The AEGIS Transition Series

Discovering who you are

A guide to self-assessment for persons with gender dysphoria

AEGIS

P.O. Box 33724

Decatur, GA 30033

Phone (404) 939-0244 (evenings)

AEGIS
American
Educational
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Service

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NOTICE

AEGIS and the author of this booklet do not see a problem with individuals trying to learn about and label themselves. Such self-assessment, however, is not a substitute for evaluation and diagnosis by a psychiatrist or psychologist or other qualified professional.

This booklet is published as a public service. AEGIS and the author are in no way responsible for any decisions made or actions taken by any individual. If you are troubled about your gender, we urge you to seek help from a counselor or psychologist with special training and expertise in gender and human sexuality.

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INTRODUCTION

This booklet is written for those who want to know more about the expression of gender, and especially for those who have questions about their own gender. The casual reader will be left with an appreciation of the distinction between sex and gender and an understanding of the multitude of ways in which individuals can express their gender and their sexuality. Those who are troubled about their gender will be able to explore their feelings and come to a better understanding of themselves.

If you are unfamiliar with the terminology, you might want to start by referring to the glossary, which can be found towards the back of this publication.

We at AEGIS believe that one's gender is a matter of informed personal choice. This series of booklets is designed to provide information which will help you to make competent and rational decisions about your gender.

PART I
A PRIMER OF SEX AND GENDER

Historically in Western society, sex and gender have been considered to be one and the same. It seemed only common sense that males were boys, and then men, and females were girls, and then women. A quick visual inspection of the infant at birth resulted in a lifelong assignment—and sometimes a lifelong misassignment—of sex based on the superficial aspects of the external genitalia. Children with ambiguous genitalia were often assigned by whim.

It was not until the 1950's that a distinction was made between sex and gender. John Money, a psychologist at The Johns Hopkins University, and his colleagues, in studying those with intersexual abnormalities (hermaphroditism), came to understand that sex does not have a single determinant, but many (see Money, 1985a, 1985b).

In studying the psychological characteristics of intersexed people, Money realized that gender—the individual's sense of being a man or a woman, a boy or a girl—was in most instances independent of sexual characteristics. Regardless of physical attributes and genetic makeup, the intersexed people studied at Johns Hopkins strongly identified with the sex to which they had been assigned at birth. In their publications, the Hopkins group began to stress the difference between sex and gender.

Most Americans still do not understand that sex and gender are not synonymous, and furthermore tend to confuse gender with sexual preference. But the distinction has for some years been taught in textbooks on human sexuality, and has been repeatedly made on talk shows on daytime television. The idea of gender as a phenomenon separate from sex has become established in science and is being incorporated into our culture.

In 1955, it ... proved ... difficult for me to transplant the term, gender, from language science to sexual science and have its new usage accepted. Very rapidly, however, it became assimilated into both scientific and literary usage as a necessary supplement to the term, sex.

—Money, 1985a, p. 71.

Scientists, following Money's lead, now utilize a variety of criteria to determine sex. Those most commonly used are chromosomal sex, gonadal sex, internal genitalia, external genitalia, endocrine (hormonal) sex, and secondary sex characteristics. Sometimes social and psychological factors are included. Michael Ross' listing, below, is one of the most complete.

COMPONENTS OF SEXUAL IDENTITY

PSYCHOLOGICAL

- **Gender identity** (sense of being male or female)
- **Social sex role** (masculinity or femininity)
- **Public sex role** (living or dressing as male or female)
- **Sexual orientation** (homosexual, heterosexual, asexual)
- **Sex of rearing** (brought up as male or female)

BIOLOGICAL

- **Genetic** (presence or absence of Y chromosome)
- **Gonadal** (histological structure of ovary or testis)
- **Hormonal function** (circulating hormones, end-organ sensitivity)
- **Internal genital morphology** (presence or absence of male or female internal structures)
- **External genital morphology** (presence or absence of male or female external structures)
- **Secondary sexual characteristics** (body hair, breasts, fat distribution)

—Ross, 1986, p. 2.

Normally, all of the indicators of sex are in concordance—either male or female. It is only when one or more are at variance that the individual is considered to be physically or psychosocially intersexed.

BIOLOGICAL COMPONENTS OF SEXUAL IDENTITY

In every cell of their bodies, human beings have 23 pairs of chromosomes. Twenty-two pairs are called autosomes, and the 23rd pair is called the sex chromosomes. Individuals may have either two X chromosomes (XX, the female pattern) or an X and a Y (XY, the male pattern). The sex of the individual is determined at the moment of conception, according to whether the sperm which fertilizes the egg carries an X or Y chromosome. The egg always carries an X chromosome.

Chromosomal sex can be determined either by microscopic study (karyotype) or by checking for presence of markers such as sex chromatin.

The gonads are the hormone-producing organs, testes (in males) and ovaries (in females). The location, morphology, and histological structures of ovaries and testes are differ-

ent, as are the hormones which they produce. The gonads differentiate early in fetal life, before the genitalia.

The prenatal hormonal environment determines the development of both internal and external genitalia. The internal genitalia in females consist of the vagina, uterus and fallopian tubes. In males, the seminal vesicles, vas deferens, and ejaculatory ducts comprise the internal genitalia. The external genitalia of females consist of the clitoris and two sets of labia, or vaginal lips; males have a penis and scrotum.

At puberty, the gonadotrophins, or sex hormones, cause the development of the secondary sex characteristics.

PSYCHOSOCIAL COMPONENTS OF SEXUAL IDENTITY

Different theorists espouse different names and definitions for the psychological and social components of sexual identity.

GENDER IDENTITY

Gender Identity is one's sense of being a boy or a girl, a man or a woman. Kessler & McKenna (1978) have noted that as gender identity is a self-attribution, it is not measurable with psychological tests. The verbal statement of the individual is the best indicator of gender identity ("I am a man." "I am a woman.").

Gender identity usually coincides with the biological determinants of sex. Exceptions occur in people with intersexual conditions which result in ambiguous external genitalia, and in persons with cross-gender disorders such as transsexualism.

Gender identity develops within the first eighteen months to three years of life, and has been considered by many scientists to be immutable thereafter. There is evidence, however, that gender identity may not be as fixed as was once thought. In fact, sex reassignment late in life is frequently successful. For example, there is an endemic population of pseudohermaphroditic males in several small villages in the Dominican Republic. These males are born with ambiguous (but basically female) external genitalia which become virilized at puberty (Imperato-McGinley, et al., 1974, 1979; Peterson, et al., 1979). Before they became aware of the characteristics of those with the syndrome, the villagers had no way of knowing which "girls" would become "boys" at puberty and which would not, so these males were assigned as females and reared accordingly. Imperato-McGinley and her co-workers reported that all but two of their 24 postpubertal subjects were readily reassigned as males. This differs from reports from the United States, where involuntary reassignment, even in early childhood, has been considered likely to lead to significant psychopathology. Cultural factors probably play a role in this difference.

GENDER ROLE

Gender identity is the private experience of gender role, and gender role is the public manifestation of gender identity.

—Money & Ehrhardt, 1972, p. 146.

Gender role can be described as the things that one says and does to indicate that one is male or female. As noted by Money & Ehrhardt (1972), it is the public expression of gender identity. Gender role has a variety of components, including physical appearance, speech and gestures, pattern of dress, interests, and emotionality. Gender role is also called Sex Role and Gender Behavior.

As gender role is defined by cultural expectations for masculine or feminine behavior, it differs between societies, and changes across time in the same society.

OTHER TERMS

Sex Assignment occurs but once in an individual's life—at birth, when there is a public announcement that the baby is a boy or a girl. Sex assignment is generally determined by superficial examination of the newborn's genitalia by the delivering physician or midwife.

Money (1969) defined *Sex Reannouncement* as the decision to change the public announcement of the sex of assignment of intersexed persons. It is a reinterpretation of the biological sex characteristics of the individual, and occurs soon after birth.

Sex Reassignment occurs when an individual who has been functioning as a member of one sex begins to function as a member of the opposite sex. It differs from sex reannouncement in that the existing sex characteristics are not reinterpreted, but changed as much as is possible to resemble those of the other sex.

Person (1986) defined *Core Gender Identity* as one's sense of being a biological male or female (as distinct from gender identity, which is one's sense of being a boy or a girl, a man or a woman).

Money (1985a) has noted that gender identity and gender role are not independent, and argued for the use of the single term *Gender-Identity/Role* to encompass public and private perceptions of the individual's gender, but as the term does not appear in the *Diagnostic and Statistical Manual* of the American Psychiatric Association (*DSM III-R*), it will not be used in this booklet.

SEXUAL ORIENTATION

Sexual Orientation, Sexual Preference and Sexuality refer to the choice of object for sexual relations. Sexual orientation may be heterosexual, bisexual, homosexual, or asexual.

INTERSEXUALITY

Those who possess physical abnormalities of the chromosomes or genitalia are said to be hermaphroditic, or intersexed. The biological determinants of sex are discordant. For example, an individual with XY (male) chromosomal makeup may be born with female external genitalia. The psychosocial components of gender identity can be similarly discordant. That is, gender identity may be feminine, while the gender role is masculine. Sexual preference

may be for males or females, regardless of the sexual and gender characteristics of the individual.

PHYSICAL INTERSEXUALITY

There are a variety of known causes and known syndromes of physical intersexuality (cf Money, 1969; and Money & Ehrhardt, 1972). Chromosomal and other studies of the neonate can provide information useful in diagnosis, which sometimes allows prediction of important future events such as masculinization or feminization at puberty. An understanding of the causes of the abnormality and the probable future course of development are of importance in determining the sex to which the infant is assigned.

Intersexuality may occur because of gross chromosomal abnormalities. There may be one or more extra X or Y chromosomes. Genetic mosaicism may develop, with chromosome count varying from cell to cell, or there may be any of a variety of autosomal errors. Fetal insensitivity to androgen or low levels of androgens during critical developmental periods can lead to feminization of the chromosomal male, and presence of fetal androgens can lead to masculinization of the chromosomal female. Insensitivity to androgens is a genetic defect. Virilization of the female fetus may be caused by the introduction of exogenous substances such as progestin. Mechanical trauma during the perinatal period (for instance, traumatic amputation of the penis during circumcision), although rare, can lead to damaged or ambiguous genitalia in the male, with the same functional result as intersexuality—the necessity of carefully considering which sex to assign to the child (cf Money, 1975).

As intersexuality results in ambiguous genitalia, it is usually readily detectable at birth. When this occurs, careful consideration can be made as to the assignment of sex. Assignment is based on the structure of the external genitalia and prediction of future development, and not necessarily on the individual's genetic constitution. In cases where assignment as a male will result in inability to perform sexually, Money (1969) and others urge that the infant be assigned as a female. Sex assignment based solely on chromosomal makeup can lead to contrast between the sex of assignment and genital appearance and body type, with resulting difficulties for the individual throughout life. Money (1985b) cautions against such chromosomal reductionism.

Whenever possible, surgical correction in the direction of assignment is done during early childhood, so that the individual will grow up with external genitalia which are not at variance with the gender identity, which is almost always in agreement with the assigned sex. Undesired organs such as ovaries or testes are removed. Additional surgeries are sometimes done later in life. At puberty, hormonal therapy may be initiated to ensure the development of appropriate secondary sex characteristics. Parents are urged to treat the child as a normal boy or girl, for development of a hermaphroditic identity can result in gender role and gender identity confusion.

Some intersexual conditions are not apparent at birth, but may only be noticed at puberty, or later, long after gender identity, gender role, and sexual orientation are fixed. In such cases, surgical and hormonal corrections are made in the direction of the assigned sex, regardless of physical characteristics.

Most intersexed people strongly identify with the sex of assignment. Occasionally, however, an intersexed person requests sex reassignment. This usually occurs when external genitalia and body type are in marked contrast to their sex of assignment, or in cases where gender identity is ambiguous because of delayed assignment or ambivalence in rearing practices.

In general, the rigorous guidelines used for reassignment of transsexual people are not applied to those who are intersexed. Surgical and hormonal reassignment is often granted upon request, especially when the request is to be reassigned as a male.

Individuals with undiagnosed intersexual conditions, believing themselves to be transsexual, have occasionally presented for sex reassignment. Whether or not there is confusion of gender identity, those with abnormal genitalia or body characteristics in complete contrast to that expected, or who have slow or late pubertal development or who develop the secondary sex characteristics of the opposite sex should consider the possibility of intersexuality or hypogonadism. Males with incompletely fused scrotum, vaginal or other openings in the perineum, hypospadias (urinary opening in an abnormal place), empty scrotal sac (undescended or absent testicles), who bleed through the penis at puberty, or who have gynecomastia (breast development), and females who begin to masculinize at puberty or remain amenorrheic (do not have menses) should be thoroughly examined by a physician to rule out intersexuality.

PSYCHOSOCIAL INTERSEXUALITY

Gender dysphoria, or unhappiness with one's sex of assignment, can be considered a form of intersexuality. It occurs when one or more of the psychological or social components of sexual identity are at variance with the other psychosocial components or with the physical determinants of sex. Psychosocial intersexuality is much more common than physical intersexuality. It may take a variety of forms and may occur at any intensity.

Some individuals develop a gender identity opposite that of the sex of assignment. This may manifest itself early in life, appearing as early as two years of age, or it may appear in adulthood, arising from a background of crossdressing or effeminate homosexuality. As gender identity is independent of body type or appearance, the most masculine-looking man can have a feminine gender identity, and vice-versa. Persons with gender identities which differ from their sex of assignment are said to be gender dysphoric. In extreme case of gender dysphoria, transsexualism can result.

At birth, individuals are assigned to one of the sexes, and expected to

exist accordingly throughout their lives. Deviation from the norm can cause significant problems, for society dictates that men dress and behave in certain ways, and women and girls in others. Family, schools, the church, the government, employers, friends, and lovers have definite notions of appropriate behavior. Males are expected to conform to societal expectations of masculinity, and females to behave in the expected feminine manner. Variance may lead to social sanctions, ostracism, and punishment. Assumptions, perhaps erroneous, may be made about the individual's sexual orientation. Males who exhibit even a moderate amount of femininity may have to endure a great deal of psychological and physical abuse. Females have more latitude in dress and appearance, but that freedom is far from complete. Nevertheless, individuals with discordant gender identities sometimes exhibit behavior which is significantly different from that which is expected, even when their physical appearance is strongly sex-typed. Others may successfully hide their gender dysphoria by behaving in unremarkably masculine or feminine ways.

Abandonment of the assigned sex role in favor of the other, while not commonplace, does occur (this is what transsexual people do), but such a transition is extremely difficult, and in most cases impossible without physically modifying the body. In many other cultures, there are institutionalized social roles for persons who live the gender role of the opposite sex without significant physical modification of their bodies, but these types of social customs are lacking in Western societies.

SEXUAL ORIENTATION

Sexual orientation may be to males, or females, or to both, or to neither. Some individuals, especially primary transsexual people, lead asexual lives. Most people are heterosexual, or primarily so. Bisexual persons are attracted to both men and women.

Homosexual people are attracted to those of the same sex. Most gay men are happy to be men, and few gay women would want to become men. Only the choice of sexual object need be discordant. Some gay men are noticeably feminine, but most are not. Conversely, gay women may or may not be masculine in appearance or dress.

Many men and women with gender dysphoria fantasize themselves in sexual relationships with others of the same biological sex. Those who engage in homosexual practices usually insist upon taking the role commonly associated with the opposite sex. They do not consider these fantasies and behaviors homosexual, but heterosexual, for they believe themselves to be members of the opposite sex.

PART II
HETEROSEXUAL CROSSDRESSERS

Anyone who wears the clothing of the opposite sex can be said to be crossdressed. Those who crossdress include actors, female or male impersonators, partygoers, prostitutes, and criminals who use the clothing of the opposite sex as a disguise (the latter, sadly, are overly represented on network television).

Usually, however, crossdressers are considered to be individuals who have a persistent desire to wear the clothing of the opposite sex. No external reason need be present, although they are often quick to take advantage of social opportunities to crossdress. These people have historically been called transvestites, but most prefer to be called heterosexual crossdressers, because unlike *transvestite*, the word *crossdresser* has no erotic or pejorative connotations.

CHARACTERISTICS

Crossdressers are almost always male. Women have only rarely been known to crossdress for reasons of sexual satisfaction. Women frequently wear masculine clothing, but they almost always dress in a way which leaves no doubt as to their true sex. Crossdressers typically attempt to present themselves as women.

Crossdressers are usually unremarkably masculine in appearance and demeanor. Many marry, and many of those who are married have children. They are heavily represented in masculine or even hypermasculine occupations, and many enjoy high levels of income and prestige.

Although some crossdressers have had homosexual encounters, the majority are exclusively heterosexual. They have been noted, as a group, to have limited sexual experience. Some fantasize about being women who are made love to by men, but their male anatomies and gender roles stop them from acting on such fantasies. Many cross-

dressers find male homosexual behavior distasteful.

Crossdressers are strongly attracted to women and to femininity, probably more so than most other men. Some years ago, Virginia Prince (Prince & Bentler, 1972) suggested that the term *transvestite*, which is Latin for "crossdresser" be replaced by *femmiphile*, the Latin for "lover of the feminine." Her term has not achieved wide acceptance, but does seem to be accurately descriptive.

Crossdressers tend to take their marriages very seriously and may be less likely than other men to engage in adultery—this probably at least partially accounts for the finding that these mens' sexual experience is with a limited number of partners. Many keep their crossdressing from their wives for fear of destroying their marriages. Revealing themselves does often have a disastrous effect on their marriages. Thirty-six percent of the divorced respondents to Prince & Bentler's 1972 survey of 504 crossdressers indicated that their crossdressing had played a significant role in their marital troubles.

Many crossdressers fantasize about finding a woman who will tolerate their crossdressing, or ideally, help them to achieve a more viable feminine presentation. It is rare that a crossdresser finds such an understanding partner, but changing social attitudes about crossdressing and increasing involvement of wives and other partners in crossdressing organizations may make the revelation of crossdressing less distressing to the partner than it has been in past generations. Most women are significantly bothered by crossdressing in the men they love, however, and this is unlikely to change in the near future.

Crossdressing is more likely to be ego-dystonic and cause distress and adjustment difficulties in young men than in older men. A survey by Peggy Rudd in 1990 showed that the majority of crossdressers begin to come to terms with themselves in their thirties. By the time they reach mid-life, most have accepted their condition and are comfortable with it. This is borne out by the age distribution of those who are members of social organizations for crossdressers; there are few young crossdressers in such clubs.

Crossdressing often arises spontaneously at puberty, but many crossdressers remember dressing in women's clothing at an early age. The individual may wear selected garments, or he may dress entirely as a woman. Especially in the early stages, wearing women's clothing or imagining the wearing of women's clothing is sexually arousing to the crossdresser. He may or may not masturbate. He may fantasize about crossdressing when engaged in heterosexual intercourse, and may suffer diminished performance if not wearing some article of women's clothing. He may dress every day, or only infrequently, or he may merely fantasize about crossdressing. He may routinely wear articles of womens' clothing under his male attire.

Most crossdressers do not go out in women's attire, but some go unselfconsciously about in public. A

few become quite accomplished at presenting themselves as women. Some join support organizations such as The Society for the Second Self (Tri-Ess), and socialize with other crossdressers on a regular basis.

With increasing age, the erotic aspects of crossdressing tend to fade. The individual continues to crossdress because he feels an inner sense of comfort or femininity, or to reduce anxiety. He will be less likely to show fetishistic arousal, and will attempt to perfect his feminine image. With success as a father and husband, and success in his occupation, he may become more comfortable with his feminine side and less prone to feel that something is "wrong" with him.

Although they may fantasize about it from time to time, most crossdressers do not want to become women. Feminization of their bodies is generally limited to removal of excess body hair and perhaps piercing of ears, but the accomplished crossdresser may seek removal of his beard via electrolysis and softening of his body contours with female hormones, or even feminization via facial plastic surgery or breast augmentation surgery. When crossdressers reach this stage, they are likely to develop problems of psychosocial adjustment related to increasing gender dysphoria.

CAUSES

The virtual absence of abnormal patterns of sexual arousal (paraphilias) in women and the connection between crossdressing and male sexuality are strongly suggestive of sex-linked genetic involvement which is hormonally triggered. However, crossdressers are not physically or hormonally different from other men. Several decades ago, there was speculation that hypogonadism or chromosomal abnormalities were responsible for crossdressing and transsexualism, but there is no evidence that this is the case.

The interplay of biological and psychosocial factors is very subtle. The effects of genes on the organism have been likened to a puppet which is controlled with rubber bands rather than strings. For example, crossdressing and transsexualism have been shown to occasionally occur in men with XXY chromosomal makeup (Klinefelter's syndrome). Despite the gross difference in genetic material, most have unambiguous gender identities as men. Nevertheless, the occurrence at levels exceeding chance indicates that there is a biological component to gender dysphoria of these men.

There has been and continues to be a great deal of speculation that subtle hormonal imbalances during some critical phase of fetal development result in later crossdressing or transsexualism. This notion is simplistic, as it is based on animal models which are at best only marginally relevant to humans. Certainly, there has never been any concrete evidence for such fetal "imprinting." A more detailed discussion can be found in Part VI of this booklet.

There are a number of psychoanalytic theories about the etiology of

crossdressing. There is an absence of data to support them. Considering the strong affinity of crossdressers for the feminine, psychoanalytic conjectures that crossdressing is a defense against homosexuality are especially unlikely to be true.

In some instances, crossdressing may be related to adjustment difficulties, borderline personality disorder, or mental illness. Crossdressing which is ordinarily well-controlled may be exacerbated in times of stress or emotional disturbance, occurring with greater frequency after divorce, loss of employment, or the death of a loved one.

Crossdressing sometimes occurs along with other unusual sexual behavior during manic states in manic-depressive illness or in those with brain damage. Schizophrenics often have profound disturbances of body image, and may crossdress or wish to change their sex. When crossdressing is a secondary or transient phenomenon, it may disappear with treatment of the underlying cause. Crossdressers, however, are subject to develop mental disturbances just like anyone else. Improvement of mental condition of a crossdresser will leave the individual still a crossdresser.

A number of case reports have linked crossdressing to neurological abnormalities such as temporal lobe epilepsy. Damage to the temporal lobe of the brain is known to sometimes result in hypersexual behavior and sexual acting out both in nonhuman animals and in humans. It seems likely that generalized excitability secondary to temporal lobe damage increases the probability of acting upon crossdressing and other urges rather than causing them.

Walinder (1965) found evidence of EEG abnormalities or borderline abnormalities in 70% of a sample of 26 men who crossdressed (many of whom, however, may have been transsexual). Other researchers have also found EEG abnormalities in a higher percentage of gender dysphoric persons than might be expected. However, as Hoenig (1985) pointed out, only one study used a control group, and the EEG recordings were not read in a blind fashion (i.e., when the reader of the EEGs did not already know whether the person crossdressed).

There is some evidence that family dynamics may play a role in the etiology of crossdressing. Crossdressers are more likely than controls to report emotionally or physically absent fathers and strong or sympathetic mothers. Some crossdressers report "petticoat punishment" (having been unwillingly dressed in the clothing of the opposite sex when young), or even having been reared as girls, but such statements sometimes seem to be attempts to restructure history. Petticoat punishment does sometimes occur, but most crossdressers report normal childhoods.

TREATMENT

Crossdressing is a lifetime avocation. It is unlikely to go away on its own. Those for whom crossdressing

is ego-dystonic occasionally present to a psychologist or psychiatrist seeking help, and sometimes a man comes to the attention of the authorities because of his crossdressing behavior and he is requested or required to obtain treatment. Not surprisingly, studies of individuals who have sought professional help for their crossdressing have indicated significant additional psychopathology. The majority of men who crossdress do not come to the attention of the authorities, and are otherwise well-adjusted. Most find the activity highly enjoyable, and many report that they would not seek a cure if one were available.

Attempts to abolish crossdressing should be done only when the individual (and not the clinician) requests it, when it is extremely ego-dystonic, when crossdressing interferes significantly with the individual's life (for instance, by jeopardizing his marriage or his job), when it is demonstrably secondary to other psychopathology, or when crossdressing co-occurs with other paraphilias or is likely to endanger the crossdresser or others. It is essential that the informed consent of the crossdresser be obtained, and that there be prior peer and community review of aversive treatment plans. Aversive procedures should be avoided, as crossdressing is a harmless activity which does not warrant such intrusion on the individual. Psychosurgery should be avoided at all costs.

Counseling or psychotherapy can be of benefit, and is the treatment of choice for those with personal or life problems caused by crossdressing. Psychotherapy will not "cure" the crossdresser, but it can help him to come to terms with himself, and can aid him in his relationships with others. When his parents, wife, or children are disturbed by his crossdressing, family therapy can help to keep the family functional. Psychoanalysis is of doubtful utility.

Behavior therapy to eliminate crossdressing is time and labor intensive, and requires substantial commitments on the parts of both the crossdresser and the therapist. Nevertheless, there have been a number of reports of behavioral attempts to extinguish crossdressing behavior. Aversive procedures such as electric shock and the administration of nauseating substances such as apomorphine have been reported to be effective in the majority of cases, (cf Gelder & Marks, 1969), but nonaversive techniques are less intrusive and ethically less objectionable (and less dangerous!) and may prove to be equally effective in reducing the frequency of crossdressing and thoughts about crossdressing. Attempts to control crossdressing behavior in adults by nonaversive means are, unfortunately, conspicuously lacking in the literature. This is curious, since the behavior of feminine boys has been successfully modified without the use of aversive techniques (cf Green, 1974).

Anticonvulsant or antipsychotic medications have resulted in decrease of the urge to crossdress in individuals with temporal lobe epilepsy, and also in men without known brain damage. The use of lithium carbonate and other medications has been

shown in case studies to decrease crossdressing behavior in individuals who do not have demonstrated brain damage. However, controlled and double-blind studies of the effects of drugs on crossdressing have not been done, and in their absence, administration of medication cannot be considered a viable treatment in the absence of epilepsy or other demonstrable brain pathology.

Administration of counter-sex hormones (estrogens) and bilateral orchidectomy (castration) have been shown to successfully decrease crossdressing behavior. Both of these procedures reduce libido. As the urge to crossdress is tied to patterns of male arousal, reduction of the sexual urge may effectively curtail crossdressing in men who routinely experience sexual excitement when engaged in the activity. Those who crossdress for other reasons are likely to remain unaffected, and may even increase the frequency of their crossdressing.

Orchidectomy is irreversible and renders the individual permanently sterile. Libido is permanently lost unless androgens are administered, and androgens are likely to increase crossdressing behavior. Orchidectomy is counterindicated in all cases except diagnosed transsexualism.

Estrogens cause sterility and physical changes which are cumulative and progressively permanent. They pose a significant risk to health. Breast development and other feminization caused by estrogens may prove embarrassing to the individual. Low doses may allow continued sexual functioning with minimal feminization, but should be considered only in extreme cases, when crossdressing is ego-dystonic or the individual has transsexual feelings. Administration of antiandrogenic substances reduce libido without causing feminizing changes, and can be considered in place of estrogens.

PART III
THE DSM III-R AND CROSSDRESSING

The Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised of the American Psychiatric Association *(DSM III-R)* lists diagnostic criteria for all currently recognized mental disorders. In the United States, most psychologists and psychiatrists refer to the *DSM III-R* when making differential diagnosis. Sexual disorders and disorders of gender identity are diagnosable with the *DSM III-R*.

The term *crossdresser* encompasses the *DSM III-R* classifications for both Transvestic Fetishism and Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT). Crossdressers may meet *DSM III-R* criteria for either classification. During the course of his crossdressing career, as the individual begins to crossdress for reasons unrelated to sexual satisfaction, the diagnosis of Transvestic Fetishism may be supplanted by a diagnosis of GIDAANT.

TRANSVESTIC FETISHISM

The *DSM III-R* regards Transvestic Fetishism as a sexual disorder, and more specifically as a paraphilia, or sexual deviation.

The essential feature of disorders in this subclass (paraphilias) is recurrent sexual urges and sexually arousing fantasies generally involving either (1) nonhuman objects, (2), the suffering or humiliation of oneself or one's partner (not merely simulated), or (3) children or other nonconsenting persons.

***—DSM III-R*, p. 279.**

In addition to Transvestic Fetishism, the paraphilias include exhibitionism, fetishism, frotteurism (rubbing against unconsenting persons), pedophilia, sexual masochism, sexual sadism, and voyeurism.

Transvestic Fetishism sometimes co-exists with other paraphilias. Crossdressing fiction, for example, is

replete with images of sexual masochism, in particular domination by beautiful women, instances of forced crossdressing, and public humiliation.

It is unfortunate that Transvestic Fetishism is classified with pedophilia, frotteurism, voyeurism, and exhibitionism, which are activities which involve nonconsenting persons, and are illegal. Crossdressing is not illegal in most places, and does not involve others, except insofar as spouses and other family members may have to deal with the crossdresser.

DIAGNOSTIC CRITERIA FOR 302.30 TRANSVESTIC FETISHISM

A. Over a period of at least six months, in a heterosexual male, recurrent intense sexual urges and sexually arousing fantasies involving cross-dressing.
B. The person has acted on these urges, or is markedly distressed by them.
C. Does not meet the criteria for Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type, or Transsexualism.

—*DSM III-R*, p. 289.

The distinguishing characteristics of Transvestic Fetishism are heterosexuality and eroticism connected with crossdressing and fantasies of crossdressing. Only a single item of clothing may be used, but with time an entire female costume may be worn.

Most heterosexual males who crossdress experience sexual arousal when they first begin to dress, and so are diagnosable as transvestic fetishists. Some show such arousal for their entire lives. Others come to crossdress for reasons unrelated to sexual arousal; these men will then meet the diagnostic criteria for Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT). Men in both categories are commonly called crossdressers.

GENDER IDENTITY DISORDER OF ADOLESCENCE OR ADULTHOOD, NONTRANSSEXUAL TYPE (GIDAANT)

Unlike those who experience sexual arousal when crossdressing, (who are considered by the authors of *DSM III-R* to have a sexual disorder), those who crossdress without sexual excitement are considered to have a gender identity disorder.

The essential feature (of gender disorders) is an incongruence between assigned sex (i.e., the sex that is recorded on the birth certificate) and gender identity.

—*DSM III-R*, p. 71.

Men and women with disturbances of gender identity which do not arise out of Transvestic Fetishism may also meet the criteria for GIDAANT. Examples are homosexuals who crossdress and persons with low-intensity gender dysphoria who do not meet the diagnostic criteria for Transsexualism. The *DSM III-R* notes that GIDAANT is common among female impersonators. Gender Identity Disorder of Childhood may also evolve into GIDAANT.

DIAGNOSTIC CRITERIA FOR 302.85 GENDER IDENTITY DISORDER OF ADOLESCENCE OR ADULTHOOD, NONTRANSSEXUAL TYPE (GIDAANT)

A. Persistent or recurrent discomfort and sense of inappropriateness about one's assigned sex.

B. Persistent or recurrent cross-dressing in the role of the other sex, either in fantasy or actuality, but not for the purpose of sexual excitement (as in Transvestic Fetishism).

C. No persistent preoccupation (for at least two years) with getting rid of one's primary and secondary sex characteristics and acquiring the sex characteristics of the other sex (as in Transsexualism).

D. The person has reached puberty.

Specify history of sexual orientation: asexual, homosexual, heterosexual, or unspecified.

—***DSM III-R***, **p. 77.**

Those with GIDAANT show significant identification with the opposite sex, and express it via crossdressing. Fantasies of sex reassignment may occur, but the individual is not preoccupied with changing his or her body to more closely approximate that of the opposite sex—or at least has not been so for two years. Those who are intent on changing sex, but have not had such feelings for two years, might be considered to be pre-transsexual. If the desire for reassignment continues, they will eventually be diagnosable as transsexual.

Most men with GIDAANT, however, do not desire to change their sex, and even after a lifetime of public appearances while crossdressed will not express a desire for sex reassignment. They retain their masculine gender identity, at the same time establishing a second, feminine gender identity which manifests itself only periodically. John Money (1974) has noted that in addition to two names and two wardrobes, there may come to be two personalities. The feminine persona may seem increasingly real, and the male persona may make concessions to improve her appearance; for this reason crossdressers sometimes seek hormonal therapy, feminizing plastic surgery, or electrolysis, even though they have no real wish to change their sex.

Occasionally, the crossdresser may come to seek hormonal and surgical reassignment; when this persists, the *DSM III-R* diagnosis of Transsexualism may be appropriate.

Masculine female homosexuals and adolescent girls who formerly had a diagnosis of Gender Identity Disorder of Childhood may meet the diagnostic criteria for GIDAANT. As there are few if any females with Transvestic Fetishism, erotic response to men's clothing does not occur, and so does not lead to GIDAANT in females. However, females with masculine appearances or who dress in an extremely masculine manner may come to show disturbances of gender identity sufficient for diagnosis of GIDAANT or Transsexualism.

Female impersonators and male prostitutes who work as women often show significant disturbances

of gender identity. To many of them, their male sexual organs are of considerable importance,-both for sexual reasons, and to signify special status as "she-males," and sex reassignment surgery or loss of potency caused by estrogens is undesired. Many, however, spend significant portions of their lives in women's attire, and may meet the diagnostic criteria for GIDAANT. These individuals sometimes seek surgical and other procedures to provide a more feminine appearance without effecting their sexual functioning—especially breast implants, facial plastic surgery, electrolysis, and illegal (and dangerous!) injections of silicone into breasts, buttocks, cheekbones, and other areas.

Once they reach adolescence, male or female children with gender identity problems may be diagnosed with GIDAANT or with Transsexualism.

PART IV
DISORDERS RELATED TO CROSSDRESSING

Transvestic fetishism frequently co-occurs with and may even be secondary to various other types of psychopathology. Langevin (1985) has noted that crossdressing often coexists with fetishism, sexual sadism, sexual masochism, bondage and dominance, voyeurism, exhibitionism, and frottage.

In the paraphilias, crossdressing appears to be of secondary importance. For instance, voyeuristic or exhibitionistic arousal may be heightened by the wearing of female attire, or a piece of clothing which is used primarily as a fetish may be worn as well as handled.

Fantasies of forced crossdressing and domination by beautiful women are frequent subjects of crossdressing literature. In these instance, the masochistic ideation is typically used to provide a socially acceptable motivation for crossdressing and relief from guilt associated with crossdressing, and so is clearly secondary. In other instances, female clothing may be fetishistically used as part of a sexual sadomasochistic ritual, with crossdressing being partial and obviously secondary to the sadism or masochism or the sexual attraction to the clothing itself.

There is a disturbing connection between sexual violence and crossdressing. A large percentage of rapists crossdress, and so do many sex killers. In these individuals, crossdressing seems to play a secondary role.

Frequently, persons with schizophrenia crossdress or manifest disturbances of gender identity. Crossdressing seems to sometimes arise at the same time as temporal lobe epilepsy or other brain pathology. Persons in manic states often show a general lack of sexual inhibition, and will sometimes crossdress. In these cases, crossdressing is of secondary

importance, and will usually decrease upon effective treatment of the disorder.

In cases in which crossdressing is of primary importance, diagnosis of Transvestic Fetishism may be appropriate. When crossdressing is secondary, diagnosis of the relevant paraphilia or other disorder is indicated, and treatment should be sought accordingly.

PART V
GENDER IDENTITY DISORDER OF CHILDHOOD

Disturbances of gender identity are often apparent by the time a child is two or three years of age. Gender Identity Disorder of Childhood manifests itself as extremely feminine behavior in boys, and as masculine behavior in girls. The child shows an avoidance of sex-typed activities, engaging instead in stereotypical opposite-sex activities. Boys may insist that they will grow up to be women, and girls that they will grow up to be men. Crossdressing is common.

The disturbance of gender identity is unlikely to persist into adulthood, but the child is apt to grow up to be a feminine man or a masculine woman. Most boys with this disorder show homosexual sexual orientations in adult life, but some become heterosexual. Crossdressing may occur throughout life. A few children with Gender Identity Disorder of Childhood eventually meet the diagnostic criteria for GIDAANT or Transsexualism.

DIAGNOSTIC CRITERIA FOR 302.60 GENDER IDENTITY DISORDER OF CHILDHOOD

FOR FEMALES:

A. Persistent and intense distress about being a girl, and a stated desire to be a boy (not merely a desire for any perceived cultural advantages from being a boy), or insistence that she is a boy.
B. Either 1. or 2.
   1. persistent marked aversion to normative feminine clothing and insistence on wearing stereotypical masculine clothing, e.g. boys' underwear and other accessories.
   2. persistent repudiation of female anatomic structures, as evidenced by at least one of the following:
      a. an assertion that she has, or will grow, a penis.
      b. rejection of urinating in a sitting position.

c. assertion that she does not want to grow breasts or menstruate.

C. The girl has not yet reached puberty.

FOR MALES:

A. Persistent and intense distress about being a boy and an intense desire to be a girl, or, more rarely, insistence that he is a girl.

B. Either 1. or 2.

1. preoccupation with female stereotypical activities, as shown by a preference for either cross-dressing or simulating female attire, or by an intense desire to participate in the games and pastimes of girls, and rejection of male stereotypical toys, games, and activities.
2. Persistent repudiation of male anatomic structures, as indicated by at least one of the following repeated assertions:
   a. that he will grow up to become a woman (not merely in role).
   b. that his penis or testes are disgusting or will disappear.
   c. that it would be better not to have a penis or testes.

C. The boy has not yet reached puberty.

***—DSM III-R*, pp. 73-74.**

Boys with Gender Identity Disorder of Childhood seek out girls as playmates, and engage in counter-sex-typed play with feminine toys. They avoid rough-and-tumble play and the companionship of boys. When playing house, they insist on taking the role of the mother or other adult female. They delight in playing "dress-up," and may, at an early age, show surprising skill in applying makeup and arranging hair. Speech patterns and gestures are extremely feminine, and often more representative of grown women than young girls. There is often a theatrical nature to their crossdressing and mannerisms. They often sit to urinate. Stoller (1968a, 1968b) and Green (1975) have characterized these boys as physically very attractive. When young, these boys often express a wish to grow up to be women, and may insist that they will. Older boys are more likely to understand that such an outcome is not likely. Feminine mannerisms and crossdressing may decline in later childhood, while the disturbance of gender identity persists.

Girls with Gender Identity Disorder of Childhood seek out boys as companions, and engage in counter-sex-typed play with masculine toys. They are often boisterous, enjoying outdoor games, and will go to great lengths to avoid being put in a dress. They avoid feminine activities, and often take the role of the father or other adult male when playing pretend games.

Because of their extreme femininity, boys with Gender Identity Disorder of Childhood may suffer from teasing and tormenting by other boys. Although they are often highly intelligent, they may do poorly in school, and often refuse to attend. Girls are rarely teased before adolescence.

There have been a number of longitudinal studies of extremely femi-

nine boys, and follow-up shows that most of them become homosexuals rather than transsexual people. In essence, researchers who have sought to identify childhood characteristics which would allow prediction of adult transsexualism selected characteristics which were more predictive of adulthood homosexuality than transsexualism. It seems likely that many, or even most pre-transsexual boys may not be extremely feminine. In adults, gender dysphoria may or may not be accompanied by counter-sex behavior; there is no reason to suspect that the same would not be true in childhood. Zucker (1985) has interviewed non-feminine boys who maintained that they wanted to be girls. It is unclear whether these boys are pre-transsexual, but they may well be. Perhaps the next longitudinal study will center not on masculine or feminine behavior of children, but on self-identified gender dysphoria; i.e., on those boys and girls who maintain that they want to become a member of the opposite sex. As it is just this self-identification which identifies adults as transsexual, it would be useful to determine whether statements of desire to change sex persist throughout life.

It has proved even more difficult to identify girls thought to be pre-transsexual, for masculine girls (tomboys) are more socially acceptable than are feminine boys (sissies), and are much more common. Most tomboys give up their masculine pursuits at adolescence and grow up to be heterosexual, non-masculine women. Some become masculine women, and some become homosexual, but few become transsexual. Feminine boys, on the other hand, usually become somewhat feminine men—also rarely transsexual.

Stoller (1978b) identified a family constellation which he thought to be predictive of male transsexualism (although, as noted above, it may better portend male homosexuality). He reported that the mothers of feminine boys were frequently tomboys in childhood who, at adolescence, grew resigned to their role as women. They had beautiful male children who they kept very close to their bodies; this presumably hindered the individualization of the child. Fathers were emotionally or physically distant, or both. The feminine behavior of the boy was not discouraged, and might even be encouraged. Although Stoller's pattern sometimes occurs in the families of feminine boys, it often doesn't.

The treatment of choice for feminine boys has been to teach them masculine behavior and extinguish feminine behavior and crossdressing—fortunately, by nonaversive means. Attempts at gender reorientation via behavior modification, training masculine behavior and speech patterns, counseling, parent effectiveness training, and identification with a same-sexed therapist have proven to be effective in eliminating or reducing feminine behavior and identification in boys, although they often grow up to be homosexuals. Interestingly, problems in treatment have arisen primarily from lack of cooperation by the parents, who often seem to have a need for the boy to be feminine, and not from the

child himself. Green (1974) reported that the parents were often unconcerned about their son's femininity until grandparents, teachers, and others voiced their concern; the parents then reluctantly sought help.

Because of the aforementioned difficulty in identifying girls thought to be pre-transsexual, attempts at gender reorientation in girls with techniques other than psychotherapy have been rare.

PART VI
TRANSSEXUALISM

Transsexual people are profoundly unhappy with the secondary sexual characteristics and gender role of their sex of assignment and persistently (and often desperately) try to change them. Their gender identity is unequivocally that of the opposite sex.

Transsexual people come in all shapes and sizes. They may be men or women, young or old, feminine or masculine, black or white. They may have heterosexual, homosexual, bisexual, or asexual sexual orientation. They may look and behave and have lifestyles typical of members of their assigned sex, or they may look and act like or even live as members of the opposite sex. Their histories and personality types may be extremely varied. They may be psychologically healthy (apart from their transsexualism), or they may be seriously disturbed.

HISTORY OF TRANSSEXUALISM

There have always been transsexual people, but until the second half of the twentieth century, techniques for altering the body to approximate that of the opposite sex were generally limited to male castration and depilation. Many non-Western societies have socially sanctioned social roles for transgendered persons, but Western societies lack such roles. Although there are a number of historical reports of men and women who successfully lived as members of the opposite sex (often being discovered only after their deaths), most transsexual people lived and died in the sex of original assignment, often keeping their gender dysphoria to themselves.

Although there were several previous unpublicized cases of sex reassignment, the notoriety surrounding the case of Christine Jorgensen, in the early 1950's, made the populace

aware for the first time that it was possible to make such a change, and that there were people who would desire it. Men and women began to approach physicians and ask for surgical and hormonal reassignment.

Publication of Dr. Harry Benjamin's *The Transsexual Phenomenon* in 1966, Jorgensen's autobiography in 1967 and those of Renée Richards and Jan Morris in the 1970's, Green and Money's *Transsexualism and Sex Reassignment* in 1969, an increasing number of articles about transsexualism in scientific journals, and the establishment of gender clinics at Johns Hopkins and other universities resulted in steadily increasing numbers of applicants wishing to change their sex. The 1980's brought increased public acceptance and visibility of transsexual persons and rapid growth of support groups. Transsexualism has become a relatively common phenomenon, and has even become somewhat institutionalized in Western society.

Tens of thousands of men and women have been successfully reassigned, but most transsexual people continue to work and live in the gender of birth. Sex reassignment remains one of the most dramatic and traumatic odysseys a man or woman can undertake. Social attitudes about transsexualism, while improved, are still largely negative; this is true both for the public and in the medical and scientific communities. There are, however, tested and approved methods for sex reassignment, and there are technologies and resources for achieving such change. Sex reassignment is difficult, but if the individual is willing to accept his or her physical and mental limitations and work hard to achieve change, it is, in most instances, possible.

ATTITUDES ABOUT TRANSSEXUALISM IN THE MEDICAL COMMUNITY

Since the report of the Christine Jorgensen case (Hamburger, et al., 1953), there has been division of opinion in the medical community about the proper method to treat people who identify themselves as transsexual. Interestingly, much of the early criticism came from psychoanalysts, despite the fact that psychoanalytic treatment of transsexual people has been considered to be notoriously ineffective. Some clinicians felt that any individual who desired to change sex was seriously disturbed. Some were of the opinion that transsexual desires were a form of psychosis. Meerloo (1967) went so far as to suggest that those who provided surgical and hormonal treatment were in collaboration with the psychosis. Others have called sex reassignment surgery (SRS) mutilating surgery or (because the body is changed to fit the mind) psychosurgery. Yet others have complained that transsexual people are self-diagnosed, and will sometimes use extreme measures, including coercion and threat, to obtain surgery. And still others have maintained that transsexualism is a pseudo-phenomenon which is secondary to severe disturbances of personality.

Physicians have, as a group, shown unreasoning bias towards sex reassignment, even to the point of

violating their Hippocratic oaths. In a survey of physician attitudes, Green, et al. (1966) found that most physicians opposed sex reassignment, even when a surgeon was available, the individual was nonpsychotic and had had two years of psychotherapy, and when not providing such treatment was almost certain to result in the suicide of the patient. Fortunately, such attitudes have moderated somewhat in recent years. (Franzini, et al., 1977).

Despite significant opposition, the opinion that surgical sex reassignment is indicated in some instances predominated during the 1970's and 1980's, especially after follow-up studies showed improvement in about 80% of operated cases. Lothstein (1983) argued that dismissal of psychotherapeutic and other techniques as ineffective has been premature, and that psychotherapy and not surgical reassignment is indicated in most cases of transsexualism. However, psychotherapy is not effective without the willing participation of the client, and transsexual people are typically not interested in psychotherapy.

Despite the demonstrated effectiveness of surgery and the lack of demonstrated effectiveness of other techniques, a portion of the medical community continues to be opposed to SRS. Interestingly, some of the most vocal opponents were formerly proponents (cf Meyer & Hoopes, 1974).

PREVALENCE OF TRANSSEXUALISM

Estimates of the frequency of transsexualism have been attempted during several decades and in several cultures. For reasons outlined below, the true incidence of transsexualism is unknown. The *DSM III-R* (1986) estimates a rate of about 1 in 30,000 males and 1 in 100,000 females.

Because transsexual people must identify themselves as such by presenting to a physician or psychologist, incidence studies show only that portion of the population of transsexual people who actually seek help—usually sex reassignment. It is likely that only a small percentage of people who are gender dysphoric reach this stage, for it is typically preceded by a great deal of self-examination and self-doubt. Therefore, existing incidence studies underrepresent the transsexual population by an unknown amount. Future improvements in treatment and changes in social attitudes are liable to increase the percentage of transsexual persons who seek reassignment, just as has occurred during the past few decades. Increasing willingness of persons with transsexualism to come forward has resulted both in increasing requests for reassignment, and in a higher proportion of females who ask for reassignment as males.

At one time, it was thought that there were far fewer female-to-male transsexual people than male-to-females (the usual estimate was 1 female to 4 males), but in recent years, the ratio in some clinics has been 1:1 or greater. The reason for the increasing proportion of females is unknown, but there has been speculation that it is at least partially due to improvement in surgical techniques.

CAUSES OF TRANSSEXUALISM

The causes of transsexualism are not known. Chromosomal and hormonal studies have revealed that transsexual men and women do not differ in major ways from control groups. Most are physically typical of members of their assigned sex. Many transsexual people are quick to examine their bodies for physical characteristics of the opposite sex, seemingly to provide a biological justification for their gender dysphoria. Actual abnormalities, however, are typically lacking.

Researchers, too, have also been quick to look for biological causes of transsexualism. At various times, there has been speculation that transsexual people vary in important physical ways from nontranssexual people. Ultimately, none of these hypotheses have held water. For example, preliminary reports (reviewed by Hoenig, 1985) by Eicher and co-workers indicated that male-to-female transsexual people lacked histocompatibility (H-Y) antigen, a factor which is found in the membrane of all male cells; Eicher also reported H-Y antigen in female-to-male transsexual people (female cells lack the factor). Other workers, however, were unable to replicate Eicher's findings, and Eicher's laboratory could not replicate under blind conditions. Hoenig's (1985) lengthy and detailed discussion of what is essentially a non-phenomenon is an illustration of the "pet" nature of the H-Y antigen and other physiological theories of transsexualism.

Transsexual people may show more EEG abnormalities than expected by chance, but data are equivocal. There have been a few reports of "transsexualism" associated with temporal lobe epilepsy, with concurrent improvement in the epilepsy and transsexualism following administration of anticonvulsant medications or temporal lobectomy. In the majority of these cases, the transsexual symptoms arose late in life, apparently as a manifestation of and secondary to the seizure disorder. Transsexual people as a group may show a statistically greater prevalence of EEG abnormalities and epilepsy than do nontranssexual people, but this has not been clearly demonstrated.

There has been widespread speculation that subtle fluctuations of hormone levels affect the fetal brain in such a way as to predispose to transsexualism. There is no direct evidence for this; in fact, the evidence of human intersexuality, in which gross hormonal abnormalities lead to physical hermaphroditism, but gender identity is almost always unambiguously that of the sex of assignment, suggests that any such subtle mechanism would be severely overridden by psychosocial factors.

Fetal androgens do seem to have a virilizing effect on the brain, but have little effect on gender identity. For example, it has been demonstrated that prenatal presence of androgens can cause psychological masculinization in females with adrenogenital syndrome (Ehrhardt, et al., 1968). Unlike typical females, women with untreated adrenogenital syndrome tend to show decreased maternal responsiveness to newborns, have a predisposition toward

tomboyism in girlhood, and have an increased incidence of homosexuality when adults. Nevertheless, gender identity is in most instances firmly female, even when the secondary sex characteristics and body type of the individual are typically male. Conversely, Money, Ehrhardt, et al. (1968) have noted that genetic males with testicular feminizing syndrome, a condition in which the individual lacks the ability to respond to fetal androgens, are behaviorally more feminine than genetic females, whose brains are masculinized by small amounts of androgens. Gender identity is, of course, female.

The above provides compelling evidence that biological factors can only predispose toward disturbances of gender identity. Psychosocial factors are of overriding importance in the development of gender identity, and hence transsexualism.

Stoller (1978b) has identified family dynamics which seem to reinforce feminine behavior in boys, but as longitudinal studies have shown that few of the feminine boys who were studied later became transsexual, it is unknown whether Stoller's family characteristics are predictive of transsexualism. It does seem, however, that one of the characteristics of Stoller's family—the emotionally and often physically absent father—is predictive of a variety of psychosocial phenomena, including male homosexuality, crossdressing, and male transsexualism. Adults with gender dysphoria sometimes report having been raised as or dressed in the clothing of the opposite sex, or of having parents who wanted a child of the opposite sex. Children with gender disturbances sometimes have dysfunctional families. Most of the time, however, it is not possible to identity family variables which are predictive of transsexualism.

The essential component of transsexualism is identification with the opposite sex. Many transsexual peoples' earliest memories are of believing themselves to be a member of the opposite sex. For whatever reason, transsexual boys develop gender identities as girls, and transsexual girls develop gender identities as boys. Once crystallized, this inversion of gender identity colors the way they perceive the world, and act and are perceived by others. As gender identity is relatively immutable, they carry their counter-sex gender identities throughout life. Even when they behave in sex-typical ways and do not allow their disturbance of gender identity to show, their internal representations of themselves and their emotions are characteristic of the opposite sex.

Physical characteristics which are typical of the opposite sex may predispose to development of a counter-sex gender identity, and hence to transsexualism. Such traits may be caused by hypogonadism (low levels of gonadotrophic hormones), or simply by a heredity which predisposes to a masculine build or appearance in a female or a feminine build or appearance in a male. It is probably psychosocial factors caused by appearance (i.e., being treated in an atypical fashion because of unusual appearance) which predispose to gender dysphoria in such cases.

Interests and personal style can also play a role in the development of transsexualism. Boys who do not like rough-and-tumble play, or who exhibit feminine mannerisms or interests may be called "sissy" or "girl"; the effect on gender identity is unknown, but such name-calling, which can be persistent and unbelievably cruel, is bound to cause a boy to question whether he really is a boy. Girls tend to experience less ridicule than boys, but adults and other children will make frequent remarks about tomboyishness, with analogous results.

Most transsexual adults report having from earliest memory identified as a member of the opposite sex. However, it is possible and even relatively common for changes in gender identity to occur relatively late in life. As previously noted, a number of hermaphroditic males in the Dominican Republic have been successfully reassigned (from female to male) at adolescence, without major difficulties. Many transsexual people can identify an adolescent or adult onset for their feelings of gender dysphoria. Additionally, some men with *DSM III-R* diagnoses of Transvestic Fetishism progress to Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type, and eventually to Transsexualism.

Transsexual people are often androgynous in appearance, behavior, and lifestyle, and may even have a presentation typical of that of the opposite sex. Some look and act like masculine homosexual women or effeminate homosexual men. But many are absolutely typical of their biological sex. They may successfully hide their gender dysphoria, even from those who are closest to them. They may marry, have children, and take sex-typical jobs. In denying their transsexual feelings, they often overcompensate. For example, George Brown (1988) has noted that the military, which reinforces hypermasculine behavior, seems to be a magnet for men with gender dysphoria.

TREATMENT OF TRANSSEXUALISM, EXCLUSIVE OF SEX REASSIGNMENT

There is no "cure" for transsexualism. Feelings of gender dysphoria, once developed, are unlikely to go away, but remain throughout the individual's lifetime. They may fluctuate in intensity, and in some cases can even be successfully repressed for short or long periods of time, but they are an integral part of the individual. While self-discipline, medication, and counseling can help the individual to cope with transsexualism, the underlying feelings of gender discomfort will remain.

Attempts to deal with transsexualism are of two types: either the body can be changed to match the mind, or the mind can be changed to match the body. Most transsexual people desire the former, and are notoriously reluctant to accept the latter.

In some cases, surgical and hormonal reassignment is a clearly preferable alternative to a marginal existence in the gender of original assignment. However, although some opt for sex reassignment, and an

unknown number commit suicide, most people with transsexualism live their entire lives in the gender of original assignment. It is essential that there be ongoing support for all transsexual persons, and not just those who decide to change their sex.

COUNSELING

Counseling and various types of psychotherapy can help the individual to make rational decisions about sex reassignment. It is critical for those who decide upon reassignment, and perhaps even more critical for those who for one reason or another elect to remain in the gender of original assignment. Transsexualism is a tremendous psychic burden, and getting through life without killing oneself or changing one's sex is no sign that one has performed optimally throughout his or her lifetime. Counseling can deal with a host of issues, including family, employment, sexual preference, finding acceptable outlets for feelings of frustration, and dealing with hostility towards society and envy of those of the preferred sex. The therapist can make the individual aware of shortcomings, erratic or self-defeating behavior, and unconscious attitudes, and can provide strategies for coping and self-expression. Therapists can prove especially helpful in times of crisis, when the individual's coping and defense mechanisms break down; it is at these times that the desire to change sex is most likely to strengthen and suicidal ideation is most likely to increase.

It is advisable for transsexual persons to find a counselor or therapist, and to schedule visits as needed.

There have been several reports of gender identity change through psychotherapy, but at least one, the psychoanalytic "cure" of Richard Raskin by Bak (Bak & Stewart, 1974), resulted in eventual sex reassignment. It is doubtful that psychotherapy can result in a change of gender identity in a true transsexual. However, nontranssexual persons who seek sex reassignment—in particular crossdressers and ego-dystonic homosexuals—may, through psychotherapy, be able to come to understand their motivations and abandon their quest for reassignment.

APPLIED BEHAVIOR ANALYSIS

Barlow, et al. (1973) achieved gender identity change in persons who appeared to be transsexual, using a combination of nonaversive (modeling and practice of masculine behavior, fantasy training) and aversive (electrical shock) techniques. Replication (Barlow, et al., 1979, and others) was successful, and, short of reassignment surgery, offers perhaps the most promise for treatment of transsexual people. Further study and replication of this successful approach, and especially investigation of the relative effectiveness of Barlow's aversive and nonaversive techniques, is needed.

Fortunately, transsexual people seem to have largely escaped the extreme aversive procedures which have been used with crossdressers and those with other paraphilias. This may be because investigators have viewed transvestism as a sexual deviation or human weakness (a set

of behaviors), and transsexualism as a disorder of self (a mental set). Gelder & Marks (1969) reported minimal success with aversion therapy of transsexual people; this is in contrast to reports of aversive techniques used with crossdressers, which have by-and-large resulted in reduction of crossdressing and fantasies of crossdressing.

Behavior analytic procedures, while promising, have not been systematically replicated, and should be considered experimental. Hypnotic and drug therapies are likewise experimental.

TREATMENT OF GENDER IDENTITY DISORDER OF CHILDHOOD

Green (1974, 1979, 1985) and others have treated extremely feminine boys with a combination of interventions including the training of masculine behavior and speech patterns, counseling, parent effectiveness training, and identification with a same-sexed therapist. While it is doubtful that more than a small percentage of subjects would have become transsexual, there was considerable success in reducing statements that the child was a member of the opposite sex or would grow up to have breasts and a vagina. Crossdressing slowed or ceased, and the boys became noticeably more masculine. Treatment effects appeared to last in most cases into young adulthood, but Green (1979, 1985) found that a large percentage of subjects reported homosexual orientations. Other researchers have confirmed Green's findings.

SEX REASSIGNMENT

Sex reassignment has been a reality for only about 40 years. Before that, treatment was unobtainable; most transsexual people had not even considered that reassignment was possible. They had no choice but to live as assigned, and manage as best they were able. At the present time, sex reassignment is a realistic option for transsexual persons.

It is impossible for an individual to actually change physical sex. Most of the physical determinants of sex (chromosomal makeup, gonads, internal genitalia) are fixed before birth, and are not amenable to change. It is possible to surgically refashion the external genitalia to resemble those of the opposite sex, and hormonal therapy (and electrolysis and sometimes plastic surgery for males) can change the secondary sex characteristics and overall appearance to more-or-less resemble that of the other sex. Somatic changes are dependent upon skeletal structure, which is affected and fixed by hormones at puberty, and is not amenable to change. For that reason, some persons can easily come to pass as members of the opposite sex, while others have great difficulty.

Except for hormonal and surgical treatments, a "sex change" consists entirely of gender role reorientation of the individual. The physical adjustments make appearance more viable, but it is up to the individual to dress and behave in a manner appropriate to the sex of reassignment.

The television industry, the medical community, and many transsexual people themselves are entirely too fixated on genital reassignment surgery, attaching little importance to the change in gender role. Too often, transsexual people view genital transformation as a magical end. Needless to say, postoperative status has little to do with the way the individual is able to function in society. Those who have trouble passing in the gender of choice preoperatively will have trouble postoperatively, and their personality traits, problems, and flaws will remain the same. Many transsexual men and women live satisfying lives in the gender of choice without ever having reassignment surgery.

Sex reassignment surgery is indicated only in those instances, as in intersexuality, when it makes no sense for a particular person to have such discordant external genitalia—when the person is totally functioning in the gender of choice.

STANDARDS OF CARE

In the 1950's, 1960's, and 1970's, reassignment surgery was often performed indiscriminantly on people who were not prepared to deal with the actualities of such a permanent change (who had little or no experience in living as a member of the opposite sex). Outcomes were sometimes unnecessarily tragic. Understandably concerned by this, the Standards Committee of the Harry Benjamin International Gender Dysphoria Association, Inc., an organization composed of physicians, psychologists, and others who provide services to transsexual persons, developed Standards of Care which were first published in 1979 and which are updated regularly.

The Standards are a set of minimal guidelines for sex reassignment. They were designed to safeguard service providers as well as transsexual people. They provide a structured and progressive framework for transition, with "bail-out" possible at any time before reassignment surgery, which is the final step. The Standards mandate regular monitoring by psychologists and physicians, with diagnosis required before hormonal therapy begins. A period of real-life test, in which the individual successfully works and lives in the gender of choice, is required before surgery, which is done only when success in real-life test is documented by two clinical behavioral scientists.

The Standards of Care are minimal guidelines, and are sometimes exceeded by gender clinics and individual service providers. Many transsexual people resent them, viewing them as unnecessary hurdles, but by standardizing services and setting timelines, the Standards have doubtless saved much heartbreak and regret.

OUTCOME STUDIES

A number of follow-up studies of transsexual people have shown a success rate for SRS approaching 80%. Criteria for "success" have varied from study to study, however, and Lothstein (1982) has rightly pointed out that the methodology of many of the studies is questionable. Lothstein fails

to appreciate, however, that much of the problem with follow-up is due to the tendency of postoperative transsexual people to become successfully integrated in society in the gender of choice, vanishing from the purview of researchers for whom they no longer have a need.

PART VII
THE DSM III-R AND TRANSSEXUALISM

Transsexualism is no longer considered to be a unitary phenomenon, but a group of syndromes a number of researchers have called the Gender Dysphoria Syndromes (cf Levine & Lothstein, 1981). Transsexualism is seen as a behavioral manifestation, or symptom; the gender dysphorias are the underlying causes. According to this model, anyone who meets *DSM III-R* criteria is considered transsexual, but may be so for any number of unrelated reasons.

DIAGNOSTIC CRITERIA FOR 302.50 TRANSSEXUALISM

A. Persistent discomfort and sense of inappropriateness about one's assigned sex.
B. Persistent preoccupation for at least two years with getting rid of one's primary and secondary sex characteristics and acquiring the sex characteristics of the opposite sex.
C. The person has reached puberty. Specify history of sexual orientation: asexual, homosexual, heterosexual, or unspecified.

—***DSM III-R***. p. 76.

Transsexual persons may experience fluctuations in the intensity of their desire to change their sex, but the desire is always there. Those who are ambivalent or on-again, off-again, or who have recently acquired the desire to change their sex are not diagnosable as transsexual, but may meet diagnostic criteria for Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type or Gender Identity Disorder, Not Otherwise Specified (a catch-all category). Additionally, those who have not yet reached puberty are not diagnosed as transsexual, but may meet diagnostic criteria for Gender Identity Disorder of Childhood.

The *DSM III-R* does not divide transsexualism into "types," but many theorists have done so. Person & Ovesey (1974a, 1974b) discriminated

between primary and two types of secondary male-to-female transsexualism. Primary transsexual persons were considered to have global disturbances of gender identity, dating to childhood. Secondary transsexual persons had backgrounds either as heterosexual crossdressers or as effeminate homosexuals, and tended to seek sex change when decompensating under stress.

Other workers have discriminated between homosexual and nonhomosexual gender dysphorias, between those who have at some point shown fetishistic arousal to female clothing and those who have not, and between those who are alloerotic (show erotic interest in others) and those who are analloerotic (lack erotic interest in others)—all in male-to-female transsexual people. Female-to-male transsexual people are considered to be a more homogenous group.

The *DSM III-R* notes that transsexual persons often show concurrent disturbances of personality, particularly anxiety and depression. Most researchers consider that a desire to change sex is necessarily indicative of serious psychopathology, and attribute a wide variety of psychopathologies to transsexual persons. Others, however, have not found a high incidence of psychopathology in their transsexual clients.

THE POLITICS OF DIAGNOSIS AND TREATMENT

In earlier years, the experimental nature of gender programs resulted in low acceptance rates. Sex reassignment was viewed as a last-ditch effort to save those with whom other therapies and interventions had failed. The majority of the transsexual persons who applied were improperly diagnosed and denied treatment. Those who were relatively well-adjusted were likely to be excluded in favor of prostitutes, those with substance-abuse problems, those who were suicidal, and others who were considered "hopeless." Those whose presentation was not strikingly that of the gender of choice were especially unlikely to obtain treatment, for transsexualism was a relatively unexplored phenomenon. Workers were unsure of the essential characteristics of transsexual people, and were likely to assume that appearance was predictive of success in reassignment, and that those who were able to achieve a convincing presentation in their assigned sex would be unable to pass successfully after reassignment.

Many of the clinics tended to force unrealistic stereotypes of femininity on transsexual people. Those who were not "Marilyn Monroe" burlesques of womanhood or "John Wayne" parodies of manhood were denied services. Transsexual people soon learned to present themselves as such caricatures. The clinicians then filled the literature with articles about transsexual peoples' stereotyped notions of gender.

The directors and staff of most of the clinics tended to view SRS as essential for satisfactory adjustment in the new gender. Those who were not accepted for SRS were not generally offered hormonal therapy,

which, for many, was necessary in order to pass successfully in the gender of choice. The clinics were, in essence, condemning the individual to live in the gender of birth.

In many instances, the treatment of transsexual people by the gender clinics went far beyond ignorance. Those who refused to provide whatever information the clinics demanded, who would not agree to participate in experiments, and who would not agree to unlimited follow-up were denied services. Those who did not structure their lives according to the demands of the clinician (changing jobs, divorcing spouses) were denied treatment. Hormonal therapy and the remote promise of SRS were used as a carrots, subject to withdrawal at any time. Many of the clinics used the ignorance and desperation of transsexual people as tools for manipulating and controlling them.

Most gender programs have learned by their mistakes, but some have not. Some still have exclusionary criteria. Males who are perceived as excessively masculine and females who are feminine are less likely to receive hormonal and surgical treatment than are those who staff perceive as "naturals"—even though those who pass may do so primarily because of having obtained previous hormonal therapy or electrolysis. Additionally, some programs exhibit bias towards those who have past history of homosexuality or fetishistic response to female clothing, those who have made heterosexual adjustments, and especially those who are married and have children.

Current theoretical notions embrace the heterogeneity of persons with transsexualism, but in too many places, practice lags behind theory. Despite their appearance and past lifestyles, those who meet *DSM III-R* criteria for Transsexualism can legitimately consider themselves to be transsexual persons and are within their rights to request sex reassignment.

PART VIII
FEMALE-TO-MALE TRANSSEXUALISM

Women who want to be men have been subject to much less study and speculation than men who want to be women. There has been only one book-length treatment (that of Lothstein, 1983), and journal articles are scarce. The sensationalistic press seems much less interested in women who become men than in men who become women.

The relative lack of interest in female-to-male transsexual people may be partially due to their scarcity, but is largely a measure of the differing values and worth placed on manhood and womanhood. We live in a culture in which it is somehow considering shocking or surprising that a man would want to become a woman, and much less so than a woman would want to be a man.

CHARACTERISTICS

Female-to-male transsexual people have usually been considered to be more reliable and to exhibit less psychopathology than male-to-female transsexual people, although Lothstein (1983) disputes this. Certainly the fetishism which is common in many males with gender dysphoria is lacking in females, who are not reported to show erotic interest in male clothing.

Female-to-male transsexual people have been considered to be less heterogenous than male-to-female transsexual people, and to exhibit less psychopathology. Most are masculine in appearance and dress. The majority report having been tomboys. Most are sexually attracted to women, and report never having had sex with a man, but some have married and borne children.

SEX REASSIGNMENT

The Standards of Care of the Harry Benjamin International Gender Dysphoria Association, Inc., hold

equally well for males and females. The stages of transition are the same, being diagnosis, hormonal therapy, real-life test, and finally, surgery.

Response to androgens results in considerable virilization of the female, who seldom has trouble passing as a male. Although there have been recent improvements in phalloplasty technique which have improved appearance and functionality, genital surgery is not as satisfactory as that for male-to-female transsexual persons. Because of the extreme expense of phalloplasty, most male-to-female transsexual people limit surgical interventions to breast reduction, hysterectomy, and bilateral oophorectomy (removal of the ovaries).

PART IX
NONTRANSSEXUAL PERSONS WHO SEEK SEX REASSIGNMENT

Persons who present with demands for surgical and hormonal sex reassignment may or may not be transsexual. For these who are not truly transsexual, sex reassignment would be a tragic mistake. Consequently, accurate diagnosis of transsexualism and scrupulous adherence to the Standards of Care is critical to rule out persons who are not transsexual.

FEELINGS OF INADEQUACY IN GENDER ROLE

The *DSM III-R* notes that persons who feel inadequate in their gender role sometimes mistakenly assume that they should change their sex. This desire frequently arises spontaneously, or in times of stress, and may just as suddenly disappear.

Disturbance in gender identity is rare, and should not be confused with the far more common phenomena of feelings of inadequacy in fulfilling the expectations associated with one's gender role. An example of the latter would be a person who perceives himself or herself as being sexually unattractive yet experiences himself or herself unambiguously as a man or a woman in accordance with his or her assigned sex.

—*DSM III-R*, p. 71.

The critical element in transsexualism is gender identity. Persons with feelings of inadequacy in their gender role may come to believe that they would be better off after sex reassignment, but their gender identity is not that of the other sex. They can be more accurately described as seeking to flee the demands of their current gender than as wanting to embrace the opposite gender. They frequently idealize the advantages and minimize the responsibilities and hardships of belonging to the other gender.

The treatment of choice for such persons is counseling, to help them

to deal with their feelings of inadequacy and unattractiveness and find better adjustment in their present gender. Treatment with antidepressant medications may also be of benefit. Sex reassignment is counterindicated for several reasons—not only because they lack the proper gender identity, but because rather than obtaining relief, they would find their present difficulties greatly exacerbated by the tremendous demands and problems of reassignment.

HOMOSEXUALITY

Homosexual men and women sometimes request sex change, either in order to deal with ego-dystonic feelings about their homosexuality, or to please a lover. In either case, sex reassignment is counterindicated.

Some gay men or women have tremendous problems in dealing with their sexual orientation. They may believe it is more socially acceptable to be transsexual than homosexual, and accordingly, may seek to decrease their feelings of guilt and dissonance by changing their sex. They may mistakenly believe that their parents and friends will be more accepting of them as a member of the opposite sex than as a homosexual, or that their effeminate or masculine mannerisms are stigmatizing or inappropriate in their present gender, but would somehow be appropriate or even appealing if they were of the opposite gender.

Alternatively, a gay man or woman may have a lover they consider predominantly heterosexual, and may mistakenly come to believe that by changing their sex, they will be able to maintain their troubled relationship. An obvious difficulty here is that the relationship may not last in any case.

In the case of the ego-dystonic homosexual, change of sex is sought primarily as a means of escape, and in the case of trying to please a lover, change of sex is sought in order to please another person. In both instances, gender identity is not that of the opposite sex.

Counseling is the treatment of choice.

Some homosexual persons come to meet the *DSM III-R* diagnostic criteria for Transsexualism, but reassignment is sought because of feelings of inappropriateness in the current gender.

CROSSDRESSERS

Frequently, persons with Transvestic Fetishism or Gender Identity Disorder of Adolescence or Adulthood will present for sex reassignment. In only a few instances is it indicated.

Many crossdressers exhibit fetishistic arousal to feminine aspects of their bodies. For example, they may become sexually excited by the sight of their shaved legs or plucked eyebrows. Similarly, they may come to attach fetishistic importance to transsexualism, and particularly to hormone therapy and sex reassignment surgery.

In these instances, gender identity is more-or-less male, and the desire

to change sex is linked to male sexuality. Change of sex is pursued blindly, as a fetish. The desire to change sex will wax and wane with arousal levels, and will become stronger during times of stress, but makes little sense in the context of the individual's life and gender identity.

Many such individuals legally or illegally obtain supplies of female hormones and ingest them, often with naive or unrealistic expectations about the changes they will cause. The somatic and behavioral changes caused by estrogens can be extremely ego-dystonic to these men. Breast development is reversible only with surgery, and testicular changes resulting in sterility may also be irreversible. Estrogen-related impotency may be especially distressful. Often, these men wish only to obtain more graceful figures so that they can fit better in the female clothing that they value so much. Hormones, however, are not "magic bullets." They act globally, and are not without health risks, and they should not be taken without medical supervision and in the absence of a *DSM III-R* diagnosis of Transsexualism.

Paradoxically, in crossdressers, treatment with female hormones will lessen the desire for them, since they have an inhibitory effect on male sexuality. A cautious and temporary trial period on estrogens can thus be used as a diagnostic tool by a physician. Counseling, however, is the treatment of choice for those with associations between transsexualism and fetishistic sexual arousal.

Although transsexualism can arise from crossdressing, it does so only because of development of a feminine gender identity and not because of association with the male sex drive.

PART X
SELF-ASSESSMENT

After reading the preceding sections, you may already have concluded that you are a crossdresser or a transsexual person or a homosexual. If you are still undecided about your "fit" in the scheme of things, the following may help you to assess yourself. You will probably not, of course, have all of the characteristics listed for any condition, but you will be likely to find the section that best describes you. You may want to compare your characteristics with those of representative persons with disturbances of gender identity and sexuality; several personal profiles can be found in the Appendix.

Please remember that you are not a diagnostician. You should consider contacting a psychologist or psychiatrist for help. In the case of suspected intersexuality or hypogonadism, you should contact a geneticist or endocrinologist, respectively.

PHYSICAL INTERSEXUALITY

You have ambiguous genitalia (hypospadias, micropenis, undescended testicles, or vaginal pouch if a male; enlarged clitoris, blind vaginal pouch, or fused labia if a female). At puberty, you develop secondary sex characteristics of the opposite sex, or there is no onset of puberty. If you are a female, you are amenorrheic. Karyotype reveals abnormal chromosome count, or biochemical analysis reveals anomaly. There is a family history of sexual abnormalities.

HOMOSEXUALITY

You are sexually attracted to members of the same sex, and not attracted to members of the opposite sex. If the attraction is unrelated to matters of gender, you are probably homosexual. If you think you may be, you should seek information about homosexuality, which is preva-

lent and more easily found than information about gender.

If you are sexually attracted to members of the same sex, and if it is related to matters of gender, you should read further.

TRANSVESTIC FETISHISM

You know that you are a man, and much and probably most of the time, you are glad of or at least content with your masculinity. You look and act like a man when you are not crossdressed, and probably have a masculine occupation and interests. Your genitals are a source of physical pleasure for you. At times, you may have feminine feelings, or even wish you are a woman, but these feelings are transient. You are sexually attracted to women; you may or may not be married. When engaged in intercourse, you may imagine yourself as a female, and your female partner as a male.

Crossdressing and thoughts of crossdressing or of being a woman are sexually exciting for you. Masturbation and sexual intercourse are usually accompanied by fantasies of crossdressing. You may be primarily attracted to one or more female garments, especially underwear, stockings, or high-heeled shoes. You may wear women's undergarments under your male clothing. You may dress entirely as a woman, or you may limit your crossdressing to a single item.

After orgasm, or at other times when your sexual desire is low, crossdressing is unlikely to play a prominent role in your thoughts.

GENDER IDENTITY DISORDER OF ADOLESCENCE OR ADULTHOOD, NONTRANSSEXUAL TYPE, ARISING FROM TRANSVESTIC FETISHISM

Your gender identity is primarily that of a male, but there are periods during which you wish you were a woman. You crossdress, but not primarily for sexual reasons. Rather, you enjoy expressing your feminine side. You may feel anxious or depressed when you have not crossdressed for some time. In your crossdressing, you strive to present yourself totally as a woman; consequently, you remove your facial hair, and perhaps the hair from your arms and legs. You may trim your eyebrows. You have selected a "femme" name, and your feminine self has come to seem like a real person to you, and perhaps to others. You may go out in public when crossdressed; if not, you fantasize about it. You may be a member of a social crossdressing group. You have a considerable feminine wardrobe. You may consider plastic surgery or hormone therapy to enhance your feminine appearance, but you derive pleasure from your genitals, and are not anxious to be rid of them or to have your sexual functioning compromised because of hormones. You are probably married.

You are sexually attracted to women, but when crossdressed, you may fantasize about making love to men. If approached by a man when crossdressed, you may find yourself responding like any woman would.

GENDER IDENTITY DISORDER OF ADOLESCENCE OR ADULTHOOD, NONTRANSSEXUAL TYPE, ARISING FROM EFFEMINATE HOMOSEXUALITY

You are sexually attracted to men, and may consider yourself to be a homosexual. However, when engaged in social and sexual relations with your partners, you feel like a woman and not a man. You rarely if ever like to use your genitals when making love, but you may take occasional pleasure in them. You tend to take the passive role in the sexual act, and prefer straight-acting partners. In fact, although your lovers may have all been gay, you prefer straight men, and fantasize about being a woman with them. In the past, you may have crossdressed for sexual reasons, or to please others, or to do a drag show, and may still do so, but your primary motivation for crossdressing is personal pleasure.

You may think about changing your sex, and may have actually taken female hormones for a more feminine appearance, but you do not actually want to be a woman, or at least, you do not consistently want to be a woman.

GENDER IDENTITY DISORDER OF ADOLESCENCE OR ADULTHOOD, NONTRANSSEXUAL TYPE, IN FEMALES

You are masculine in appearance and dress, eschewing makeup and feminine hairstyles, and favoring slacks or jeans and comfortable shoes. You are sexually attracted to women. You have had only limited sexual relations with men, and if you have, you probably didn't like it—but you may have been married, and even have children. You may publicly identify as a lesbian, but you tend to feel like a man in your sexual relationships, and your partners tend to treat you as such. You may sometimes fantasize about being a man, but such fantasies are not consistent.

GENDER IDENTITY DISORDER OF CHILDHOOD

If you are a boy, you favor play with girls' toys, and avoid masculine toys. You take female roles in make-believe games. You seek the company of girls and avoid boys, who may tease you and call you "girl" or "sissy." Because of this harassment, you dislike and avoid school, and consequently, your grades are poor. Your speech and gestures are feminine, and may have an exaggerated, theatrical quality (perhaps less so in later childhood). You may state that you want to grow up to be a woman, or you may keep your feelings to yourself. When you were younger, you crossdressed whenever possible, but you may do so less frequently now. You dislike your genitals and wish that they could be changed to female genitalia. You sit to urinate. You have not yet begun puberty.

If you are a girl, you favor play with boys' toys; you tend to be boisterous and active. You take male roles in make-believe games. You may be teased at school and called a tomboy. You wear slacks or jeans and shirts, and avoid skirts or dresses. You dislike your genitalia, and

the thought of growing breasts or menstruating horrifies you. You wish you did not have to sit to urinate. You have not yet reached puberty.

MALE-TO-FEMALE-TRANSSEXUALISM

Although you realize that you are a biological male, you may believe and state that you are indeed a woman. You have probably felt this way for as long as you can remember. Certainly, you are unhappy with being a man, and you wish you were a woman. This desire has persisted unabated and with great intensity for at least two years, and has likely lasted all your life—although early on, you may have not known why you didn't seem to "fit" in society. You hate your secondary sex characteristics and your genitals, and wish to replace them with the secondary sex characteristics and genitals of the opposite sex. You may have considered mutilating your genitals. You dislike engaging in masculine activities and occupations, even though, for reasons of appearance, you may do so. You often or always sit to urinate. You dislike touching your genitals or using them for sexual intercourse. You have reached adolescence.

You may be sexually attracted to men or to women, or to both, or you may have little sexual experience or desire for such. You may, however, be married. When engaged in intercourse with either men or women, you prefer the subordinate position, and fantasize yourself as a woman during lovemaking.

Your appearance and past history may be very feminine, or, alternatively, very masculine. Regardless of your appearance, your gender identity is feminine.

You may or may not have a history of crossdressing. You do not crossdress for sexual reasons. You have probably never been fetishistically aroused by the wearing of women's clothing.

FEMALE-TO-MALE TRANSSEXUALISM

You realize that you are a biological female, but you feel that you are or should be a man. This desire has persisted without remission for at least two years, and has likely lasted all your life. Your earliest memory may be of believing you were a boy. You hate your secondary sex characteristics and your genitals, and wish to replace them with the secondary sex characteristics and genitals of the opposite sex. You hate being a woman, and dislike engaging in feminine activities and occupations. You prefer dressing casually in frankly masculine clothing, and do not wear makeup. You have reached adolescence.

You are sexually attracted to women, and may publicly identify as a lesbian. However, you feel like a man in your sexual relationships, and your partners may treat you as such. Your gender identity is masculine.

A FINAL WORD

If you did not "find" yourself in this booklet, then chances are that you are not gender dysphoric. If you have given yourself a "diagnosis," or if you have confirmed what you already suspected about yourself, you should congratulate yourself, for you have taken a big step forward.

Now that you have a name for what you are, knowing who you are will come easier. You must learn to accept your true nature. This will not be easy.

By learning as much as you can about crossdressing and transsexualism, you will be able to better understand yourself and the nature of your desire to crossdress or change your sex.

By coming to grips with your emotions and feelings, you will be better able to plan and run your life.

The Bibliography and the Reading and Resource List at the end of this booklet will direct you to relevant publications and organizations, so that you can continue your exploration. The AEGIS booklet, *Sorting Out Your Feelings About Your Gender Dysphoria: A Guide to Coming Out*, will help you to further explore and hopefully become comfortable with your gender dysphoria.

Those who believe that they are transsexual should also send for the AEGIS booklet, *Deciding What To Do About Your Gender Dysphoria: Some Considerations For Those Who Are Thinking About Sex Reassignment*. This booklet discusses in detail the lifestyle options of transsexual persons, and the ways in which transition will affect their lives. You should also consult a psychologist or psychiatrist.

Other AEGIS booklets are in preparation.

APPENDIX

The following are representative examples of persons with *DSM III-R* diagnoses of Transvestic Fetishism, Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type, Gender Identity Disorder of Childhood, and Transsexualism.

TRANSVESTIC FETISHISM

BOB

Bob is a 40-year-old married man with two children. Since adolescence, he has worn panties under his otherwise masculine apparel. He is sexually excited by lingerie and thoughts of lingerie, and frequently masturbates into a pair of panties. His fantasies while engaged in intercourse with his wife involve the wearing of various items of female attire. On several occasions, his wife reluctantly allowed him to wear a nightgown when they made love.

Bob has dressed completely as a woman several times. He stood in front of a mirror and admired himself. Although he was sexually stimulated, his feelings of guilt led him to quickly take the clothing off after orgasm.

GENDER IDENTITY DISORDER OF ADOLESCENCE OR ADULTHOOD, NONTRANSSEXUAL TYPE

CHRIS

Chris' first memory of crossdressing dates to the summer after he finished the first grade. He was spending the summer at his grandmother's house. One afternoon, he casually tried on a dress one of his cousins had left in the closet. He felt compelled to put it on on several occasions. When summer was over, he left the dress at the grandmother's house, thinking that would be the end of his crossdressing. He was surprised to find that the desire continued unabated.

At adolescence, Chris discovered that wearing womens' clothing had become sexually exciting. He began to crossdress with some regularity, and fantasized about going out in public, but was afraid to. College gave him little opportunity to crossdress. Shortly after graduation, he married Gloria. They promptly had two children.

Throughout the course of the marriage, Chris would crossdress in motel rooms on the infrequent occasions on which he traveled on business. He was 40 when Gloria discovered his cache of female clothing and cosmetics in the trunk of his car. She accused him of having an affair, whereupon he told her of his crossdressing.

The revelation of Chris' crossdressing caused Gloria considerable distress, but the marriage endured. Chris agreed to see a therapist, who suggested that he contact Tri-Ess, a national organization for heterosexual crossdressers.

Although the Tri-Ess chapter Chris joined had an active contingent of wives, Gloria refused to participate. She did, however, allow Chris to attend the monthly meetings.

At age forty-three, Chris crossdresses primarily to express what he calls "the woman within." He finds great psychic relief in dressing as a woman, and finds that he becomes irritable when he has not crossdressed in some time. He has occasional erections when crossdressed, which he regards as a nuisance. He shaves his legs and underarms to provide a more feminine appearance. He is proud of his name, which he finds works equally well in both his masculine and feminine modes.

When having intercourse with Gloria, Chris has always fantasized himself as a woman. He thinks often about being a woman, but is not willing to sacrifice his job, wife and family for the uncertainties of sex reassignment.

LANNY

Lanny works as a female impersonator. He has had numerous illegal injections of silicone to reshape his chin and cheekbones. Effeminate in appearance as a man, but glamorous as a woman, he finds that dressing as a woman gets him lots of attention from the masculine men whom he prefers as sex partners. He took estrogens for a brief period, but stopped as soon as it became apparent that his sexual performance was negatively affected.

Lanny thinks from time to time about changing his sex, but he realizes that the actualities of being a woman are a far cry from the illusion which he portrays on stage.

GENDER IDENTITY DISORDER OF CHILDHOOD

RICKY

Almost as soon as he could walk, Ricky began clumping around the house in his mother's high-heeled shoes. He has always insisted that

he will grow up to be a girl. He sits to urinate. His mannerisms and speech are extremely feminine, which has resulted in teasing by his peers. Consequently, Ricky often "plays sick," refusing to go to school. Ricky has always favored dolls over boys' toys, and has chosen girls for companions.

SHAWNA

Shawna has always been a tomboy. She resists wearing dresses and demands that her hair be kept short. She avoids other girls as companions, and insists that she is a boy. She is very athletic, competing with the neighborhood boys on their own terms. She has never shown an interest in sex-typed activities.

When she was four years old, her father discovered her in the bathroom with shaving cream all over her face and a razor in her hand.

TRANSSEXUALISM

STEPHEN

From earliest memory, Stephen wanted to be a girl. Although he was not a feminine child, and grew up to be typically masculine in appearance, he has steadfastly maintained that he is really a woman. He does not crossdress. He attempted it once, but felt like an imposter.

After his marriage of six years broke up, Stephen began aggressively seeking sex assignment. He has begun taking female hormones and is having electrolysis in anticipation of beginning real-life test.

MIKE

Until he was fourteen years old, Mike was unsure why he felt he didn't "fit." He had always felt a sense of inappropriateness about his gender, but it wasn't until he saw a television talk show that it occurred to him that his problem might be transsexualism. He contacted a support group for transsexual people, who referred him to a psychologist who diagnosed gender dysphoria.

The thought of sex reassignment frightens Mike, but he has chosen to pursue that course.

LARRY

Larry thought he was the most normal boy in the world. Then adolescence hit, and he felt a strong sexually-related tendency to crossdress. He quickly began to dress totally as a woman, and by the time he was sixteen, he was going out in public.

Larry, or Lauren, as he called himself when in female attire, made a very believable and attractive girl. He found himself aggressively pursued by men, to whom he was not particularly attracted. He liked their attentions nevertheless, and began to grant them small sexual favors, always being sure that he was not "found out."

Lauren's life was much more exiting than Larry's, and Larry spent more and more time in female attire. He acquired a driver's license in Lauren's name, and, upon graduation from high school, it was Lauren, and not Larry, who went to work.

Lauren made the acquaintance of a female impersonator who gave her the name of a doctor, who she went to see for hormone injections. The physical changes caused by the estrogens delighted Lauren, and for the first time, she began to consider the possibility of sex reassignment.

Lauren is now 23 years old, and Larry is a distant memory. Lauren had saved most of the money she needs for sex reassignment surgery.

BARBARA

Barbara was a tomboy, and became a masculine woman. She had her first sexual experience with another girl when she was twelve years old. When she was fourteen, a boy kissed her; the experience made her physically ill.

Barbara is active in the lesbian community, but she does not feel like a lesbian. She feels that inside, she is a man, and thinks of Lucy, her girlfriend, as her "wife."

Barbara is desirous of taking male hormones, but does not know how to go about getting them. She has begun to bind her breasts, and is trying to persuade her physician to remove her healthy ovaries and uterus.

GLOSSARY

Adrenogenital Syndrome: An intersexual condition in which a biological female fetus, if untreated, develops as a phenotypic male.

Amenorrhea: Abnormal lack of or suppression of menstruation.

Androgens: The male sex hormones.

Androgyny: To have the characteristics of both sexes.

Chromosomal Sex: The genetic constitution of the cells of the body, being either XX (female) or XY (male).

Crossdresser: One who wears the clothing of the opposite sex.

EEG (Electroencephalogram): A recording of the electrical activity of the brain, obtained by placing electrodes at various locations on the scalp.

Electrolysis: The removal of hair by the application of electric current. Electrolysis is the only permanent method of killing hair.

Estrogens: With progesterone, the female sex hormones.

External Genitalia: The external genitalia of females consist of the clitoris and two sets of labia, or vaginal lips; males have a penis and scrotum.

Fetishism: A sexual disorder in which erotic feelings are caused by a disembodied object or body part, such as a foot, glove or shoe.

Gender: Being a woman or a man, a boy or a girl. Gender is a social construct, and is distinct from sex, which is the individual's state of maleness or femaleness (a biological quality).

Gender (Sex) of Assignment: The gender (sex) in which one is currently expected to function.

Gender Dysphoria: A sense of discomfort or inappropriateness in the gender of assignment.

Gender Identity: One's sense of being a man or a woman, a boy or a girl. The private expression of gender role.

Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT): A *DSM III-R* term for a disturbance of gender which falls short of transsexualism. The individual feels discomfort in the gender of assignment, but is not persistently preoccupied with changing primary and secondary sex characteristics to those of the opposite sex.

Gender Identity Disorder, Not Otherwise Specified: A *DSM III-R* catch-all term. Persons who seek sex change, but do not meet the diagnostic criteria for Transsexualism are sometimes given this diagnosis.

Gender Identity Disorder of Childhood: *DSM III-R* term for marked disturbance of gender identity, resulting in femininity in boys and masculinity in girls, avoidance of sex-typed activities, and crossdressing.

Gender Role: The things that one does and says to indicate that one is male or female. The public expression of gender identity.

Gonads: The organs which produce reproductive cells and gonadotropic hormones, ovaries in females, and testicles in males.

Gonadotropins: The hormones, androgens (in males) and estrogens and progesterone (in females) which cause the development of secondary sex characteristics.

Hermaphroditism (Physical Intersexuality): Having the characteristics of both sexes, especially insofar as the genitalia are concerned.

Homosexuality: Sexual preference for those of the same sex.

Hormonal Sex Reassignment: Administration of the gonadotrophins of the opposite sex. Used to masculinize females and to feminize males.

Hypogonadism: A lower than expected output of sex hormones by the gonads.

Hypospadias: In males, urinary opening someplace other than at the tip of the penis.

Internal Genitalia: The internal genitalia in females consist of the vagina, uterus and fallopian tubes. In males, the seminal vesicles, vas deferens, and ejaculatory ducts comprise the internal genitalia.

Intersexuality (Hermaphroditism): Having the physical characteristics of both sexes, especially insofar as the genitalia are concerned.

Karyotype: A method of determining the chromosomal makeup of a cell.

Libido: Sex drive.

Orchidectomy: Male castration (removal of the testicles).

Paraphilia: A sexual disorder characterized by sexual urges and fantasies involving nonhuman objects, suffering or humiliation, or the involvement of nonconsenting persons.

Phalloplasty: Surgical construction or reconstruction of the penis.

Psychoanalysis: In-depth exploration of the subconscious motives for behavior.

Psychosurgery: Surgery of the brain, done in an attempt to control behavior.

Psychotherapy: Intensive psychological counseling.

Secondary Sex Characteristics: Those traits arising as the result of the action of gonadotrophins at puberty: includes development of facial hair and lowering of the voice in males, and breast development and widening of the hips in females.

Sex: The biological quality of maleness or femaleness, as opposed to gender, which is a social construct.

Sex Assignment: The determination of the sex of an infant, at birth, usually based solely on the appearance of the external genitalia.

Sex Reassignment: Modifying the body to make it as much as possible like that of the opposite sex, and permanently living in the social role that is associated with that sex.

Sex Reassignment Surgery (SRS): Surgical refashioning of the genitalia to resemble the external genitalia of the other sex.

Sex Reannouncement: A reinterpretation of the biological characteristics of sex, in infancy. Done only in cases of intersexuality.

Sexual Orientation: Sexual preference. Choice of erotic partner of the same or opposite sex.

Standards of Care: A set of minimum guidelines formulated by the Harry Benjamin International Gender Dysphoria Association, Inc., and designed to safeguard both transsexual persons and those who provide professional services to transsexual persons. By imposing various requirements on both the service provider and the transsexual person, the Standards of Care minimize the chance of an individual regretting the decision to change gender.

Testicular Feminizing Syndrome: An intersexual condition in which a biological male fetus is insensitive to androgens, and develops as a phenotypic female.

Transvestic Fetishism: A *DSM III-R* term for a condition found in males, in which crossdressing is associated with sexual arousal.

Transvestite: One who wears the clothing of the opposite sex, generally for erotic reasons.

Transsexual: An individual who is profoundly unhappy in the gender of original assignment. The transsexual

person wishes to change the body to be as much as possible like that of the opposite sex and to live in the gender normally associated with that sex.

Virilization: Masculinization due to the action of androgens.

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Many of these books are available from:
The International Foundation for Gender Education (IFGE)
P.O. Box 367
Wayland, MA 01778
Phone: (617) 899-2212

Heterosexual crossdressers might consider contacting:
The Society for the Second Self (Tri-Ess)
P.O. Box 194
Tulare, CA 93275

The Standards of Care are available from:
The Harry Benjamin International Gender Dysphoria Association, Inc.
HBIGDA
1515 El Camino Real
Palo Alto, CA 94306
(415) 326-4645

The following booklets are currently available from AEGIS:

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ABOUT THE AUTHOR

Dallas Denny has nearly twenty years experience in the mental health field, and has worked with persons with gender dysphoria since 1989. She is a licensed psychological examiner in Tennessee. She has a B.A. from Middle Tennessee State University and an M.A. from the University of Tennessee, and has completed the coursework for the doctoral degree from Peabody College of Vanderbilt University. She is a prolific writer, and has been published in both professional journals and popular magazines.

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The American Educational Gender Information Service

P.O. Box 33724
Decatur, GA 30033

(404) 939-0244 (evenings)

Ms. Dallas Denny, M.A., Director

The American Educational Gender Information Service (AEGIS) is a not-for-profit business which disseminates information to persons interested in issues of gender. **AEGIS** provides free referrals to support groups and gender clinics, and free referrals to physicians, psychologists, psychiatrists, social agencies and private social workers, ministers and attorneys to those not within range of a gender clinic or support group. We maintain a worldwide database of helping professionals, including surgeons who perform sex reassignment. Our magazine, **Chrysalis Quarterly**, is published four times a year, and we will be offering other publications as they are readied. We work actively with our sister organizations, exchanging newsletters, information, and referrals, and helping to organize cooperative projects and events.

AEGIS supports the **Standards of Care** of the **Harry Benjamin International Gender Dysphoria Association, Inc.**, and makes referrals contingent upon documentation of adherence to these standards. We actively support the professionalization and standardization of services for transgendered persons. We promote nonjudgemental and nondiscriminatory treatment of persons with gender dysphoria, and advocate respect for their dignity, their right to treatment, and their right to choose their gender.

AEGIS was founded and is managed by a licensed human service professional with knowledge of the professional literature of gender issues and more than a decade of experience in the delivery of psychological services.

The word **AEGIS** means, variously, shield, protection, and sponsorship. We will strive to live up to our acronym by at all times maintaining confidentiality and by helping transgendered persons make reasoned and informed decisions about the ways in which they will live their lives.

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aegis (e'jis), n. **1.** in Greek mythology, a shield or breastplate used by Zeus and, later, by his daughter Athena; hence, **2.** a protection. **3.** sponsorship; auspices.

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