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Transgender Emergence: Understanding Diverse Gender Identities and Expressions

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Learning Objectives:

1. To increase social workers' understanding of gender identity and transgenderism.
2. To increase comfort in working with transgender, transsexual, intersex, and other gender-variant people
3. To develop and enhance specialized skills for provision of services to transgender people and their family members.

I. Transgender: An Overview

Transgenderism, a subject that was virtually unheard of a decade ago, has become a focus of increased media attention, and an area of interest for social workers as well as the lay public. Helping professionals of all types (physicians, psychologists, social workers, and educators) are now grappling with understanding gender-variant behavior and cross-gender expression. Students and experienced social workers alike are requesting specialized education regarding sex and gender issues in order to be better prepared to provide quality and effective treatment to those requesting their services. In response to these concerns this issue of FOCUS Continuing Education will offer an in-depth examination of transgender issues.

Professional Responsibility

The National Association of Social Workers has adopted a clear and coherent policy position on Transgender/Gender Identity issues that emphatically states "... people of diverse gender expression and identity ... should be afforded the same respect and rights as those whose gender identity and expression conform to societal expectations" (Social Work Speaks, 2000, p. 302). This is a progressive and vital step for our profession especially since the policy specifically "...encourages the development of supportive practice environments for those struggling with transgender issues (both clients and colleagues) [emphasis mine]," recognizing that social workers are not just impacted professionally, but also personally.

Policy statements are foundational for organizational development and instrumental in determining professional training goals and priorities, but they are often more visionary than functional. Social workers in the field may idealistically agree that transgender and transsexual people deserve "respect and rights," but may not have the necessary knowledge base or feel they have the clinical acumen to implement respectful treatment strategies. Many social

workers are beginning to recognize the basic lack of civil rights with which transgender people live, and that effective psychological treatment often requires advocacy and community organization skills in addition to clinical expertise.

As transgender people emerge from a veil of shame and societal stigma, social workers are encountering gender-variant people in diverse settings – schools, hospitals, mental health clinics, and work-related environments – highlighting the need for transgender education to become integrated into the generalist education all social workers receive. A decade ago, when social work students were asked to define the word transgender, they had rarely heard of the word. Currently, students routinely bring case material from their field placements into the classroom describing clinical contact with gender-variant children and youth in the school system, and adult transsexuals transitioning their sex and coping with related job loss, marital problems, and financial stresses. Occasionally students will also seek advice on upheavals in their own work environment as a social work colleague begins the often awkward transition across the gender binary. Social work programs, educational institutions, and training curricula are beginning to address the vision outlined in the NASW policy statement in order to better prepare social workers for a wide range of professional situations where expertise in gender variance will be required; this continuing education program is part of this evolution.

Transgender Emergence

The subject of transgenderism is one that produces an array of reactions; many people find themselves confused and uncomfortable dealing with the idea of transsexualism and "sex change" surgery. There is sometimes an emotional mix of an almost morbid curiosity on one hand, and profound revulsion on the other. Sometimes when issues of transgenderism are raised, socially as well as clinically, there is often a shifting of people's eyes, a raising of the eyebrows, and a sudden change of conversation, even among people who are quick to tell you that they are not judgmental about this issue. Cross-gender behavior can invoke a sudden and piercing humor that is intended to hurt. Rarely do people engage in intellectual inquiry about transgender issues -- a fascinating, intriguing topic that could surely engage intellectuals into scholarly discourses on far-ranging topics from brain chemistry and law to anthropology and organizational development. Even people who do not harbor negative feelings about gender-variant expression often do not understand the intense, emotional journey that transgender people travel in order to simply present themselves publicly in an authentic manner.

In the last decade people who identify as transgender, transsexual, or intersex have come to be a visible political force, a topic of discussion in the public forum as well as a consumer market.

Television talk shows, mainstream movies, and tell-all biographies have flooded the media. As transgenderism becomes a part of popular culture, transgender people—and their families—are becoming increasingly aware that they are living within a culture that has degraded and marginalized them, but even worse, has psychologically pathologized them.

The history of gender-variance and the mental health community is a history of diagnostic labeling and pathologizing mental disorders within a medical model that assumes that cross-gender expression, by nature, is a mental illness. For the past 200 years, western civilization has relegated gender-variant people to the realm of the psycho-medical establishment for analysis, treatment, and “cure.” This complex field of sexology has generally pathologized all human sexual and gender variations outside of heteronormative male/female sexual expression. Same-sex intimacy has only recently emerged from the intense scrutiny of the psychological community within the past few decades, although lesbian, gay, and bisexual people continue to struggle for full equal rights.

Social justice strategies, based on knowledge and experience with other successful civil rights struggles, have become the focus for many transgender activists who are challenging the view that they are mentally ill simply because their gender is not normative. Transgender and intersex people are struggling to define themselves and the parameters of their own lives outside of an illness model.

Gender-variance and cross-gender experience are not new psychological or medical “conditions,” nor is it a recent social or legal dilemma. Gender-variant people, those known today as transgender, transsexual and intersex, have always existed throughout human history and transculturally across all nations and ethnic groups. Long before the advent of modern synthetic hormones and surgical reassignment, individuals lived cross-gendered from the biological sex in which they were born and outside of the social restrictions of their assigned sex. Different societies and cultures addressed these issues in diverse ways, from complete acceptance and integration to ostracism, maltreatment, and violence.

Within contemporary western culture, changes within the social climate - politically and technologically - have created an environment within first world countries in which contemporary transgender identities can now be forged. Although diverse sexual and gender identity expression and behavior has always existed, the emergence of a community of people who express gender identities outside of the social norm is a nascent sociological phenomenon within contemporary western culture. In the last two decades social and political organizations have developed – many established on the Internet – that foster social identities for gender-variant people, creating a distinct category of people deserving civil rights and social justice. This movement, politically organized and self-determined, defies previous views of transgender expression as a mental health problem, and views diverse gender expressions – like same-sex sexuality – as a normative, potentially healthy human potentiality. Indeed, it reframes the dysfunctionality often seen in transgender individuals as the residuals and sequelae of oppression, not the manifestations of a mental disorder.

The psychological and social work professions are in the process of revisiting previous conceptions of gender-variance as psychopathological issues. Viewing transgenderism outside of a pathologizing model initiates a new cultural conversation that examines the essential nature of biology and gender, and the social construction of sexuality and culture. The mental health problems that have been associated with transgenderism may not be etiologically related to the gender-variance per se, but caused by the social and political ramifications of being a member of a despised group. Instead of examining transgender people through a lens of disorder and dysfunction, clinicians need to ask what it means to be a healthy functioning gender-variant person in a society with strict gendered spheres, where transgression of traditional roles can have serious social consequences.

This perspective shakes up fundamental assumptions about sex and gender, and shifts the paradigm from two sexes that are opposite and different from one another to a conception of sex and gender identities as potentially fluid. Transgenderism describes the meeting ground where the social construction of gender intersects with the individual’s personal psychological experience of gender, and where biology is not the only determining factor of identity. Within this newly emerging paradigm, transgenderism, transsexuality, and intersexuality are portrayed as normative human variations.

In many ways the transgender liberation movement is shaking the foundations of the mental health system in much the same ways that the civil rights movement, the feminist movement and the gay liberation movement have done. Transgenderism, like the ongoing discussion of race/ethnicity, women’s roles, and same-sex intimacy, challenges deeply held social constructs about human embodiment within social and cultural contexts. If gender variance is a mental health condition, then it, by definition, requires therapeutic intervention; pathology, however, has never been a useful model for a burgeoning liberation movement. Awareness of this dialectic tension - between the psychopathologizing medical model and a transgender specific identity that is emerging from oppression - is essential to understanding the nature and meaning of transgender identity in the early days of the twenty-first century.

In response to this dialogue, many professionals are also rethinking older treatment models that were based in mental health diagnoses, and developing more humanistic, narrative, post-modern, and advocacy-based perspectives. However, the first task for all clinicians working with gender-variant people is to recognize that we enter into this field of study with entrenched beliefs systems about gender that will likely be challenged. It is a rare helping professional that can change their treatment approaches to gender-variant people, without first examining their own epistemology of gender.

The Scope of Gender-Variance

Previously ignored, vilified, and underserved, in the 1990s gender-variant people developed a broader, more inclusive community and began using the term transgender as an umbrella term to describe their identity. The term transgender is now used to include crossdressers, male-to-female transsexuals (MTFs), and female-to-male transsexuals (FTMs). Additionally, the term also includes

people who identify as androgynes, third-sex, and of mixed-gender. Some would broaden transgender identity to also embrace all people who exhibit some cross-gender behavior such as gay and heterosexual males who are “effeminate,” lesbian and heterosexual females who are masculine, drag queens, and those who have intersex conditions. This does not mean, however, that all people who exhibit cross-gender expression would use the term transgender to describe themselves or want to be categorized beneath the transgender umbrella. For example, a subset of transsexual women (i.e., male-to-female) resists the term transgender, believing that transsexualism is markedly different from other cross-gender behavior and they do not want to be classified within this larger group.

Historically, transsexuals and crossdressers (previously referred to as transvestites) represented two distinct diagnostic categories of gender dysphoria. Crossdressers were defined in the literature as heterosexual males who crossdressed for erotic purposes, commonly beginning in adolescence. They were said to present convincingly as men in social situations, were not particularly feminine in appearance, and tended to work in traditional male-dominated careers. Most importantly, they rarely expressed a desire for sex reassignment surgery (SRS). Erotic crossdressing was believed to be a hallmark of transvestism, and in those born males, had been used to rule-out “true” transsexualism.

Transsexuals, at the other end of the continuum, were identified in the literature as people with atypical cross gender-identity development starting in early childhood (i.e., “sissy boys”), lifelong gender dysphoria, hatred of their genitalia, and a persistent desire for sex reassignment surgery. Transsexuals generally believed that their physiological body did not represent their true sex. Crossdressing was not experienced as erotic, but rather as clothing that felt natural for them to wear. They often appeared to be homosexual in sexual orientation (i.e., they were attracted to men); however, since they experienced themselves as women, labeling their sexual desire for men as homosexual is confusing at best. Post-operatively, they often identified as heterosexual women.

This diagnostic blueprint distinguishing crossdressers and transsexuals is based in a medical model first identified by Harry Benjamin, a pioneer in treating people with gender dysphoria at a time when medical providers routinely referred them to psychiatrists. The model that Benjamin outlined in the 1960s classified and treated transsexualism as a syndrome of gender dysphoria based in genital distress. According to this model the defining trait of transsexualism has been the transsexual’s desire, insistence, and even obsession with body modification; the most salient diagnostic criterion was hatred for one’s genitals and need for sexual reassignment. This classification paradigm has been referred to as the “wrong body thesis” and “anatomical dysphoria” was the primary symptom used to define transsexualism.

Distinguishing types and subtypes of gender-variant people has been a pursuit of gender researchers attempting to outline discrete syndromes. The underlying concern has been to insure that only “true” transsexuals receive medical and surgical treatments, therefore the eligibility standards have been rigidly enforced. Of course, there is a legitimate concern that people will have irreversible sur-

geries they will later regret; however, the evaluative processing became prohibitively exclusive, belying an underlying attitude of social control and paternalism.

Classifying types of gender-variance etiologically and diagnostically is somewhat complicated and cumbersome and in some instances has created a fury of political outcry from the transgender community. One example is the debate over the term autogynephilia, defined by Ray Blanchard as a type of transsexualism whereby the person fantasizes about possessing female anatomy, and is erotically excited by the thought or performance of activities that symbolize femininity. This idea of linking transsexual desire to sexual eroticism has caused both relief and rage within the transgender community. There are those that feel it is an accurate description of their own motivations and desires and others who feel that it trivializes their gender dysphoria by sexualizing it. There are yet others who feel that this level of diagnostic sub-typing is simply bad science. Contemporary researchers continue to examine different classifications of gender-variance, but this perspective is slowly giving way to a broader paradigm of gender diversity, less focused on the minutia of classification, and more engaged in treatment strategies that empower authentic identity development.

The distinctions between crossdressers and transsexuals contain some clinical wisdom in a general sense that is observable to most experienced gender specialists, but this model may also have very serious limitations that are currently being addressed in research and the development of clinical treatment models. The most notable difficulty with the medical model is that it has been developed examining gender dysphoria in males. The experience of female-to-male transgender people was less of a focus of early researchers for complex reasons, partially because they were thought to be rare. However, it is likely that fewer females in past decades had the social or financial freedom to seek out sexual reassignment, since currently females with gender dysphoria routinely seek out services. The bulk of the research data that has been collected about male-to-female transgender people—the definitions, categorizations and classification nomenclature—do not adequately represent the experiences, behaviors, or identities of female-to-male (FTM) people, or the spectrum of masculinity they exhibit. Additionally, some of the information is blatantly misinformed, rendering invisible certain populations of female masculinity. For example, the literature often states that females never crossdress for erotic purposes, and that female-to-male transsexuals are uniformly attracted to females; neither of these “facts” is born out by contemporary research and clinical experience.

Another problem with the medical model has been the realization that although male-to-female transsexuals often experience severe gender dysphoria and desire sexual reassignment surgery, many do not seem as obsessed with it as previous literature has described. Some transsexuals (both male and female) eschew surgical options and genital reassignment, although they desire to live full-time as members of the opposite sex. Additionally, some male crossdressers – previously defined by the erotic nature of their behavior and their disinterest in sexual reassignment – have begun requesting body modification and medical treatment, as well as minimizing the erotic component to their behavior, stating that crossdressing simply feels more comfortable or natural for them. It appears from contemporary research that the idea that all transsexuals desire sur-

Transgender Emergence: A Developmental Model

Transgender emergence involves a complex interaction of developmental and interpersonal transactions. The process of developing a gender identity is a normative process that everyone experiences, but for gender variant people the process is complicated by cultural expectations that are at dissonance with their core sense of self. The emergence process describes an adaptive stage model for transgender men and women who are coming to terms with their own gender variance and moving from an experience of denial and self-hatred to one of self-respect and gender congruence. These stages are not necessarily linear and are impacted by other identity issues. These stages are not meant to “label” people or define transgender maturity. It describes what clinicians may witness when clients seek help for “gender dysphoria.” Many transgender people negotiate these stages without professional assistance.

Awareness: In this first stage of awareness, gender variant people are often in great distress; the therapeutic task is the normalization of the experiences involved in emerging transgender.

Seeking information/Reaching out: In the second stage, gender variant people seek to gain education and support about transgenderism; the therapeutic task is to facilitate linkages and encourage outreach.

Disclosure to significant others: The third stage involves the disclosure of transgenderism to significant others - spouses, partners, family members and friends; the therapeutic task involves supporting the transgender person's integration in the family system.

Exploration – Identity and Self-Labeling: The fourth stage involves the exploration of various (transgender) identities, and the therapeutic task is to support the articulation and comfort with one's gendered identity.

Exploration – Transition Issues/possible body modification: The fifth stage involves exploring options for transition regarding identity, presentation, and body modification; the therapeutic task is the resolution of the decisions, and advocacy towards their manifestation.

Integration – Acceptance and post-transition issues: In the sixth stage the gender variant person is able to integrate and synthesize (transgender) identity; the therapeutic task is support in adaptation to transition related issues.

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gery and do not experience eroticism while dressed, as well as the idea that crossdressers never desire surgery or always are eroticized by being crossdressed, is an oversimplified dichotomy.

Clearly, the distinct classifications developed within the medical model have some severe limitations that impact current treatment strategies as well as the options for self-actualization available to gender-variant people. It has become increasingly obvious to many clinicians, writers, and activists that many people do not easily fit into the categories that have been delineated, and yet are seeking clinical and medical treatments to redefine their gender presentation. The need for more inclusive research on both males and females and the development of newer treatment models has become the focus of the field of transgender studies in the past decade.

Setting aside the medical model, it appears that people struggling with gender issues represent a broad range of people, representing both male and female experiences, and numerous trajectories of expression. In addition to heterosexual male erotic crossdressers, and male-to-female transsexuals desiring SRS, there are various other ways that gender-variance can be experienced and expressed. Some males with little or no desire to live as women or have sex reassignment surgery, have strong desires to wear women's clothing and express a female persona at least some of the time, with little or no eroticism attached to being crossdressed. Some males crossdress for comfort; some do it for social fun (i.e., doing “drag”) and others to alleviate anxiety. Some crossdressers desire body modification through the use of hormones, but not surgical alteration, which clinically (and perhaps surprisingly) resembles the way some transsexuals utilize cross-sex hormones, but do not feel a need for surgical changes. Some transsexuals appear to be comfortable legally living and working full-time as women, but remain ambivalent about, or even resistant to, genital surgery. The distinctions between these groups may not be as fixed as previously believed.

Additionally, some crossdressers do not identify as heterosexual - a diagnostic hallmark of transvestism - but rather as gay men. Furthermore, a subset of gay male crossdressers, referred to as drag queens, dress as women in an extreme feminine manner for fun or “camp,” but not as a way to self-actualize. Some males work as female impersonators and dress as women as part of their job; they may or may not be transsexual or erotic crossdressers. Some gender-variant people believe their cross-gender identity to be an “essence”—who they are in the deepest part of their psyche and experience themselves as being in the wrong body; others explain it as a “birth defect” that needs to be corrected. Clearly, cross-gender behavior is not easily defined without an in-depth assessment regarding the person's motives and experiences, as well as their goals.

Gender-variant behavior in females has been assumed to be statistically rare; however the relative freedom that women have in our culture regarding dress and appearance can mitigate to some extent their gender dysphoria, and perhaps has led fewer females to seek treatment through medical and clinical avenues. Additionally, some expressions of female masculinity have been acceptable within lesbian subcultures; it is possible that many female-to-male transsexuals have lived as butch lesbians and not come under the scrutiny of researchers and clinicians. Historically, researchers as-

sumed that FTMs were exclusively attracted to women, but more recent studies are revealing a diversity of sexual orientations and gender expressions for transgender females. Trying to categorize this diversity within a simple medical model does not do justice to the diverse gender expressions possible.

One theme that is emerging with the growth of the transgender community is an alternative narrative about gender-variant identities, one that is outside of a gender binary model involving “opposite” sexes within a two-gender option. Some express feeling confined by the restriction imposed by either gender and choose to live in a mixed, dual, or bi-gendered manner sometimes referred to as “gender blending” or “bigenderism.” This fluidity of gender presentation recognizes a broader spectrum of ways to explore and experience gender identity. Some variations of transgender experience include: moving from one side of the gender binary divide to the other on a permanent basis (i.e., many transsexuals); moving backwards and forwards over the gender border, only temporarily resting on one side or the other (i.e., many crossdressers); gender-blending (i.e., androgyne, or bigendered). Some enjoy the performativity of gender and blend or mix their gender style as a way to express diverse aspects of themselves. These ideas were originally developed within the trans-liberation movement, and are increasingly becoming a part of clinical theories and treatment models.

The only way to determine the meaning of each person’s experience is through dialogue with them, rather than seeking to fit him or her into official classifications systems. In order to understand the diversity of gender expressions possible, it is important to have a broader understanding of human sexual identity, and how the components of sexuality interact with one another.

II. Sex and Gender Identity

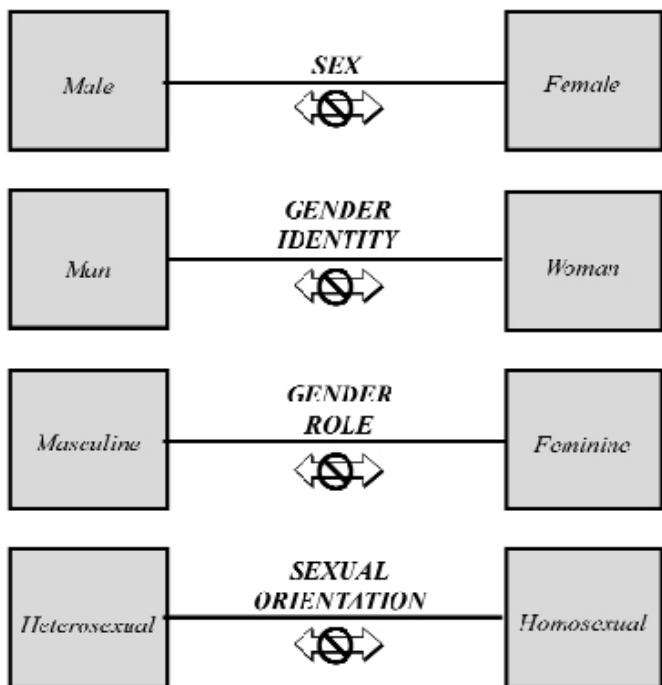
Understanding gender diversity and the relationship between gender identity and sexual orientation is undoubtedly complex. The term sexual identity is used here to describe a broad paradigm that includes many aspects of gender and sexuality. Sexual identity delineates a biopsychosocial integration of four component parts including biological or natal sex, gender identity, gender role expression and sexual orientation. The four components are outlined below.

Biological Sex and Intersexuality

The first component of human identity is biological sex. Biological (or natal) sex is actually a complex relationship of genetic, hormonal, morphological, chromosomal, gonadal, biochemical, and anatomical determinates that impact the physiology of the body and the sexual differentiation of the brain. Sex is generally determined at birth (or during a sonogram) based on an examination of

Figure 3.2

Sex, gender identity, gender role and sexual orientation are assumed to be bipolar opposites.

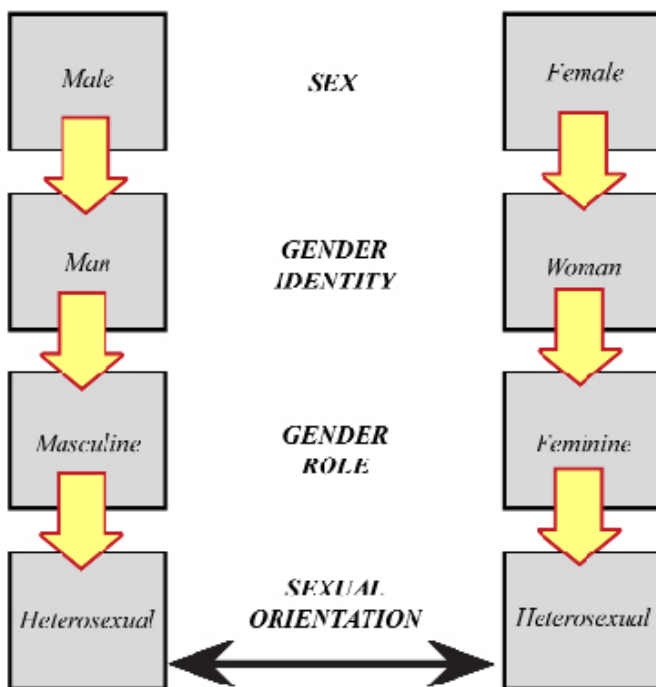


This bipolar system renders those who are intersex, gender variant, androgynous, cross-gendered, and/or bisexual invisible.

Figure 3.3

It is assumed that each of these components lines up and ensures the next:

- *If a person is a male, he is a man;*
- *If a person is a man, he is masculine;*
- *If a person is a masculine male man he will be attracted to a feminine female woman.*
- *If a person is a female, she is a woman;*
- *If a person is a woman, she is feminine;*
- *If a person is a feminine female woman she will be attracted to masculine male men.*



the visible genitalia. The presence or absence of the phallus is the first, the most salient, and often the only variable that determines whether one is a boy or a girl. In reality, physiology is only one determinant of natal sex, and it is possible for a child to visibly look like a boy, but have a genetic or chromosomal make-up that belies that conclusion.

A brief overview of fetal development will outline the process of sex determination. The biological differences between males and females develop at about 6 weeks into gestation, and before this stage male and female (XY and XX) appear the same, although genetic or chromosomal sexual differences are established at conception. The primitive duct systems are identical until the presence of male hormones triggers the development of male gonads, the differentiation of the duct systems, and the formation of external genitalia. Without the presence of male hormones, the fetus develops female gonads, which has led scientists to label the female development process a “default” system. This means that if the XY fetus does not trigger the correct masculinizing process it will develop as a female. The gonads produce various hormones that further differentiate male from female, and eventually stimulate the development of internal and external genitalia.

Biological or natal sex, simply defined, is the bipolar categories of male and female. Due to the numerous biological variables intervening in the fetal developmental process it is possible for sexual differentiation to take place atypically. For instance, an irregularity in hormone production, such as an over or underexposure to particular hormones, or certain genetic conditions, can cause the internal or external genitalia to develop outside the expected parameters. If the external genitalia appear ambiguous, it may be difficult to easily assign natal sex; however, sometimes the physiological differences are internal and an intersex condition may go unnoticed until puberty, when fertility is compromised. When sex is not easily assigned, or a mixed reproductive system is evident, the person is referred to as intersex.

Most infants born with intersex conditions in first world countries have been surgically altered with “corrective” surgeries at birth to match the physicians’ sex assignment fit into the appropriate dimorphic sex category. These surgeries have been justified because of a concern that these children will develop confused gender identities due to their physical differences. It is, however, not clear that being surgically altered — often leaving visible scars and an ongoing need for medical attention — will eliminate the potential gender dilemmas intrinsic to being born with an intersex condition.

Medical science has assumed that gender identity emanates as the logical outcome of physiological sex, and that the creation of a morphologically correct body can determine the internal experience of gender. The relationship between natal sex, physiology, and the development of gender identity is far more complex, since some people without intersex conditions develop gender dysphoria, and many people with intersex conditions develop stable gender identities. Intersexuality stands as the most direct evidence that biological sex is not simply dimorphic and that calling a baby a “boy” or a “girl” is more of a social decision than a biological one.

There is a growing movement of people born with intersex conditions, who are protesting the standard medical treatments. One organization, The Intersex Society of North America [ISNA], under the leadership of Cheryl Chase, has developed an extensive grassroots network for intersex people. Additionally, ISNA continues to educate the medical profession about changing the protocols for the treatment of intersex infants. As issues facing intersex people are becoming part of the public discourse through interviews on television shows and newspaper articles, people who have been surgically altered at birth are seeking out professional assistance to make sense of what has happened to them—information that was often kept from them by family and the medical community.

Understanding human sexual and gender diversity requires a commitment to treating intersex people, from birth through adulthood, with dignity and respect, while they negotiate challenges in sexual and reproductive development. Families who have a child born with an intersex condition are in need of qualified medical social workers to assist families in education and ongoing family therapy, particularly regarding decisions about genital surgeries. Newer treatment models support a “wait-and-see” approach to early genital surgeries. Medical experts and families should work together to make an educated and informed decision about sex assignment, however, it is suggested that families should allow the child to stabilize in a gender identity before surgical alteration.

People with intersex conditions may need different kinds of social work services at different stages of their lifecycle. Parents may need assistance accepting the challenges of having a child with ambiguous genitalia; children will likely need support during puberty and as part of their sexual exploration. Many adults who have been surgically altered struggle with issues of gender dysphoria, and some people do not discover their conditions until adulthood. Social workers need to become aware that people with intersex conditions often live with emotional pain, shame, and stigma that can be the legacy of these early surgical procedures.

Gender Identity and Transsexualism

The second component of sexual identity is referred to as gender identity, which is defined as the internal experience of gender, how one experiences his or her own sense of themselves as gendered beings. Gender identity is experienced as a core identity, a fundamental sense of belonging to one sex or the other. The sense of being a “man” or being a “woman,” is an essential attribute of self; many people would have trouble identifying their sense of “self” outside of the parameters of gender. Nearly everyone has an understanding of themselves as a man or a woman, a boy or a girl.

Gender is a social construct that divides people into “natural” categories of men and women that are thought to derive from their physiological male and female bodies. Gender attributes vary from culture to culture, and are arbitrarily imposed. A person’s self concept of his or her gender, regardless of biological sex, is called gender identity.

Gender identity is established early in life and is thought to be relatively impervious to change. Children begin to identify their gender as young as two years old; the sense of gender identity generally stabilizes within the first few years of life. For most people their

gender identity is congruent with their assigned sex. This means that if they are “male,” they experience themselves as “men” and if they are “female” they experience themselves as “women.” People may feel confined by some of the societal assumptions about proper male or female behavior, or they may resist certain role restrictions associated with proscribed genders (i.e., men don’t cry, or women are passive), but most people experience congruence with the sexed label they have been given. They may believe the categories themselves are restrictive, but not that they have been wrongly classified.

Typically gender identity is consistent with one’s natal sex, but for transgender and transsexual people, their gender identity is discordant with their natal sex and is in direct conflict with the biological facts of their bodies. Their gender identity is experienced as dysphoric, or dystonic, to their physicality, and this is referred to as transgender, or more specifically, transsexual. Cross-gender behavior is often present from a very young age. This is not to be confused with a psychotic process where people will deny that they have the physiology that they actually have. Transsexual people are aware of the “reality” of their physical bodies; they just do not feel that it describes who they “really” are inside. It is interesting to note that many intersex people also have stable male or female gender identities, even though their sex classification may be less easy to ascertain.

Transsexual people are dependent on the medical profession for their actualization. In order to transition their sex, they require hormonal treatment, which will significantly change their physiology and morphology so they can more accurately appear to be a member of the opposite sex. Due to prevalent homophobic bias, ap-

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proval for surgical treatment once rested upon a heterosexual identity after sexual reassignment, although this is rarely currently true in the United States. Transsexuals generally prefer to simply be called men or women, recognizing their preferred gender identity, regardless of their natal sex.

Hormonal treatment for FTMs can profoundly alter their physicality. Even females of short-stature will effectively appear male once they’ve experienced a lowering of their voice, loss of hair, and the growth of a full beard. Many FTMs also have chest surgery, removing their breast tissue, and reconfiguring a male chest. Some also have “lower surgery,” but given the extreme expense, as well as experimental nature of these surgeries, many FTMs live without genital surgeries. MTF also receive hormonal treatment, which will assist in the development of female breasts, as well as redistribute body shape, creating a female physique. However, facial hair must be removed with electrolysis, and balding hair cannot be re-grown. Additionally, MTF’s who are tall, and have strong male features – large hands, broad shoulders, prominent jaw lines – of-

ten have trouble easily passing as women. This presents numerous social and employment related issues that can be an important focal point of therapy.

In order for transsexuals to receive medical services, they need to be evaluated by a behavioral specialist, i.e., social worker, nurse, psychologist, psychiatrist, counselor, etc. as outlined in the Standards of Care for ethical treatment, a document distributed by the Harry Benjamin International Gender Dysphoria Association (HBIGDA). Clients must meet the criteria for a DSM diagnosis of Gender Identity Disorder, and must be referred to an endocrinologist for treatment. There are few psychotherapists who specialize in evaluation and treatment, and not all physicians will work with this population, creating a sub-specialty of both medicine and psychology. It is to be noted that many people sidestep these treatment protocols, buying hormones on the Internet, or working with physicians unfamiliar with the Standards of Care.

Gender Role and Social Norms

The third component of sexual identity is known as gender role, which is the expression of masculinity or femininity, more commonly referred to as “sex role.” Gender role is the socialized aspect of gender that impacts appearance, behavior, and personality. Socially dictated and reinforced, gender roles are thought to be a reflection of one’s gender identity (which is assumed to describe one’s biological sex) but may or may not be related to gender identity or natal sex. Gender roles are how gender is enacted or “performed” (consciously or unconsciously) and which John Money has referred to as the “public expression” of gender identity. It is assumed that people enact the gender role that reflects their gender identity. However, people who are transgender may choose to hide their true gender identity from others, and enact the gender role that is expected of them.

The acquisition of gender roles is a social process; it is achieved through socialization. Gender role is expressed in a variety of ways including clothing, mannerisms, grooming or adornment habits, voice inflection and social interests. For example, in western cultures males are expected to be independent, logical, objective, active, competent, and instrumental, while females are assumed to be passive, dependent, emotional, warm, expressive, and nurturant. Additionally, there are restrictions on clothing styles, mannerisms, haircuts, and even job choices that are enacted through gender roles, and that are assumed to be an outgrowth of gender identity as derived from natal sex.

Despite the restrictions on extreme cross-gender expression (particularly for males), gender role behavior is probably the most flexible of all these variables of identity. Many people express their sense of masculinity or femininity in cross-gender expression without experiencing any discord with their biological sex and without severe social punishment. For many people there is a range of feminine and masculine behavior that they are comfortable expressing in terms of clothing or mannerisms. One may dress and behave differently playing softball, attending a profes-

sional conference, fighting for a seat on the subway, and preparing for a romantic date. Some young people are especially flexible about gender role expression and enjoy stretching approved gender behavior past its approved edges. Western society has experienced huge upheavals in the rules determining proper male/female gender role expression in the past forty years. Due to the success of feminist organizing, there is significantly greater freedom for women in terms of clothing and work related choices, although true political equality has not yet been achieved. Feminism has, in many ways, laid the foundation for greater gender role expression for both males and females, although feminism has expressed ambivalence towards the transgender liberation movement. Feminism has insisted that biology is not destiny, but has interpreted this to mean that people should be able to enact a wide spectrum of gender roles without social punishment. Some feminists have accused transgender people of reifying gender, suggesting that by modifying their bodies they are succumbing to societal gender expectations. Other feminists have embraced the transgender liberation movement, seeing it as a positive and necessary component of human identity.

Gender role diversity can be enacted by people who identify as transgender, crossdressers, gender-blenders, or gender-benders. Additionally, men who are more feminine, and women who are more masculine, would be seen to exhibit a cross-gendered role expression. Many expressions of gender in the lesbian and gay community have celebrated cross-gender expression (butch lesbians and nelly gay men), and may be considered to be transgender. Most people with cross gender role expression have stable gender identities.

Sexual Orientation

Sexual orientation is the self-perception of a person's sexual and/or emotional desire. It describes both sexual preference and emotional attraction. Some people experience their sexual orientation as an unchanging essential part of their nature, and others experience it in more fluid way. Sexual orientation can be directed towards members of the same sex (homosexual) or the opposite sex (heterosexual), both sexes (bisexual) and neither (asexual).

Although homosexual behavior has always existed it is only in the modern era that this has been a way to define a person's nature, or assumed to be an innate part of personhood. Sexual orientation has many constituent parts, including physical preference, affectional preference, fantasy, and social relationships; it is more than just sexual behavior. Although sometimes the terms sexual orientation and sexual preference are used interchangeably with the term sexual identity, they are actually subsets of the broader category of sexual identity.

Sexual orientation is particularly complex in a world where certain sexual expressions (i.e., homosexuality and bisexuality) have been despised and criminally punished. Due to the societal stigma surrounding homosexual behavior, lesbian, gay and bisexual people have to "come-out" of the assumption that they are heterosexual, not only to others but also to themselves. Sexual orientation, especially if it is not normative heterosexuality, must be achieved through a process of self-discovery and coming-out. Sexual orientation may reveal the "love-object choice" of a person, but not

whether or not they act on those desires. Individuals can engage in same sex behavior and not identify as homosexual, and inversely individuals can "be" homosexual (i.e., prefer or desire partners of the same sex) and not engage in homosexual behavior.

Sexual orientation – the desire for particular categories of sexed or gendered people – may not be the only or best way to describe the complexity of human sexual desires. The concept of "same-sex" or "opposite-sex" attraction is specifically based on assumptions about the biology of the persons involved; definitions of homosexual and heterosexual sex assume stability of biological sex, and congruence of gender identity and natal sex. The notion of a "same-sex" relationship assumes that the biological similarity of the partners' bodies is the salient feature of the relationship. In some tribal cultures, relationships are only considered to be homosexual if the partners express the same gender (i.e., gender role), regardless of their biological bodies.

Relationship of Components

The four components of sexual identity have been generally thought to be completely bipolar and divergent, truly opposite. If one is male, one is by definition not female. If one is a man, they are not a woman. Someone who is masculine is thought to be not feminine. And a gay person is viewed as the opposite of a heterosexual person. This model has rendered people who are intersex, transgender, transsexual, crossdressers, gender-benders, homosexual, bisexual, or simply "nelly" men and "butch" women to be socially and culturally "invisible." People who do not easily fit into this model of sexual identity have "disappeared" from the human family, easily assumed to not exist, to be odd, or "perverted."

Additionally, each component part is conceived of as a building block, one built upon the other, and fit together like matryoshka dolls one nesting within the other, i.e., if a person is male, he is a man; if he is a man then he is expected to be masculine. Consequently, the logic follows, that a masculine male man is assumed to be attracted to a feminine female woman creating a bipolar jigsaw puzzle, with parts that naturally "fit" together.

Certainly the social world continues to become less rigid regarding gender role expression (at least for females) and more accepting of same-sex sexuality. It is easy to understand the historic resistance to more flexible gender roles and gay and lesbian relationships in examining this model of sexual identity. Since opposites are assumed to attract, men and women must have divergent ways of dressing and behaving. Since same-sex pairings do not match within a bipolar sexual system they are assumed to be unnatural. This model of sexual identity based in bipolar opposites infers and reinforces a heterosexual (and heterosexist) social world.

The four parts that make up the components of sexual identity are in reality not truly bipolar, but rather have potential fluidity. Each component part — natal sex, gender identity, gender role, and sexual orientation — has fluidity between the poles, and has multiple variables and expressions. Additionally, each component part interacts with one another in complex ways, developing and integrating in various patterns that become the foundation of human sexual identities. It is worth noting that none of the above categories offer much information about human sexual expression (i.e.,

sexuality, what people actually do in bed) since the four components outlined above do not explore sexual desire, erotic identity, erotic role, or erotic acts.

Understanding the difference between these parts of identity is very important for social workers — particularly sexual orientation and gender identity — because clients often express confusion in these areas, and do not understand the differences themselves. For example, a person who comes from a religiously constricted family may have same-sex desires, but because these are vilified within their religious community, they may present in therapy wanting a sex-change, believing that is “better” than being homosexual. Or, a male may be very feminine in his appearance and therefore assume that he is gay (or others may assume it of him), because sexual role behavior is often conflated with sexual orientation. Awareness of these component parts of sexual identity can assist social workers in clarifying the distinction between a transsexual’s desire for full medical and legal transition, and a crossdressers request for hormones to enhance some feminine aspects that would be concealed beneath male clothing.

Ultimately, understanding this model of sexual identity, creates a kind of blueprint for human sexual potential and expression, and allows for the “natural” presence of gender-variant people. The treatment model outlined below assumes that all gender-variant people — intersex, transgender, transsexual, crossdressers, gender-benders, bigender — represent a normative variation of human potentiality. However, due to the forced invisibility and pathologizing of gender differences, identity development has taken place within an oppressed culture. Treatment therefore involves assisting clients in actualizing a more authentic identity as a gender-variant person within a gender-rigid social world.

II. Treatment Considerations

Clients Seeking Treatment

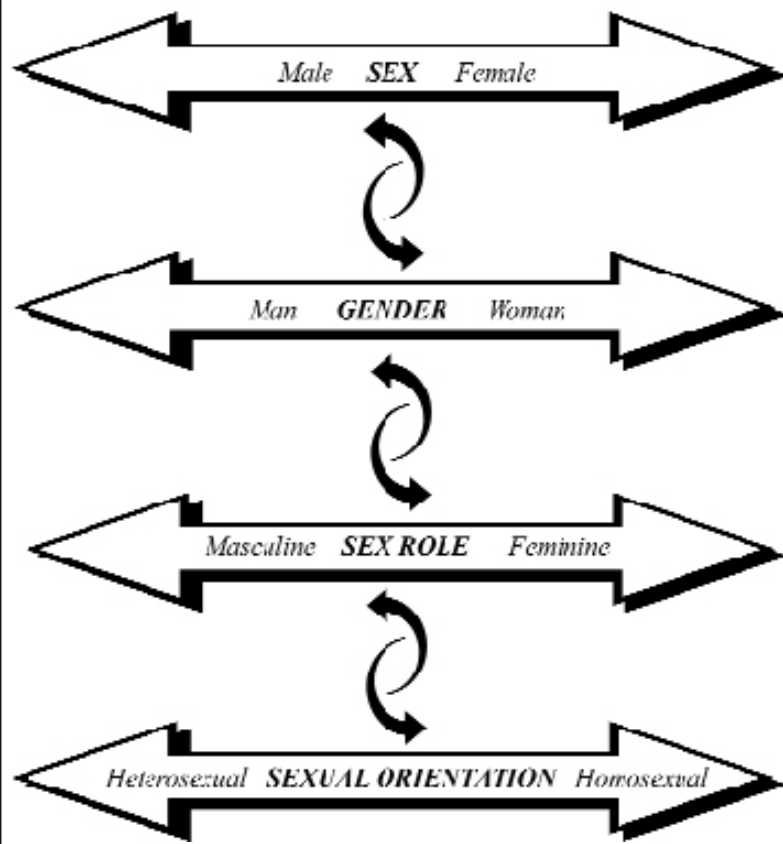
Transgender, transsexual, and intersex people come from all walks of life, represent people of all races, ethnicities, and class backgrounds, and seek out services at all stages of their lifecycles. It is important for helping professionals to recognize that gender-variant people can be school children as well as the elderly. They can be in heterosexual marriages and gay or lesbian partnerships. They can appear totally gender normative or be more obviously cross-gendered in appearance. Transgender people are found in wealthy communities, and established in professional jobs, and are also represented in high numbers among those who are homeless, engaging in prostitution for survival. Those with greater access to financial privilege often have greater access to health care, and services to assist in transition. Those who are poor, incarcerated, living with HIV, often procure treatments through any means possible, risking their lives and health.

Given the diversity of gender-variant people, it is obvious that they can also express a range of emotions about their gender issues, from revulsion to fierce pride. They may be angry towards clinicians, feeling hostile that they have to spend money on an assessment for a medical referral, or they may feel deep shame, bordering on suicidality, when revealing their gender feelings to a provider.

Generally speaking, people contacting therapists seeking services for gender related issues fall into three broad categories. First, transgender people seek out services because they are in deep emotional pain and seek information and counseling. They also seek out professionals for assistance in obtaining medical treatments, because in order to receive hormones and surgery for sex reassignment, they must be evaluated by professional social workers or psychologists for eligibility and readiness. They are therefore seeking “the letter,” i.e., a referral letter for medical treatment. Additionally, gender-variant clients seek therapeutic assistance dealing with family related issues. This last category includes both the gender-variant person, as well as his or her loved ones who seek treatment because they are struggling with their significant

Figure 1.4

All components of identity are actually on a continuum. Sex, gender identity, gender role expression and sexual orientation all exist on a spectrum and are not mutually exclusive (i.e., moving in one direction does not necessarily mean that one cannot also move in the other direction).



others' gender issues. Gender expression can profoundly impact the familial and social relationship of gender-variant people, and is often a major focal point of treatment issues.

Regardless of why gender-variant people are seeking therapy, treatment is most effective when gender-variance is assumed to be a normal expression of human diversity. Commonly clients are fearful of being judged, and have come into therapy already having diagnosed themselves with serious psychological "problems." The treatment model presented here postulates that transgender people need to emerge from this shame and self-hatred and that a significant amount of the problems gender-variant people experience is caused by societal oppression. Dysphoria and dysfunction are the sequelae to the experience of being stigmatized, both socially and clinically, and the therapeutic relationship can serve as a reparative to the emotional isolation.

Diagnosis and Gatekeeping

The bulk of contemporary research on gender variant people has maintained a pathologizing medical model perspective, ignoring or minimizing the influence of family systems, social environment, or normative biopsychosocial development. Research within this medical model has shown transsexuals to have significant mental health issues, but there was little examination of the biopsychosocial issues they had to face living within a transphobic social system. Historically, people seeking medical treatment have had to fit into rigid and limited diagnostic classification boxes. Recent research shows that whether or not clients meet these guidelines, they are aware of their existence and will comply with them by lying about their history instead of telling their actual story and risking medical rejection.

Therapists who specialize in gender issues have been forced to become gatekeepers, whose job has been to assess the accuracy of the transsexual narrative, making sure the person's story fits the approved narrative. Since referral for medical treatment has rested on this evaluative process, clients have been strongly motivated to tell a story that clinicians have deemed the only acceptable narrative. This has unfortunately created a clinical environment based on lies, rather than an authentic telling of the gender-variant person's experience. It has also effectively suppressed any alternative stories, which of course reinforced the belief that there was only one narrative.

This medical model of diagnosis and approval based on psychosocial assessment has come under critical examination in the past de-

cade by clinicians as well as activists. Clinicians have begun questioning the accuracy of the classification systems and the necessity to approve or refuse those seeking medical treatments based on rigid diagnostic markers that may not represent the diversity of extant gender expressions. Broader based models which see gender identity on a continuum and encourage educated consent and advocacy instead of expert approval are being promulgated. It is important to note that there is no research to date on the effectiveness of any treatment perspectives working with transgender people.

The medical model of gender identity as a disorder is currently being re-examined as damaging to transgender people's self-esteem and has potentially negatively impacted their social cohesion and their collective sense of identity. It is no coincidence that new clinical models based in empowerment and self-identification is developing along side of the growth of transgender politics and community organizing. This is a familiar trajectory for those knowledgeable about the community-building in the early days of the lesbian and gay liberation movement that culminated in the removal of homosexuality from the Diagnostic and Statistical Manual of Mental Disorders [DSM].

Homosexuality, long considered a psychopathology, was removed from the DSM in 1973 because of the tremendous pressure of the burgeoning gay liberation movement. The emergence of a politically organized lesbian and gay civil rights movement was instrumental in the depathologizing of homosexuality. It is arguable whether the success of this movement for LGB civil rights would have been possible if homosexuality had remained a diagnosable mental illness. Would gay marriage, employment and job protections, or gay adoptions be on the public agenda if same-sex sexuality was still considered a psychopathological perversion? Throwing off the yoke and stigma of "abnormality" allowed not only for the psychological growth of self-esteem on the part of gay, lesbian, and bisexual people, but also allowed for legal and political transformations that could never have been granted a "mentally ill" population.

Unfortunately, the struggle for civil liberties for lesbian, gay, and bisexual people was established by normalizing same-sex (i.e., natal) sexual desire and downplaying the relevance of gender identity and expression in identity development. Indeed, gender-variant behavior became separated from sexual orientation completely within the clinical discourse and among political activists (despite its frequent expression within the LGB community and despite the role played by gender-variant people in the early days of the gay liberation movement).

Interestingly enough, the development of a diagnosis Gender Identity Disorder coincided with the removal of homosexuality from the DSM. Furthermore, Gender Identity Disorder has been used to diagnose gender-variant homosexuals, especially youth, raising ethical questions about the continuing psychiatric treatment of homosexuality. It also shows the continuing conflation and confusion within the medical and psychiatric communities of gender identity and sexual orientation. It is important to note that

an organized and vocal faction still exists within the psychological community who still consider homosexuality a mental illness, and advocates reparative therapy for gay, lesbian, and bisexual people. The struggle to depathologize homosexuality has not ended; the need for ongoing professional social work advocacy and affirmative treatment strategies for lesbian, gay, bisexual, and transgender (LGBT) people remains paramount.

Since the relationship of the DSM diagnosis and medical care for transgenderism is entwined, a brief overview of diagnosis will be presented. There are two disorders in the DSM-IV-TR that refer to gender-variant people, both listed in the section on Sexual and Gender Identity Disorders. Gender Identity Disorder (GID) is the official diagnosis for transsexualism; Transvestic Fetishism, is the official diagnosis for erotic transvestism, and is listed in the Paraphilia sub-section. There is some question about whether GID actually meets the criteria for a mental disorder as described in the DSM, since “deviant behaviors,” including political and sexual ones, as well as “conflicts between the individual and society” are excluded from categorization as mental disorders (APA, DSM-IV-TR, 2000, p. Xxxi).

Approval for medical treatment for transsexualism (i.e., hormones and surgery) currently rests on a psychological assessment process and diagnostic confirmation. The guidelines for ethical Standards of Care for treating transgender people are outlined by the HBGDA, and include the need to meet the GID criteria. The DSM criterion is currently used in diagnosing two discrete groups of people. The first group - gender variant children and adolescents - are treated for their gender inappropriate behavior and cross-gendered identification. The second group - self-identified transgender and transsexual people - depend on the diagnosis to assist them in receiving the medical surgical treatments. For adults who are gender-variant and seeking medical assistance, the diagnosis of GID is their “admission ticket” for hormonal and surgical treatments.

There are four main reasons why the GID label does not adequately serve either of these populations. First, the criteria is based in an outmoded view of gender-variance, assuming gender transgressions in themselves are disordered and that only certain cross-gender expressions adequately fit the criteria for bona fide transsexualism deserving medical treatment. Secondly, the diagnosis is based on having a certain degree of distress regarding gender-variance. In a circular logic, people are diagnosed as mentally ill for having distress about a sexual or gender expression that has been defined as deviant. Part of the stress of being gender variant is being labeled as a deviant with a mental illness, and then the distress itself solidifies the justifications for the diagnosis. Gender-variant people are assumed to have distress; if someone doesn't exhibit distress they do not fit the criteria for diagnosis and therefore cannot receive medical treatment for gender issues. Gender dysphoria is assumed, indeed prescribed.

Furthermore, serious ethical questions are raised diagnosing young gender-variant people. Retrospective studies have shown that gender variant boys often grow up to be homosexual, not transsexual, meaning that it might not be “gender” identity dysphoria that is being identified in the DSM, but early manifestations of sexual orientation diversity. This raises a red flag about the treatment of

potentially pre-homosexual children in a psychiatric system that supposedly does not identify homosexuality as a disorder. It is questionable whether the diagnosis as it currently stands is able to adequately identify young children who are struggling with gender dysphoria, and if they can be differentiated from gender atypical children who are not in distress. Finally, the diagnosis as it currently stands is a clinical reification of sexism. An examination of the diagnostic criteria indicates a reliance on socially determined assumptions about proper boy/girl behavior. Sexism is ubiquitous in this section of the DSM; there are no indications or guidelines on how to assess for the distinction between social nonconformity and intrapsychic illness.

Despite all the above difficulties with the GID diagnosis, the reality remains that transsexual and transgender people seeking medical treatments have relied on this diagnosis for their actualization. Unlike LGB people, gender-variant people depend on the medical field for their actualization. Without a diagnosis, insurance coverage for expensive medical treatments will be even more difficult to attain. As a solution to this problem, it has been recommended that the ICD-10 medical diagnosis of transsexualism be used, and that psychological problems related to gender could still be covered using other DSM diagnoses (i.e., Adjustment Disorder).

As it stands right now, in order to receive medical treatment, transgender and transsexual people must prove themselves “disordered”; in order to be granted civil rights, transgender and transsexual people must prove themselves mentally sane. Paradoxically those who can most benefit from the removal of a diagnostic category that pathologizes them, have the most at stake in maintaining it. Approval for treatment should not depend on being mentally ill, but on being mentally sound enough to make empowered and healthy decisions regarding one's body and life.

A Developmental Treatment Model

Clinicians working with gender-variant people need to create a safe space for clients to talk about their experiences, to tell their stories, even if they are outside of the diagnostic parameters. This means finding ways to set aside the role of “gatekeeper,” in order to engage in an authentic dialogic relationship.

Gender variant people reaching out for therapeutic help are not only seeking information about transgenderism (they could just go to the library or Internet for that) but are seeking assistance because they want to tell their story to someone who can listen and reflect it back to them. The therapeutic encounter is an opportunity for a conversation to take place in which clients can hear themselves into existence; the therapist serves as a mirror, as a foil, as a compatriot on the client's internal journey. Clients struggling with gender identity issues need to tell their own stories in their own words; it is an evocative process where the therapist is the midwife, assisting in the birthing, offering encouragement and support, but essentially witnessing the client's own birthing process. The goal of treatment is to assist the client in finding significance and purpose in the lives they have lived, to develop organization and structure in which to make sense of it, and to determine direction and goals for their future.

Gender-variant people have often repressed their opposite sex

selves, the parts of them that feel the most genuine. The psychotherapy process can help in the transition from living a false life to the awakening to an authentic self. This is a developmental process of retrieving parts of self, and allowing them to mature in a fuller life. The therapist may be the first person to acknowledge the client's gender, and referring to them in a name and pronoun that most reflects their sense of self can be enormously empowering.

Psychotherapy can be useful for transgender, transsexual, gender non-conforming, and gender dysphoric clients at many stages of life. It can provide education about alternative explanations for gender dysphoria and the range of options for its resolution. The treatment process 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. Psychotherapy can be helpful to alleviate feelings of shame about gender issues; to examine the context, meaning, or roots of gender dysphoria; to discuss possibilities for managing gender expression or the impact of transitioning on family, career, and personal integrity; to explore various life options, including those that are related to gender as well as those that are independent of it; or to cope with post-transition issues.

Coming out transgender or emerging transsexual, is an inherently social process (unlike becoming gay which can remain hidden from public view) and involves both micro and macro components. Therapists serve as advocates assisting clients in making social and self-help connections to others who also experience gender variance. Clinicians may also need to assist clients in legal name changes, transitioning on the job, or coming out to children.

This author has described a model, called Transgender Emergence, that outlines the developmental stages that transgender people experience, while they engage in conscious decision-making regarding sex reassignment. It is a model based in client empowerment where the therapist is an advocate, an educator, and a mentor, but minimizes her role as a gatekeeper. This model supports clients' unique gender narratives and minimizes placing the clinician in the role of gatekeeper for medical treatments.

Although it is important to recognize the seriousness and irreversibility of transsexual surgeries, as well as the importance of a mental health evaluation within the dialogic clinical relationship, it is equally necessary to recognize client autonomy and the limits of clinical control. It is important to note that it is rare for those who have been approved for treatment to have post-surgical regrets. This may be a result of the comprehensive evaluative process in place. Yet it might also be true that those who seek these services are intrinsically prepared for the inherent stress; it possibly might even suggest that a more flexible evaluative process might yield similar satisfactory results. HGIBDA, the only professional organization devoted to the understanding and treatment of gender identity issues, continues to reevaluate the Standards of Care in light of evolving paradigms.

Although this model is based in non-pathologizing view of gender diversity, it does not mitigate the very real issues of gender dysphoria, or the fact that some transgender people (like some people of any social group) do have mental health issues that need to be

addressed clinically.

Gender dysphoria describes the psychological discomfort experienced with the physiological body and associated gender expectations, as well as a presence of clinical symptomatology associated with emotional difficulties. In a society where cross-gender expression is believed to signal extreme mental illness, experiencing cross-gender feelings can create numerous reactive symptoms in addition to anxiety and depression. These can include dissociation, suicidality, sexual dysfunction, substance abuse, self-mutilation, or even intense hostility against other differently gendered people. It is rare for someone struggling with gender incongruence to not experience some psychological symptomatology, i.e., insomnia, isolation, dysthymia, anxiety, weight loss or gain, and work or school difficulties.

It is easy to understand how someone experiencing the kind of symptoms listed above might be perceived as dysfunctional or even emotionally disturbed in the eyes of most mental health specialists. Acceptable gender behavior is profoundly mandated - culturally, religiously, and even economically - and the realization of being relegated to the category of the stigmatized "other" can create extreme discomfort. It is to be assumed that most clients who reach out for therapeutic services are experiencing some distress. The experience of gender dysphoria is a natural outcome of living within a culture with an explicit gender system that associates certain appearances and behaviors with particular gender categories.

However, it cannot be assumed that gender dysphoric individuals who seek out psychotherapeutic services are representative of all gender-variant people. It is possible that some transgender people do not experience any "dysphoria," but are able to experience their gender differences in an accepting and celebratory way. These people would be less likely to seek out professional counseling, except for a letter of recommendation for hormonal and/or surgical treatment. It is, however, rare for persons to experience their gender identity in conflict with their assigned sex within a society with rigid gender normative rules, especially before the rise of a transgender liberation movement, and have this not be distressing in some manner.

Family Emergence

Gender variant people including those who identify as transsexuals, crossdressers, transmen, transsexual women, bigendered, Two-Spirit, third sexed, or gender-benders as well as those who are femme or butch are born into families, live in families, and seek support and refuge in families. The acceptance or rejection they experience from their families is a core issue in their ability to integrate their gender identity into their lives in productive and meaningful ways. Supportive systems-based psychotherapy for gender-variant people and their families will assist in the development and maintenance of healthy stable families, and consequently will yield greater success for gender-variant members of those families, particularly those engaged in sex reassignment.

Gender variant experience is not simply an internal psychological process that needs to be navigated by transgender and transsexual people, but it is also a relational and systemic dynamic that intimately involves family, friends, loved ones, and all social rela-

tionships. Social workers share with their professional colleagues in other disciplines a long history of negligence regarding advocacy and clinical treatment of transgender people. However, social work—which professes to maintain therapeutic focus on the needs of “persons in environment” has been particularly remiss in addressing the emotional issues faced by families with gender variant members.

Gender variant people are embedded in a complex matrix of familial and societal relations and their unique relationship to their sex and gender identities impact family members in numerous ways. Parents struggle to understand the issues facing gender-variant children and youth, and children often need to address the concerns of parents who are facing gender transitions. Spouses of transgender and transsexual people—husbands, wives, partners, and lovers—are often thrown into emotional chaos following the disclosure of a desire to transition; this is equally true for gay, lesbian, and bisexual spouses as it is for heterosexuals. Brothers, sisters, aunts, uncles, adult children, and grandparents, all struggle with trying to make sense of and come to terms with transgender identity and/or transsexual sex changes in their loved ones. Families of infants born with an intersex condition are faced with making immediate decisions about irreversible surgical procedures with little information to guide them. Until very recently family members have managed these emotional upheavals in their family life-cycle with little actual “help” from helping professions.

Gender dysphoria often begins in childhood, although not all children who express gender-variant behavior grow up to be transgender or transsexual. Children and youth with crossgender expression are a neglected population, whose issues are either minimized (“They will grow out of it”) or pathologized, i.e., treated to have these behaviors eliminated. Sorting out normative but variant gender expression in children, from early manifestations of divergent sexual or gender identities, requires knowledge of child development, as well as sexual and gender identity and expression. Families with gender-variant children often seek out services from professionals. There is currently an increase in youth seeking medical treatments for sex reassignment, raising ethical issues about early gender transitions. Research from the Netherlands show excellent results for gender-variant youth who receive thorough assessment and psychotherapy. Medical treatments are initiated in later adolescence (instead of waiting until adulthood); and young people seem to successfully transition, and begin new lives in their chosen gender. These early sex changes mitigate some of the impact of later puberty on their physiological development allowing them to pass more effectively, as well as allow the youth to establish themselves socially and professionally as young adults.

Heterosexual males with long histories of cross-dressing sometimes seek out counseling in their forties and fifties. Often shame-filled and confused, many of these men have hidden their female selves from their wives for decades-long marriages; they often

seek counseling having never talked about their crossdressing with anyone in their lives. When they disclose to their wives (or in some cases are caught), their marriages must cope with not only the confusion of gender issues, but also the reality of betrayal at the exposure of such a long-time secret. Additionally, there is sometimes confusion on the wife’s part regarding her husband’s sexual orientation (“Is he really gay?”) or even her own. In long time lesbian relationships, if a partner begins a sex transition, this may raise equally confusing questions regarding sexual orientation and identity. For many lesbian women having a partner begin to live as a man raises complex issues around community affiliation, in addition to personal challenges of being in a relationship that is now perceived to be heterosexual.

Families also experience an emotional process coping with loved ones’ gender related issues. Family Emergence involves a complex interaction of both developmental and interpersonal transactions. It is an adaptive process, and unlike the developmental experience of gender-variant people which emerges from an intrinsic need for biopsychosocial authenticity, family members are often unwilling participants on this journey. The stages are outlined below:

Stage One

Discovery and Disclosure: The first stage for family members involves the Discovery and Disclosure of the gender transgression which is often met with shock and betrayal. Disclosure can include revealing a history of crossdressing behavior or the sharing with a loved one of increasing discomfort regarding cross-gender feelings that have been hidden or minimized. Discovery can take place accidentally, which may evoke feelings of betrayal, anger, fear, and potentially, shame. Research has shown that disclosure and discovery can raise questions about what other secrets their partner is hiding. Questions are raised about how it will impact the children, how to protect their family from

what others might think, and how this will impact sexual intimacy. Children with a transgender parent might experience concerns about whether gender issues are inheritable. Children who are gender-variant themselves often express gender dysphoria at remarkably young ages. Sadly, the discovery and disclosure of gender variance in families is rarely met with compassion and support, but more commonly, with emotionality and turmoil.

Stage Two

Turmoil: Although some spouses, partners, children, and parents accept gender variance, and even sexual reassignment, with grace, ease, acceptance, and support, it is more common for a parent, child, spouse, or partner to have an initial response that is intense and emotionally labile. Spouses report feelings of betrayal, shame, revenge, fears of abandonment, disbelief, rage, depression, anxiety, confusion, low self-esteem, sexual difficulties, anxiety and suicidality; they have reported sexual dysfunction, substance abuse, weight loss or gain, and physical health problems. Families often reach out for services during this stage, and therapists, who may

“Gender variant experience is not simply an internal psychological process that needs to be navigated by transgender and transsexual people, but it is also a relational and systemic dynamic that intimately involves family, friends, loved ones, and all social relationships.”

not be knowledgeable about transgenderism, can increase the level of turmoil in a family by expressing a sense of hopelessness about the family's ability to navigate through the storm, instead of treating gender issues in the same manner as other normative family lifecycle crises (death, disability, divorce, illness, etc.)

Stage Three

Negotiation: The next stage for families is negotiating acceptable boundaries and how they will process the gender issues and the resulting impact on their relationships. When a partner discloses a desire for complete sex transition and surgery, and is insistent that this must happen quickly, the intensity and turbulence created in the relationship is usually more difficult to overcome. It is sometimes hard for the transgender person to realize that although he or she has always struggled with these issues, it is still a new situation for others to assimilate. Transgender people who are still unsure of their goals, or who are willing to move slowly through a transition process while their partners emotionally “catch-up,” are more often able to successfully negotiate their transition while remaining in their intimate relationship.

The process of limit setting and boundary marking is necessary in gender/sex transitions and assists in the accepting of transgenderism within families. Some of the issues that often need to be negotiated in relationships include: frequency of crossdressing or “outings,” how to leave or enter the home when crossdressed, public appearance, disclosure to significant others, how much money can be spent on clothing or medical treatments, revealing the gender issues to the children, health risks of hormone treatments, name-changing and the use of proper pronouns, and sexual accommodation including crossdressing or cross-gender play in the bedroom. Timing of transition related issues become an important focus during the Negotiation stage.

Negotiating gender variance in children and youth is extremely complicated since young people are often considered unable to fully understand the consequences of their decisions, and parents ultimately have the legal power to make decisions for them. Children often act out their gender issues or learn to repress them, and the parents either insist that the child conform or allow him or her to experiment. Negotiation can involve professionals, school systems, and in some cases legal questions of the parent's right to allow children their own gender expression.

Stage Four

Finding Balance: Balance does not mean that the gender issues are resolved, nor does it necessarily mean that the transgender person has transitioned, although it might mean a significant shifting of family roles and relationships. Balance means that transgenderism is no longer a secret, that the family is no longer in turmoil, and that the family has integrated the transgender person—as a transgender person—back into the normative life of the family. Every family comes to their own unique resolution, which may include complete sex reassignment, or full time cross-living, or may involve boundary setting about crossdressing. Most importantly, the transgender person is no longer stigmatized within the family, but accepted for who he or she is, and treated with respect and dignity. Conversely, family members are allowed to experience a range of emotions regarding having a transgender family member.

Balance might mean living with private crossdressing, or it might mean living with a spouse who is transitioning. It can also mean living with the uncertainty of not knowing the trajectory of the transsexual process and learning to live with the “unknown.”

Not all families “make it” through the process of sex reassignment or gender re-assessment. However, families can successfully negotiate these processes, whether or not marriages survive, which is especially important for children of transgender parents who need to retain a healthy relationship with both parents.

Transgenderism is commonly rooted in lies, secrecy, and hidden family secrets. Secret keeping, as family therapists have long noted, is an act of self-preservation, a way to manage pain. Secrecy has been detrimental to the family life of transgender people. At the stage of Balance family members know the difference between secrecy and privacy. Families that are able to move through their betrayal and lost trust regarding gender variance are often able to find contentment and satisfaction in their daily family lives.

Conclusion

The need for social work education in the areas of sexual and gender diversity is paramount for our profession. Clinical social workers and family therapists must be educated about the diversity of gender expressions and experiences so that they can offer support to their clients and not require their clients to educate them.

Transgender and transsexual people face a large array of social and environmental challenges including a lack of employment protection, court bias in child custody decisions, lack of quality treatment by medical professionals when seeking routine medical care, and mistreatment and prejudice within the educational system from kindergarten through college. For those people with gender-variant expression who are also dealing with mental health issues, their gender issues are often seen as part of their psychiatric disturbance, instead of as part of their human identity while they struggle mental illness. Social workers that are knowledgeable about the needs of this diverse population are needed in all areas of treatment – medical, psychiatric, and educational. Gender-variant children and youth need school social workers who are able to develop educational policies that protect them within often-hostile environments. Social workers need to become part of treatment teams serving families when children are born with intersex conditions.

As of this writing, only 35 social workers are members of the Harry Benjamin International Gender Dysphoria Association (HBIGDA), which is the only professional organization devoted to the understanding and treatment of gender identity disorders. As the largest providers of services in the United States, social workers should be at the forefront of working with this population whose needs are not simply psychological, but at the intersection where individuals and the environment meet, the arena of specialty for the profession of social work. No population is in greater need of the kind of skills social workers excel at: strength-based advocacy within an ecological framework.

Guidelines for Therapists Working With Transgender Clients

- Therapists working with transgender clients must have a thorough understanding of gender identity issues, including information on the differences between gender and sexual identity, and the social construction of gender dimorphism.
- Therapists must be knowledgeable about the current DSM diagnosis of Gender Identity Disorder, and the most recent Standards of Care developed by the Harry Benjamin International Gender Dysphoria Association.
- Therapists must be aware of the issues being raised within the Transgender Liberation movement regarding the socio-political forces in the construction of gender identity and the limitations of a bipolar gender system, as well as the diversity of gender expressions.
- Therapists must have a general knowledge of mental health issues, human development, and training in eclectic psychotherapeutic techniques. Therapists must be able to assess for mental illness, as well as addictions and trauma related symptomatology.
- Therapists must be cognizant of the impact of stress on gender dysphoria and not pathologize the clients' stress related symptoms.
- Therapists must have a humanistic perspective that supports the empowerment of client self-identification.
- Therapists should be knowledgeable about issues related to gender identity, sexuality, sexual identity and gender role development, and be comfortable talking about these issues.
- Therapists should be sensitive to the impact of family systems concerns including family of origin and current partners and children, and able to provide services or referrals for family members.
- Therapists should have resources available for clients, including referrals to endocrinologists and/or psychiatrists, gender clinics, and support groups, as well as recommendations for bibliotherapy and Internet sites.

Definitions

Sexual Identity: An overall term that describes an individual's sense of their own sexuality, including the complex relationship of sex and gender as components of identity. Sexual identity includes a biopsychosocial integration of biological sex, gender identity, gender role expression and sexual orientation.

Sex: Sex is the physiological makeup of a human being, referred to as their biological or natal sex. Sex is usually thought of in a bipolar way, dividing the world into males and females. In reality, sex is a complex relationship of genetic, hormonal, morphological, biochemical and anatomical determinates that impact the physiology of the body and the sexual differentiation of the brain. Although everyone is assigned a sex at birth, approximately 2% of the population is intersex and do not easily fit into a dimorphic division of two sexes that are "opposite."

Gender Identity: Gender is a social construct that divides people into "natural" categories of men and women that are assumed to derive from their physiological male and female bodies. Gender

attributes vary from culture to culture, and are arbitrarily imposed, denying individuality. Most people's gender identity is congruent with their assigned sex but many people experience their gender identity to be discordant with their natal sex. A person's self concept of their gender (regardless of their biological sex) is called their gender identity.

Gender Role: Gender role is the expression of masculinity and femininity and has often been referred to as "sex roles." Gender roles are usually a reflection of one's gender identity and are socially dictated and reinforced. Gender roles describe how gender is enacted or "performed" (consciously or unconsciously) and may or may not be related to gender identity or natal sex.

Sexual Orientation: Sexual orientation is the self-perception of the direction of sexual desire. It describes sexual preference and emotional attraction. Some people experience their sexual orientation as an unchanging essential part of their nature, and others experience it in more fluid way. Sexual orientation can be directed towards members the same sex (homosexual) or the opposite sex (heterosexual), both sexes (bisexual) and neither (non-sexual). Sexual orientation is not merely "same-sex" attraction, but is experienced through the person's gender identity (regardless of their biology). A male-to-female transsexual can be heterosexual, lesbian or bisexual. A female-to-male transsexual can be heterosexual, a gay man, or bisexual.

Transgender: Transgender is an umbrella term including many categories of people who are gender variant. This can include people who identify as transsexuals, crossdressers, masculine identified females, feminine identified males, MtF's, FtM's, transmen, transgender women, and other differently-gendered people.

Transsexuals: Transsexuals are people who believe that their physiological body does not represent their true sex. Most transsexual people desire sexual reassignment surgery (SRS) but transsexual people may be pre-operative, post-operative, or non-operative (i.e., choosing to not have surgical modification). Some transsexual people prefer to not have their birth sex known and to "pass" or go "stealth," and others are comfortable being known as transsexual and take pride in this identity. Most transsexual people prefer to be referred to simply as men or women, according to their gender identity and gender presentation, regardless of their surgical status.

Crossdressers: Crossdressers are people who wear the clothing usually assigned to the opposite sex. They have been referred to in the clinical literature as "transvestites" (TV's), but most prefer the term crossdresser. Some crossdress for erotic fulfillment, some for social fun (i.e., doing "drag") and still others just for comfort. Since women have more freedom of dress in American culture, crossdressers are, by clinical definition, males who dress in women's clothing, and most are heterosexually identified. Many crossdressers purge their female clothing periodically as a way to try to cure themselves of their behavior. The length of time a person crossdressers can vary from infrequent to full-time.

Drag queens are males, often gay men, who dress as women, in an extreme feminine manner, for fun, or "camp." Drag kings are the

females, who dress as men, in an extremely masculine manner, often for entertainment. Some drag queens and drag kings might live full-time in these identities. Female impersonators are men who work in the entertainment industry and who dress as women as part of their job; they may be crossdressers or be transgendered but not necessarily; male impersonators are their female counterparts.

Intersex: Intersexuality refers to people who are not easily classified into the binary of male and female categories. They have physical sex characteristics, often including ambiguous genitalia, of both males and females, and are not easily differentiated into established sex divisions. Intersex people are assigned to either male or female categories at birth and many have been surgically altered at birth. Intersexuality and surgical alterations are often a secret, sometimes even to those who have been altered whose medical records are kept from them. Intersex people can be heterosexual, gay, lesbian, bisexual, transgender, or transsexual from the perspective of the sex and gender identity that they have been assigned. Approximately 2% of the population may be broadly classified as intersex.

Female-to-male transsexuals (FtM's or FTM's): Female-to-male transsexuals, commonly referred to as "transmen," are natal females who live as men. This includes a broad range of experience from those who identify as "male" or "men" and those who identify as transsexual, "transmen," "female men" or as FTM as their gender identity. FtM's are often contrasted with "biomen" or biologically born men. Some transsexuals are comfortable being included in the category of transgender and others are not.

Male-to-female transsexuals (MtF or MTF): Male-to-female transsexuals are natal males who live as women. This includes a broad range of experience including those who identify as "female" or "women" and those who identify as transsexual women. Some words used to refer to transsexual women are "Tgirl" and "new women" which is contrasted with "GG's" or genetic women. Some transsexual people are comfortable being included in the category of transgender and others are not.

Bigender: Some gender variant people reject the choices of male/female, man/woman and feel their gender encompasses "both" genders. Some feel that they are androgynous, simultaneously exhibiting masculine and feminine traits, and others feel they are neutral, or without gender. This steps outside of a "changing sex" paradigm and allows for more flexibility of gender expression and identity. Bigender people often identify as being of both genders. Transsexual people do not commonly consider themselves to be bigendered. Within some American Indians cultures expressing both genders is referred to as "Two-Spirited." Within contemporary urban life bigendered people often refer to themselves as "gender queers," "gender benders," "gender-blenders," "third sex" and "gender perverts" as terms of pride.

Gender Community: This is a colloquial term for the transgender community or people who are dealing with issues of gender identity. It often includes the significant others of transgender people, referred to as SOFFA's (significant others, family, friends and allies).

Emergence: The process of become aware of, acknowledging, accepting, appreciating, and letting others know about one's (trans)gender identity. It is similar to the "coming out" experience for lesbian, gay men and bisexual people, but can also involve body modification and changes in pronoun use; it is, therefore, less easily hidden socially or vocationally. Emergence is normative within a culture that allows only dimorphic immutable gender expressions; it describes an adaptive process that is necessary within a confining social system.

Transition: The process that transgender people move through in accepting their gender identity, particular the physical, legal and psychological experience of moving from one gender identity to another, or allowing others to see their authentic identity. Transition is similar to a re-birthing experience, where the person re-emerges with a social identity that is the best expression of their internal core gender identity. Part of this process is cross-living as the other gender or going through the real life experience to understand what living as the other gender before being referred for sexual reassignment surgery. Transition often implies hormonal and surgical treatment and the physical changes that accompany them.

Passing: To pass is to be able to successfully assume the gender role opposite sex when interacting with society and being able to function in public situations as a member of that gender. When someone does not pass well, or can be easily "read" as a member of his or her assigned sex, it can invite public ridicule and violence. Some transgender activists reject the idea of trying to pass, seeing it as playing into a dual-gender system, however for many transsexual people passing well is seen as affirming their re-integration into society.

SRS (Sexual Reassignment Surgery): SRS, also referred to as GRS (Gender Reassignment Surgery), is the surgical process involved in changing one's sex. This most often refers to genital reconstruction, but also can include mastectomy and chest reconstruction for female-to-male transsexuals, and can also include a variety of cosmetic surgeries to enhance one's gender presentation. Genital surgeries for male-to-female people are currently more advanced than those available for female-to-male people.

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Transgender Emergence: Understanding Diverse Gender Identities and Expressions

Post-Test

Please circle the one correct answer for each question.

- 1) Transgender is a term:
 - a) coined in the 1960s.
 - b) inclusive of all gender-variant people.
 - c) preferred by most transsexuals.
 - d) used as a non-clinical way of distinguishing transsexuals from crossdressers.
- 2) Research on gender-variant people in the past 30 years has:
 - a) consistently shown anatomical dysphoria for crossdressers
 - b) focused primarily on female-to-male transsexuals.
 - c) shown high levels of regret following sexual reassignment surgeries.
 - d) described crossdressers as motivated by erotic desires.
- 3) Children born with intersex conditions:
 - a) are confused about whether they are a boy or a girl.
 - b) primarily struggle with issues of stigma and shame.
 - c) only have surgery at birth when there is a medical need.
 - d) have access to all their medical information.
- 4) Social workers:
 - a) represent the primary treatment providers working with transgender people.
 - b) generally have enough basic knowledge of sex and gender identity to work effectively with people in transition.
 - c) have national policy directives in place regarding the treatment of transgender people.
 - d) are at the vanguard of non-pathologizing treatment strategies working with gender-variant people.
- 5) Gender Identity is:
 - a) the same as gender role.
 - b) assumed to develop consistent with natal sex.
 - c) changeable with behavioral treatment.
 - d) formed in early adolescence.
- 6) Research has shown that newer treatment models are more effective than older models:
 - a) True
 - b) False
- 7) Research has shown that gender-variant youth
 - a) are actually intersexed.
 - b) who receive appropriate evaluation and treatment have successful sex reassignments.
 - c) have a high incidence of post-surgical regret.
 - d) never grow up to be gay.
- 8) Female partners of FTMs are usually relieved to no longer be viewed as lesbian.
 - a) True
 - b) False
- 9) Transgender Emergence describes:
 - a) a developmental model of transgender identity formation.
 - b) sexual identity role confusion.
 - c) a socio-political process establishing a transgender social justice movement.
 - d) crossdressing and passing in public.
- 10) Crossdressers:
 - a) are all heterosexual men.
 - b) never have interest in taking female hormones.
 - c) are usually gay men.
 - d) can successfully hide their crossdressing from their wives for decades.
- 11) Female-to-Male transsexuals:
 - a) are commonly known as transmen.
 - b) cannot convincingly pass.
 - c) rarely seek out professional services.
 - d) are exclusively heterosexual post-transition.
- 12) Gender Identity Disorder:
 - a) is only useful when working with people with psychiatric disorders.
 - b) was removed from the DSM in 1993.
 - c) confuses sexual orientation with gender role expression.
 - d) is useful for insurance reimbursement of transsexual treatments.
- 13) Natal Sex:
 - a) is always consistent with gender identity.
 - b) does not exist in people with intersex conditions.
 - c) can only be determined by medical doctors.
 - d) is determined by anatomy, hormones and genetics.
- 14) A transsexual woman involved in a relationship with a natal male, would most likely identify the relationship as same-sex, i.e., "gay."
 - a) True
 - b) False
- 15) Transgender experience is:
 - a) a new idea, invented in the last few decades.
 - b) a universal experience, cross-culturally and historically.
 - c) more common in males than females.
 - d) protected in most federal, state, and local laws.

(Continued on next page)

Transgender Emergence: Understanding Diverse Gender Identities and Expressions

Focus CE Course Evaluation - February 2006

Please indicate whether the stated learning objectives were achieved:

1. To increase social workers' understanding of gender identity and transgenderism.

Achieved in full 5 4 3 2 1 *Not Achieved*

2. To increase comfort in working with transgender, transsexual, intersex, and other gender-variant people.

Achieved in full 5 4 3 2 1 *Not Achieved*

3. To develop and enhance specialized skills for provision of services to transgender people and their family members.

Achieved in full 5 4 3 2 1 *Not Achieved*

Please evaluate the course content:

4. This course expanded my knowledge and understanding of the topic.

Achieved in full 5 4 3 2 1 *Not Achieved*

5. The course material was clear and effective in its presentation.

Achieved in full 5 4 3 2 1 *Not Achieved*

6. This course was relevant to my professional work/interests.

Achieved in full 5 4 3 2 1 *Not Achieved*

7. As a result of this course, I learned new skills, interventions or concepts.

Achieved in full 5 4 3 2 1 *Not Achieved*

8. The resources/references were comprehensive and useful.

Achieved in full 5 4 3 2 1 *Not Achieved*

9. This course addressed issues of diversity and/or the social justice implications of the topic.

Achieved in full 5 4 3 2 1 *Not Achieved*

10. Please provide comments on current course and suggestions for future courses.

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