

## *Foreword*

In 1966 Harry Benjamin, M.D., published the pioneering book *The Transsexual Phenomenon*. For three decades Benjamin's work continued to be the best medical and psychological reference book available for transsexuals, their friends and families, and the professionals who treated them. Benjamin's work sparked a short-lived era of academic interest in transsexuals. From the late 1960s to the late 1970s, many medical schools sponsored gender clinics for the study and treatment of transsexuals.

Unfortunately, the university gender clinics came to be universally unpopular. Transsexuals correctly felt put upon by having the access to their medical care controlled by opinionated researchers. Academic physicians and psychologists were often more interested in validating their own theories of the etiology of transsexualism than in helping transsexuals to live happier lives. Transsexuals learned to alter their own life stories to better match the pathologic model favored by the institution to which they were applying for their medical care. The research produced under these circumstances is highly suspect and of questionable value.

Gender researchers were usually conservative, and always nontranssexual. They did not mind having transsexuals as research subjects or patients, but they did not view us as social equals. Few would have been pleased to see a transsexual marry into their family. One example of this mindset: Robert J. Stoller, M.D., wrote me a letter in 1977 advising me not to even consider applying to medical school. The late Dr. Stoller was a UCLA psychiatrist, professor, and author of early gender studies based on psychiatric theory. He considered transsexualism to be a mental illness caused by poor childrearing practices. He felt that no medical school in the country would admit a known transsexual, whether pretransition, preoperative, or postoperative. This is not surprising,

given his beliefs. If medical schools had a negative opinion of transsexuals, Stoller was among those who contributed significantly to this attitude.

Many physicians involved with gender-reassignment programs required their applicants to promise to be exclusively heterosexual following their reassignments. Not surprisingly, gay rights activists became suspicious that the practice of gender reassignment was a heterosexist plot to eliminate homosexual behavior. Some went so far as to assert that transsexualism was not a distinct entity at all, but merely a manifestation of homosexuality with internalized homophobia. Other scholars, especially feminists, asserted that gender roles were a cultural artifact. Feminists would argue that gender reassignment was in conflict with their goal of altering culture to produce a nonsexist society. Lesbian feminists were especially unhappy that some postoperative male-to-female transsexuals would adopt lesbian identities and seek entry into the lesbian subculture. Ironically, although transsexuals were often unwelcome in gay and lesbian circles, the organized anti-gay movement that emerged around 1977 considered transsexuals to be especially abominable. Transsexuals were an anathema to both the left and right in this politically charged environment.

In 1979 a highly flawed academic paper was published that suggested that transsexuals did not even benefit from gender reassignment. Finally; the consequences of the often poor quality of psychological and surgical work being done by university-based gender clinics became evident. Transsexuals sued their academically based health care providers for malpractice and sometimes won. Medical schools came to be embarrassed by the presence of these controversial gender clinics. One after another, the clinics, now economic and political liabilities, were closed.

For the past decade and a half, most medical and psychological care of transsexuals in the United States has been provided outside the university system. Transsexuals and other transgender consumers have benefited in several ways. Private practitioners have been much more flexible in accepting diverse individuals for gender-reassignment treatment. The free market has helped eliminate many of the practitioners who consider gender-identity issues as pathologic and who treat those with such issues in a denigrating or patronizing manner. The quality of surgical care has improved considerably, and the vast majority of gender operations are now done by a handful of surgeons, each of whom performs more than a hundred such operations a year.

Unfortunately, the free market has also had its downside. Funding for research into the care of transsexualism has vanished. Academic publications about transsexualism and other gender issues have been few. Transsexualism itself does not exist as a defined entity in medical textbooks or medical school curriculums. In the absence of medical advocacy for transsexuals, insurance companies frequently exclude medical coverage for genital reassignment with impunity. Imagine the uproar from hematologists if insurance companies chose to exclude medical coverage for leukemia. Concerning transsexualism, there is a deafening silence.

To fill this vacuum, a new generation of writers about transsexualism and other gender-identity issues emerged in the mid-1990s. Many, including my friend and colleague Gianna E. Israel, are transgender persons themselves. Ms. Israel is one of several of us who developed the professional skills to treat transsexuals and other transgender persons after undergoing gender reassignment herself. Her counseling practice grew, not from any arid academic theory, but from a heartfelt desire to help other transsexuals find happiness in their lives. This project, which gave her the opportunity to collaborate with a prominent gay African American psychiatrist, Donald Tarver, M.D., has been a labor of love, bringing cultural sensitivity to the treatment needs of transgender men and women. The work involved in publishing a book of this breadth and magnitude is enormous, and Ms. Israel did not have the luxury of being supported by an academic salary in undertaking her role as principal author.

Ms. Israel's sacrifices and Dr. Tarver's contributions are much needed. Most transsexuals do not have the benefit of living in the San Francisco area, where knowledgeable gender counselors and physicians are plentiful. Many transsexuals find themselves in the awkward position of being the first transsexual their counselor or physician has treated. Likewise, many transgender persons may not even realize that treatment plans exist for their needs. It is for the benefit of these persons that this book is intended. The Guidelines comprehensively cover the essentials of transsexual and transgender care. In addition, other important topics, such as human immunodeficiency virus (HIV) infection in transgender persons, are covered for the first time in any such volume.

Gianna Israel has contributed significantly to the burgeoning movement to depathologize transsexualism and transgenderism, and to improve the quality of care. Her efforts form a bridge to the longed-for day when transsexualism is a standard subject in medical school and in medical texts. Dr. Harry Benjamin would be proud; I certainly am. May this book grace every library.

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January 1997

# *Introduction*

## **Chapter 1**

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Uncovering current educational resources, assessment tools, and recommendations in support of the many different types of transgender individuals has been difficult for professionals as well as for consumers who are experiencing gender concerns. In 1979 the Harry Benjamin International Gender Dysphoria Association (HBIGDA) drafted its “Standards of Care for Gender Dysphoric Persons,” which consists primarily of recommendations for hormonal and surgical treatment for transsexuals. Over the years that document and its subsequent revisions have come under sharp criticism for being too narrow in scope and pathologizing to transgender individuals. We would, however, like to commend those founding professionals who initiated safety measures where no formal precautions previously existed and that undoubtedly prevented a variety of psychological and surgical mishaps.

As we approach the new millennium, providing professional transgender support services has become all the more complex as the special needs of multiple populations come to the surface. As an example, over the years the staff at the Tom Wadell Medical Clinic in San Francisco noted the plight endured by transgender individuals surviving in the city’s Tenderloin district, a zone of high poverty, violent crime, and drug addiction. Not only were these individuals underserved with regard to basic medical and psychological support services, they were frequently resorting to self-medication with black-market hormones or visiting irresponsible practitioners who promoted hormone administration and silicone treatments without appropriate medical follow-up. Clearly, few resources existed that addressed these individuals’ special needs, or provided necessary consumer education and regular medical follow-up.

The cases of *transgenderist* individuals who are unable to obtain support services provide yet another example of how complex providing transgender sup-

port services has become. (Transgenderist individuals are those who live “in role,” that is, as a member of the opposite gender, part or full time, yet are not interested in Genital Reassignment Surgery.) These individuals have been routinely turned away from mental health services or denied hormone administration and associated gender-confirmation surgeries. Since these individuals are not transsexuals, no resources have existed that define this subpopulation and its specialized needs or provide recommendations for its support and care.

The Guidelines provided herein do *not* supplement any existing literature or resources. Rather, they refine existing knowledge by addressing the uncertainties many professionals and consumers face in this rapidly evolving specialty field. Questions such as these are answered: How does one support the transgenderist’s specialized needs? Can transgender HIV-positive individuals be referred for hormones and surgery? What options are available to transgender youth? How can mental health and social service providers best offer residential placement for transgender individuals, including the homeless? How do novice care providers distinguish between true mental disorders and a transgender identity? In addition, current recommendations for hormone administration and surgical treatment are presented. The latter subjects have been addressed in such a manner as to respect the individual’s right for self-determination while promoting realistic models for medical follow-up and consumer self-protection.

The Guidelines provide the framework for further development of professional support of transgender individuals. Newly introduced is the concept of the Gender Specialist, a care provider who possesses a distinct body of knowledge gained within the context of support for transgender individuals and through professional peer consultation. Although no such specialty certification exists within larger professional organizations, the introduction of this concept herein provides not only the validation of such need but also gives consumers an easy-to-understand framework for determining which professionals are qualified to support their unique needs.

The development of the Guidelines from concept to authorship, then through the review and editing processes, has not occurred without obstacles. It has been an ongoing growth process in which the chief difficulties have been promoting nonpathologizing support models that protect the individual’s right for self-identification while preserving and further defining medical, psychological, social support, and consumer protections. Language usage itself also presented some difficulty, as we endeavored to illustrate the support needs of *all* transgender populations—transsexuals, transvestites, transgenderists, androgynes, and including even the intersex and hermaphrodite individuals who sometimes self-identify as transgender.

One such question about language arose around so-called *cross*-words, that is, those beginning with the prefix *cross*, for example, crossdress, crosslive, crossgender. Several individuals on the Review Committee voiced objection to the application of *cross*-words, which they felt were inappropriate to use when describing transsexual-oriented behavior. In response, we searched the entire manu-

script while asking whether *cross-words* were in fact being utilized in areas solely dedicated to transsexual individuals or were being used as an instrument to provide a broader frame of reference so as to be inclusive of other transgender populations. More information on *cross-words* may be found in the vocabulary section below.

The healthy process of asking questions such as these directly mirrors the developmental pathways encountered by transgender individuals, the transgender community, and supporting care providers. The whole process begins when a person asks, “What gender am I?” The process continues with professionals and transgender support organization leaders asking themselves, “How can we best provide resources and educational options so that transgender individuals can make informed choices?” Nationally, this has taken shape in many forms. Some of the results include passage of a city ordinance in San Francisco as well as similar legislation elsewhere that provides antidiscrimination protection for transgender individuals. In upstate New York one transgender social-educational organization is developing a health collective of physicians, psychologists and other care providers interested in making support accessible for transgender individuals.

One of the singular difficulties faced by these endeavors and by transgender individuals nationwide is the hesitancy with which medical, psychological, and mental health providers approach transgender issues. Their hesitancy is due for the most part to a lack of resources that would demystify the support process. The Guidelines address those needs; they constitute a resource that begins by answering basic questions and continues by covering issues not addressed in current literature. *Transgender Care* is the first resource of its kind, and it addresses some very current issues; thus, it should not be misconstrued as the “final word” regarding transgender support, but, rather, as a catalyst encouraging further inquiry, growth, and change by consumers and care providers alike.

Several members of the Review Committee raised the question as to what transgender individuals need psychotherapy support services or guidelines at all when in fact most transgender individuals are emotionally balanced and mature enough to make responsible decisions. We hope that this resource, reflects that very sentiment while concurrently promoting recommendations for the provision of necessary consumer education and safeguards, as well as for dialogue between care providers and consumers. Recognized guidelines are necessary, and not solely for consumer protection. Both care providers and insurance companies need recognized guidelines in order to establish standards for professional services and insurance coverage. This is particularly true in the case of care providers who are unfamiliar with transgender needs. The Guidelines should prove a useful resource as care providers and consumers maintain dialogue regarding services and their insurance coverage. However, as practicing Gender Specialists we believe that, with the exception that they may require medical intervention to bring their body in line with self-image, transgender consumers are in fact not unlike their nongr transgender counterparts: Most individuals are emotionally bal-

anced and mature, and so they can easily do without unnecessary mental health and medical interference. Some, however, may need to utilize professional services in order to gain the tools to improve their quality of life.

The Review Committee that helped develop the Guidelines is as unique as the resource itself. This independent body is composed of a balanced selection of specializing care providers and knowledgeable transgender consumers, many of whom are both. Each brought to this project invaluable insights based on his or her academic, clinical, social, and life experiences. Review Committee participants and several guest authors were offered an opportunity to contribute by submitting essays, which can be found in Part II. The inclusion of an essay does not constitute an endorsement of the particular psychotherapeutic, surgical, or theoretical model expressed by the writer of that essay. A list of resources can also be found in the Appendix. Biographical information on, each contributing participant is provided in a concluding section.

## **The Vocabulary and the Issues**

This important reference section will help the reader understand the terminology and concepts that are essential to a discussion of the support of transgender individuals and their special needs, and to an understanding of the Guidelines themselves. Some of the terminology presented reflects the stability of what might be considered common knowledge, and thus is an excellent starting point for newcomers to this specialty field. Other terms reflect the evolutionary process language undergoes as it responds to various growth processes, in this case, that of the development of fuller understanding of transgender individuals, of their needs, and of this specialty field. Some terms introduce new concepts; one example is *Gender Specialist*, a term designating those who have long labored in this specialty field without recognition.

The terminology used throughout the text has been chosen to reflect the transgender individual's right of self-identification as well as the need to promote better education of consumers and improved consumer-professional interaction.

### ***Gender Identity***

*Gender identity* refers to an individual's innate sense of maleness (masculinity) or femaleness (femininity), or both, as well as to how those feelings and needs are internalized and how they are presented to others. Rather than being fixed opposites, masculinity and femininity may graduate markedly, depending on individual and social interpretation. Biological sex is established by a medical assessment of genitalia in utero or at birth; subsequently, individuals are typically reared in their biological sex, with little additional thought given to an individual's psychological and behavioral self-identification. Many transgender individuals re-

port having experienced conflict over such gender assignment throughout childhood and puberty, and it is not unknown for conflict to arise later in life.

### ***Gender Pronouns—He, She or . . . ?***

“How do I refer to *this* individual?” is typically the first question nontransgender professionals and other interested people ask. Following the premise that transgender individuals (like their nontransgender counterparts) have the human right to individually explore and determine self-identification, one should refer to transgender individuals on the basis their current presentation or their specified pronoun preference. If unsure, ask!

### ***MTF and FTM***

*MTF* and *FTM* are acronyms that refer, respectively, to “male-to-female” and “female-to-male” transitions. These designations identify which direction of transition or which established identity a transgender individual has chosen. Thus, a biologically determined male who self-identifies as female would be known as an MTF transsexual, crossdresser, or transgenderist. The acronym FTM is seen more often in print because MTF issues have largely dominated professional and transgender consumer resources, with the result that readers frequently assume that materials referring to transgender individuals or concerns refer to MTF individuals or concerns, when not otherwise specified.

### ***Sexual Orientation***

The term *sexual orientation* refers to the gender(s) of persons to whom an individual is sexually attracted. This could be the same or the opposite gender, or both. There are also transgender men and women who are attracted to other transgender persons, as well as those who are asexual or not attracted to anyone. Detailed information on how to refer to a transgender individual’s sexual orientation is provided in the sexual orientation section of Chapter 2.

### ***Gender Dysphoria***

*Gender dysphoria* is a discomfort characterized by a feeling of incongruity with the physical gender assigned to one at birth. Frequently misunderstood by the individual, these feelings can remain suppressed and hidden from others. Unhealthy coping mechanisms include self-abuse, addictions, relationship difficulties, and suicidality, and they may mask gender dysphoria, making it difficult for care providers to detect. When conflict with one’s gender identity is triggered (such as by a life change or personal crisis), the discomfort for many persons may reach crisis proportions. Gender dysphoria may be experienced by genetic males or females of any cultural, ethnic, or socioeconomic background.



The term *gender dysphoria* is often misapplied to individuals with self-actualized and stable transgender identities. It is most applicable to individuals who are in the beginning stages of transition and who yet may be unaware that they have a transgender identity. Once an individual has self-identified transition goals or has established a self-defined transgender identity, she or he is no longer considered to be gender dysphoric.

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This self-actualization process or exploration of gender (and of sexual and self-identification developmental pathways), though more sharply defined where pretransition transgender individuals are concerned with gender identity, is a natural, life-long developmental process that is experienced by all individuals of all genetic, cultural, ethnic, and socioeconomic backgrounds. These processes, including delayed gender-identity development, are not considered pathologic. Professionals wishing to classify an individual for medical or mental health treatment are encouraged to utilize a medical or mental health diagnosis appropriate to actual symptoms. (See the discussion of psychiatric diagnosis in Chapter 2.)

The key factors that help Gender Specialists determine whether an individual has successfully moved beyond gender dysphoria into self-identifying as a transgender individual are these:

- The ability to accurately describe in his or her own wording the difference between gender identity and sexual orientation, and how those constructs apply to his or her own experience.
- The ability to provide an easy-to-understand explanation of why he or she has self-identified as transgender.
- The ability to describe how his or her presentation fits in with a perceived sense of gender identity and self-defined goals.
- The ability to stay consistently within one's chosen presentation.

For more detail, see the Gender Identity Profile in Chapter 9.

### ***Transgender Identity***

*Transgender identity* is a term used to describe a number of groups of people: transvestites, transgenderists, those with androgynous presentations, or the inter-sexed. Any such individual may self-identify or be described as being transgender or having a transgender identity. A person may self-identify and be referred to as a “transgender individual” or having a “transgender identity” even if he or she has not yet found permanent roots within a specific transgender subpopulation. Once someone is self-identified as a transgender individual, it is inappropriate to refer to her or him as gender dysphoric. Although the individual is experiencing

gender-identity concerns, has subsequently self-identified as transgender, and thus may no longer be considered gender dysphoric, there does exist the likelihood that he or she may still encounter some feelings of discomfort over gender-identity issues as he or she further explores his or her needs and moves toward self-identification with a particular subpopulation.

The term *transgender* has quickly become the word of choice for both professionals and consumers when referring to individuals or the community as a whole. Bringing individuals together under a common label is not without consequences. Potentially this may encourage people to overlook the unique traits and needs that distinguish various subpopulations. Additionally, some individuals abhor the thought of being associated with other subpopulations under a transgender label. They may feel that such an inclusion may be misperceived as pathologizing by others, or they may think inclusion inapplicable as a result of personal ideology.

The Guidelines advise that no agency, organization, or professional discriminate against any transgender individual or deny her or him services on the basis of ethnicity, sexual orientation, marital status, or social status. Transgender individuals exist in all ethnicities and social classes. The transgender population embraces a host of sub populations affirming various gender and sexual identities; these include those who identify as lesbian women or gay men, as well as bisexual and heterosexual individuals.

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### ***Crossgender, Crossliving, and Crossdressing***

The *cross-* terms are grouped together for clarity. Each represents a transitional state within the framework of gender identification. To an extent, these terms help to perpetuate the misconception that gender is strictly a polar or binary state. Therefore, their usage, when referring to individuals who have permanently self-identified as living in role, may be inappropriate.

*Crossgender* is a self-identification commonly associated with transgenderist individuals (see the section below on transgender populations), bi-gendered individuals, and, to a lesser extent, other transgender populations such as transsexual individuals.

The terms *crossliving* and *living in role* are not exactly synonymous. The term *crossliving* is more appropriately used to refer to transgenderist individuals who maintain strong associations with both masculine and feminine presentations. Occasionally, *crossliving* is used to describe transsexuals early in their transition processes. Once an individual has strong associations with and self-identification as a transgender woman (MTF) or transgender man (FTM), then *living*

*in role* more accurately describes her or his self-identification, actions, and processes.

*Crossdressing* is most appropriately assigned to crossdressers and transgenderists. After permanently self-identifying as a transgender man (FTM) or woman (MTF), transsexuals rarely self-identify with or describe themselves as crossdressing. To describe a permanently self-identified transgender man or woman's activities as "crossdressing" may be perceived as misinformed, inaccurate, and condescending.

### ***Real-Life Test***

*Real-life test* is a primary assessment term used to describe the period from the time a transsexual individual begins living in role to the time when he or she has been doing so long enough to be considered an appropriate candidate for aesthetic or Genital Reassignment Surgery. Primarily, the real-life test is thought to apply to Genital Reassignment Surgery; however, it also has been applied to breast procedures and hormone administration. Regrettably, we believe that the disparate uses of the term *real-life test* have confused professionals and consumers, undermining professional support services utilized by transgender individuals.

Regardless of the standards by which a real-life test protocol is defined, we believe that care providers and transgender individuals place far too much emphasis on the amount of time one must spend living in role prior to receiving recommendations for surgery. As a consequence, individuals often believe that all they have to do is conform to a stereotypical label, and, after a set period of time, they will receive the sought-after procedure. Furthermore, many feel that they will be punished or denied the procedure if they do not conform exactly to a real-life test as established by a care provider or program protocol. Because standards and protocols are typically written to protect care providers against malpractice suits as well as protect consumers from making harmful choices, rarely is emphasis placed on the individual's need to explore and define gender presentation, gender identity, or sexual-orientation issues. Consequently, many spend far too much time conforming to gender stereotypes to fulfill a real-life test requirement, and far too little time defining a place in society for themselves. Although this situation has little impact on the efficacy of hormones and surgical procedures, it does mean that even far beyond Genital Reassignment Surgery some individuals will be facing exacerbated self-identification, presentation, and social-role issues that have affected them from the onset of gender-identity issues.

It is generally understood that the real-life test is considered a primary assessment tool. What is not readily recognized, however, is that the definition of what constitutes a real-life test may vary widely, depending on location, since each care provider or gender-identity clinic typically establishes its own hormone

and surgical protocols. This fact frequently goes unrecognized by transgender consumers. Particularly vulnerable are those who feel such an overwhelming sense of gratitude and relief to at long last find a care provider sensitive to their needs that they will do just about anything to fulfill a care provider's real-life test protocol in order to reach their hormonal and surgical objectives.

Some care providers may strictly adhere to the HBGDA Standards of Care; others have membership in this organization yet establish their own protocol, some university programs create protocols to facilitate research endeavors. Many of these unofficial standards and protocols are arbitrary and may discriminate against those who do not meet their requirements. This has been particularly true in the case of transgenderist individuals, who frequently seek hormone administration, aesthetic procedures, or gonad removal (castration), yet are not interested in Genital Reassignment Surgery, which is the end objective of many protocols. There are also other protocols that link hormone administration and aesthetic surgery (primarily, breast procedures) to a real-life test or to a desire for Genital Reassignment Surgery; these in some circumstances sabotage an individual's chances of successfully completing a real-life test.

Some (although clearly not all) individuals may have physical attributes so incongruent with their developing or establishing gender identity that a real-life test may be physically impossible. Such test attempts by individuals whose physical characteristics are markedly inconsistent with presentation are frequently met with ridicule, derision, and even physical violence. Minimally androgenizing hormones and surgical procedures should be available for the transgender individual intending to live in role part time. Those with an established goal of living in role on a full-time basis may be initially provided androgenizing hormones and minor, aesthetic surgical procedures, which later can be advanced into masculinizing or feminizing procedures, depending on the presentation desired.

There are those who call for the abolishment of real-life tests and appropriate protocols. Such is the case with what is generally called "hormones-on-demand" or "surgery-on-demand." To date, no known competent care provider has voiced support for this concept. Invariably linked with this concept, however, are several principles that should not be overlooked. Many transgender individuals and practicing Gender Specialists alike recognize that care providers are advised not to unnecessarily interfere in the lives of transgender people or set protocols that do not allow such individuals the same right of self-determination of gender identity routinely extended to nontransgender individuals. Nor should professionals erect unrealistic protocols as barriers to further treatment. Protocols that fall short of these essential principles amount to nothing more than discrimination and an abuse of consumer trust.

Most real-life tests are designed to achieve the following goals:

- Prevent inappropriate or unprepared individuals from undergoing hormone administration or surgical procedures.

- Provide surgeons, professionals, and insurance companies with protection against negative outcomes in malpractice suits initiated by dissatisfied or regretful postsurgical patients.
- Protect nontranssexual and unprepared individuals from undergoing hormone administration or surgical procedures and incurring physical, psychological, or social damage.

The Guidelines do not endorse the abolishment of the real-life test for transgender individuals seeking hormone administration or surgical procedures. Instead, the Guidelines present recommendations for hormone administration and aesthetic or Genital Reassignment Surgery that adhere as closely as possible to the principle of self-determination for all transgender individuals, while preserving real-life assessment functions that are recognized and usable by professionals, surgeons, and insurance providers.

### ***Gender Specialist***

The *Gender Specialist* may be a professional, paraprofessional, or peer-support care provider. The Gender Specialist is an active practitioner in psychotherapy, counseling, or education directly oriented toward gender-identity issues. It is recommended that care providers interested in establishing themselves as Gender Specialists undergo a minimum of two years of direct supervision or consultation with a practicing Senior Gender Specialist who is recognized as having advanced experience in providing consultation to peer practitioners.

### ***Senior Gender Specialist***

The *Senior Gender Specialist* is a care provider who has actively practiced as a Gender Specialist for five years. Senior Gender Specialists are deemed appropriate to provide assessment and evaluation letters, as recommended for Genital Reassignment Surgery. At their discretion, Senior Gender Specialists may also provide training, supervision, or consultation to Gender Specialists.

Care providers who hold advanced degrees in psychology, medicine, sexology, clinical social work, or other medical or mental health fields may become Senior Gender Specialists following two years of active practice while receiving consultation in a role as a Gender Specialist. Those holding advanced degrees in sexology may have completed coursework that included training in gender-identity issues and therefore already possess skills necessary for supporting transgender clients.

### ***Principles of Gender-Specialty Practice***

Providing support to transgender clients requires a specialized body of knowledge that extends beyond the traditional training offered to psychotherapists, psychiatrists, and other mental health professionals. In recognition of this and of

consumers' interests, the Guidelines endorse care providers who have committed themselves to seeking gender-specialized education, supervision, and peer consultation.

Curriculum for Gender Specialists should include:

- Familiarity with suicide and crisis intervention.
- A basic ability to recognize mental health disorders requiring appropriate referral.
- An ability to promote consumer awareness of critical gender-oriented consumer needs.
- Appropriate intervention and educational skills relating to “safer sex” and sexually transmitted disease.
- An understanding of basic gender- and sexual-identity concerns.

Familiarity with these subjects may, in most circumstances, be gained through recognized coursework and certification programs in an academic setting.

Mainstream care provider organizations and regulatory agencies at the present do not recognize transgender consumer needs and issues, or Gender Specialists. Care providers who self-identity as Gender Specialists are therefore encouraged to maintain formal membership or affiliation with recognized specialty provider organizations familiar with gender-oriented medical, psychotherapy, and consumer education. Examples would include the American Educational Gender Information Service (AEGIS), the Harry Benjamin International Gender Dysphoria Association (HBIIGDA), and the International Foundation for Gender Education (IFGE). These organizations serve a critical professional need in providing up-to-date information on gender issues to which Gender Specialists typically would not have access via traditional professional channels.

We urge Gender Specialists to be aware that many transgender men and women are unable to afford basic medical and mental health services. Furthermore, a disproportionately high number of these individuals are people of color, HIV-positive, or transgender youth who are also socially or medically underserved. Public mental health services are encouraged to recognize this problem. Bearing in mind that profiteering is unethical, Gender Specialists should consider providing services on a sliding scale or without charge to selected individuals. Optimally, practitioners undergoing the process of supervision might volunteer a portion of their time to assist those with legitimate need.

Gender Specialists are encouraged to maintain letters of recommendation and collaboration from their Gender Specialist supervisors, consultants, and peers, as well as up-to-date state licenses, evidence of continuing educational credits, and complete, accurate resumes. Consumers are advised to inquire about and check the references of care providers specializing in gender issues. Because licensure in a traditional health field is not enough to guarantee proficiency in gender issues, consumers are encouraged to inquire about a care provider's standing by contacting a local support organization—AEGIS, HBIIGDA, or IFGE.

## Transgender Populations

Care providers, in their endeavor to support transgender individuals and consumers in their self-identification goals, should understand the various types of transgender individuals and their specialized needs. Care providers and consumers are advised that usage of labels is inherently risky, particularly because no single reference can include all the needs of each individual. Identification as a transgender individual or as belonging in any one transgender subpopulation remains the responsibility solely of the person exploring his or her own gender-identity issues. Moreover, hasty self-definition carries heavy risks: no one should rush into surgery or other irreversible life changes without significant reflection upon the consequences, particularly since individuals often do not fall entirely into one category or another, but, rather, into a number of categories.

*Irresponsible usage of labels may result in the following situations:*

- Care providers who stop listening once they decide an individual falls within a subpopulation.
- Encouragement of an individual to conform to models that are inconsistent with that individual's needs or self-identity.
- Individuals who feel they may want or are ready for hormones or surgery, and aggressively pursue such, when in actuality they are only experiencing a few coming-out highs in relation to a new self-discovery of gender identification.
- Transgenderist or transsexual individuals who feel pressured to conform to stereotypes in order to please friends, partners, or care providers and thus receive support, hormones, or surgery that may not be right for them.

## Transsexuals

*Transsexuals* are individuals who feel an overwhelming desire to permanently fulfill their lives as members of the opposite gender. For such persons, an interest in crossliving, sex hormones, and Genital Reassignment Surgery is most often paramount. Transsexuals commonly experience the most acute effects of gender dysphoria. This phenomenon generally commences during early childhood and remains throughout an adult's lifetime. If suppressed, gender-identity issues may be brought to the surface during intense periods of change or personal crisis.

Support initially includes assessing and addressing gender dysphoria and parallel issues. At this time, the counseling focus should be on ruling out underlying personality or psychotic disorders. Ongoing counseling includes exploring and restructuring internal coping mechanisms and references to self-identity. Transition itself is a lengthy and difficult process, requiring in-depth exploration of support, relationship, employment, and other survival issues. Following the Guidelines includes educating, assessing, and referring individuals for hormone, cosmetic, and surgical options.

### ***Transvestites or Crossdressers***

*Transvestites or crossdressers* are individuals who dress in clothing of the opposite gender for emotional satisfaction or erotic pleasure, or both. Transvestites wishing to permanently retain their biological sex express little or no desire for hormones or Genital Reassignment Surgery. Frequently, a recurring desire to crossdress provides an outlet for the individual to explore feelings and behaviors associated with the opposite gender. At times, a sexual fetish may be emphasized or an individual may wish to completely crossdress and discreetly pass as a member of the opposite gender for a limited time. These individuals are generally heterosexual, less frequently bisexual, gay, or lesbian. Traditionally, the majority of these individuals prefer to be known and referred to as *crossdressers* rather than *transvestites*, which is the more clinical term.

Supportive counseling provides the individual an opportunity to move beyond denial and to explore safe options for integrating and supporting crossdressing needs. Addressing social hostility and gender stereotypes helps reduce fears about being found out and thus jeopardizing relationships, employment, or social status. Building communication and relationship skills helps crossdressers introduce their needs to family and friends or attend “safe” private social activities, thus reducing isolation.

### ***Transgenderists***

*Transgenderists* are individuals who live in role part or full time as a member of the opposite gender. Sometimes their transgender identity is carried into the workplace; more often it is not. Emotionally, these persons need to maintain certain aspects relating to both their masculinity and femininity. Understanding this process can be difficult, particularly in situations where an individual’s gender identity constantly fluctuates or where he or she is unaware that the transgenderist identity exists. Transgenderists are frequently interested in hormones and occasionally in cosmetic surgery and castration, but not Genital Reassignment Surgery. Because professional literature regarding transgenderists is sparse, the vast majority of these persons are unrecognized by care providers and have difficulty obtaining services or validation. Occasionally transgenderist individuals may self-identify with the label *bi-gender*. (See the Special Advisory, below.)

### ***Androgynes***

*Androgynes* or those with androgynous presentations, contrast with transgenderists by adopting characteristics of both genders or neither. Examples of individuals who self-identify as androgynes include those who present bi-gender mannerisms, those who intentionally wear androgynous or gender-neutral clothing, and those who do not wish to be identified as either male or female. An individual who self-identifies as an androgyne may wish to be identified as both male and female. Some individuals may self-identify as androgynes to fulfill identity



needs; others may do so to challenge social stereotypes. (See Special Advisory, below.)

### ***Special Advisory on Transgenderists and Androgynes***

Neither transgenderist nor androgyne individuals should be required to conform to transvestite, transsexual, or other stereotypes or support models. In the past, such ill-suited advice was erroneously encouraged by misinformed professionals and consumers. For some, the end result was a misdirected focus on Genital Reassignment Surgery rather than integrating their actual gender-identity needs. Support for these individuals provides an opportunity to define their place within the gender spectrum, reduce isolation, and focus on options correlating with their unique needs.

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### ***Intersex or Hermaphrodite Individuals***

*Intersex or hermaphrodite individuals* are those with medically established physical or hormonal attributes of both the male and female gender. Some, but not all, of these individuals self-identify as transgender. Though these conditions are relatively rare, they are well documented in the literature of general medicine and endocrinology. Gender Specialists may encounter these individuals and are advised to be familiar with their support needs.

Examples of intersex or hermaphrodite conditions include androgen insensitivity syndrome and congenital adrenal hyperplasia. When these conditions are detectable at birth, these individuals are almost always assigned a gender on the basis solely of physical appearance. Occasionally, these conditions do not appear until puberty or shortly thereafter. The practice of assigning gender in utero or at birth has been successful in some cases but questionable in others. Those cases that are successful do not draw much attention; however, unsuccessful cases may result in sex reassignment during puberty or later on in life. Tragically, some individuals are never able to find a sense of gender congruency after having been surgically altered without appropriate presurgical counseling or informed consent. This is particularly true in situations where parents made final surgical decisions without the child's understanding the full consequences of such procedures.

It is common for pubertal and adult medical treatment to include psychological referral for the individual and family. Physicians are advised to refer such cases to care providers familiar with these individuals' special needs and a full understanding of the various medical interventions available. Improper counsel-

ing or lack of informed consent regarding juveniles can result in serious long-term consequences. Individuals who are unable to adjust in an assigned-gender role are often mistakenly classified by physicians as having a severe psychiatric disorder and thus unnecessarily victimized. Intersex or hermaphrodite individuals in particular should have the opportunity to self-determine gender identity.

We advise that postnatal and pre- and postpubertal intersex or hermaphrodite conditions not be determined by physical appearance alone, but include parental counseling and informed consent, hormonal and genetic evaluation, regular prepubertal medical follow-up, youth-oriented counseling, and informed consent of the young person. Intersex or hermaphrodite youth should not be subjected to testing or research beyond what is required for medical intervention, particularly since children cannot speak for themselves but must rely on a parent's informed consent. Gender Specialists are advised that ongoing support for these individuals may include (but is not limited to) concerns regarding exploitation and medical victimization; gender, sex, and self-identity development; isolation; and other transgender-related concerns. Individuals whose intersex or hermaphrodite condition is caused by congenital adrenal hyperplasia may have other birth defects, as well.

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Intersex or hermaphrodite youth should not be subjected to testing or research beyond what is required for medical intervention, particularly since children cannot speak for themselves but must rely on a parent's informed consent.

### ***Drag Queens, Kings, and Performance Artists***

*Drag queens, kings, and performance artists* are individuals who crossdress for entertainment, for sex-industry purposes, to challenge social stereotypes, or for personal satisfaction. These persons are stereotypically associated with gay and lesbian society. However, it should be noted that a small proportion of gays as well as lesbians identify as gay male or lesbian crossdressers and, as such, have needs paralleling the heterosexual crossdresser. These issues would include social support and problems with victimization, relationships, and identity integration.

### ***Transgender Youth***

Typically, transgender youth are persons under age twenty-one who self-identify as transgender or who have questions about their own gender identity. These young persons frequently need specialized professional and community resources services, and protection. The Guidelines emphasize the fact that, as a result of family and social abandonment, many of these young people encounter victimization through homelessness, drug use, and prostitution. Transgender youth are a hidden and underserved population. More information about youth issues and the Guidelines for their care can be found in Chapter 8.

### ***Medically Compromised Individuals***

The Guidelines advise that medically compromised persons, including HIV-positive individuals, not be discriminated against or discouraged from seeking or denied equal access to medical and psychological support services on the basis of their medical status. Prior to the adoption in 1990 of the Americans with Disabilities Act, federal, state, and private institutions and practitioners routinely denied basic gender-oriented support services to these individuals. Assessment of each person's quality of life, his or her medical and psychological history, and his or her self-identity as a transgender individual should all be factored into service-provider decisions. A special focus on transgender HIV and AIDS issues can be found in Chapter 6.

Diabetes, prostate disease, high blood pressure, epilepsy, aging, alcoholism, and substance abuse are additional issues that may affect transgender individuals' lives as well as their access to support services. Future editions of *Transgender Care* will provide further information on these concerns, as it becomes available through professional and consumer channels.

### ***Professionally and Scientifically Victimized Individuals***

*Transgender Care* promotes awareness that transgender individuals have been victimized in the past and remain at risk of victimization by government and private academic and scientific institutions, gender programs, psychoanalysts and other therapists, behavioral scientists, and other professional persons and organizations. Without informed consent or advisement that realistic and psychologically healthy options do exist to fulfill transgender needs, transgender individuals have been inhumanely subjected to research methods using intimidation, electroconvulsive therapy (ECT or "electric shock"), sensory deprivation, psychoactive medications, and other noxious treatments. In the past, these studies, conducted under a faulty psychopathologic framework, were often used in an attempt to "cure" transgender-oriented behaviors. Gender Specialists now recognize that a transgender identity is a primary element of the transgender individual's self-identity and psychological make-up.

Academic or scientific research should be viewed as being without merit by professional and transgender communities if the individuals studied were solicited without full informed consent, under nonadvisement of other treatment-oriented alternatives, or under the use of coercion, sensory deprivation, psychoactive or other pharmacological medications, or behavioral-aversion techniques. It is recommended that professionals proposing to do research on transgender individuals do so within the framework of a review process that includes professional peers and transgender consumers.

It is recommended that all consumers inquire into the background of and request references for any organization or professional claiming to have developed successful "cures" or "treatments" for transgender behaviors or identity. Parents, of youth should be particularly wary of detrimental approaches by pro-

professionals and verify that they are placing their child under the care of a recognized transgender program or Gender Specialist.

*Transgender Care* is intended to promote awareness that even at present there remain transgender individuals who have been victimized by these processes. Professionals and transgender communities need to address these issues and create a forum where victimized individuals' needs and grievances can be addressed.

### ***Institutionalized and Incarcerated Individuals***

One subpopulation of transgender individuals consists of those who are incarcerated in correctional facilities or are receiving long-term inpatient care at a hospital or mental-health facility. The Guidelines recognize the special needs of institutionalized individuals facing gender-related issues and advises that no facility should discriminate against them or deny them access to any service or care that is available to others.

*Transgender Care* also advises that government or private institutions and correctional facility administrations protect transgender individuals from others in the institutional population to prevent victimization (rape, beatings, and so forth) as a result of their gender-identity issues. Failure to protect these individuals may result in suicide or homicide. Victimization of transgender persons is also known to be carried out by institutional staff or encouraged by staff in nontransgender populations. Institutions are advised to provide inservice training of staff to prevent these situations.

The Guidelines advise that government or private institutions and correctional facilities provide hormone treatment to transgender individuals, as outlined in Chapter 3. Failure to provide hormones has been linked to an increased risk of self-mutilation (auto-castration), heightened clinical depression, behavioral difficulties, illegal drug use, and suicide attempts. These circumstances may place institutions and correctional facilities at liability, depending on state, provincial or federal laws. Hormone administration, in addition to support groups or psychotherapy or both, where needed, can dramatically reduce the potential risks that accompany gender-conflicted conditions or that occur in response to preestablished transgender identities, as might be the case for individuals who previously received hormones outside the institutional or correctional facility. The symptoms and behaviors accompanying both gender dysphoria and hormone withdrawal in previously established transgender individuals are frequently misperceived as manipulative gestures on their part. In fact, malingering and misrepresentation by transgender individuals are rare.

### ***Socioeconomically Disadvantaged Individuals***

*Transgender Care* is intended to promote recognition among care providers that social and economic marginalization frequently accompanies the transgender experience. Family, social, and community rejection, in addition to reduced educational and employment opportunities create an environment in which trans-

gender individuals are commonly subjected to discrimination, homelessness, unemployment, and poverty. Medical, mental health, and social services commonly fail to recognize or address the needs of transgender individuals.

*Transgender Care* notes that owing to socioeconomic hardship, many transgender individuals, particularly those within minority subpopulations, are targeted as desperate victims by unscrupulous care providers who offer hormones, silicone injections, aesthetic and gender-reassignment surgeries or other services without informed consent, appropriate medical administration, or follow-up. At times, individuals are coerced into trading sex for services. These practices are detrimental to both ethically practicing professionals and transgender individuals alike, and sometimes such practices lead to the death of the latter. Professionals and consumers should be wary of any individual posing as a Gender Specialist yet having no references or affiliation with appropriate gender-specializing organizations.

*Transgender Care* notes that transgender individuals, particularly those going through transition processes, experience severe emotional, physical, and financial burdens. Legitimate Gender Specialists, care providers, and support organizations know that it is unethical to charge transgender individuals for research services, to charge them for treatment that cannot benefit the individual, or to charge fees in excess of those normally charged to nontransgender persons for similar services.

Scientific, medical, and mental health professionals are strongly discouraged from portraying transgender individuals or transgender-associated experiences, feelings, or thoughts as pathologically diseased, mentally ill, deviant, or in any other manner that exacerbates marginalization of the transgender individual within social, medical, and mental health infrastructures. Information on up-to-date charting and insurance-claim processing using nonpathologic models may be found in the Psychiatric Diagnosis section of Chapter 2. Professionals and gender-specializing organizations are encouraged to adopt uniform language that is not deprecating to transgender men and women.