anatomical or surgical considerations. If the objectives of phalloplasty are a neophallus of good appearance, standing micturition, sexual sensation, and/or coital ability, the patient should be clearly informed that there are several separate stages of surgery and frequent technical difficulties which may require additional operations. Even metoidioplasty, which in theory is a one-stage procedure for construction of a microphallus, often requires more than one surgery. The plethora of techniques for penis construction indicates that further technical development is necessary.

Other Surgery for the Female-to-Male Patient. Other surgeries that may be performed to assist masculinization include liposuction to reduce fat in hips, thighs and buttocks.

XIII. Post-Transition Follow-up

Long-term postoperative follow-up is encouraged in that it is one of the factors associated with a good psychosocial outcome. Follow-up is important to the patient's subsequent anatomic and medical health and to the surgeon's knowledge about the benefits and limitations of surgery.

Long-term follow-up with the surgeon is recommended in all patients to ensure an optimal surgical outcome. Surgeons who operate on patients who are coming from long distances should include personal follow-up in their care plan and attempt to ensure affordable, local, long-term aftercare in the patient's geographic region. Postoperative patients may also sometimes exclude themselves from follow-up with the physician

prescribing hormones, not recognizing that these physicians are best able to prevent, diagnose and treat possible long term medical conditions that are unique to hormonally and surgically treated patients. Postoperative patients should undergo regular medical screening according to recommended guidelines for their age. The need for follow-up extends to the mental health professional, who having spent a longer period of time with the patient than any other professional, is in an excellent position to assist in any post-operative adjustment difficulties.

