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THE GENDER VARIANT COMMUNITY AND THE IMPLICATIONS FOR COUNSELORS

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DISSERTATION APPROVAL

This dissertation submitted by Harold E. Love has been read and approved by three faculty members of the American Academy of Clinical Sexologists at Maimonides University.

The final copies have been examined by the Dissertation Committee and the signatures which appear here verify the fact that any necessary changes have been incorporated and that the dissertation is now given the final approval with reference to content, form, and mechanical accuracy.

The dissertation is therefore accepted in partial fulfillment of the requirement for the degree of Doctor of Philosophy.

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VITA

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ABSTRACT

Gender is a fundamental element of self (Ekins & King 1997). Gender identity is often defined as a person's identification of maleness or femaleness regardless of anatomy or sexual orientation (Benjamin 1966). The transgender person is one whose gender identity and/or expression are not congruent with their anatomy (Bullough 2000).

Traditionally constructed boundaries defining binary gender categories leave people identifying as intersexed, transsexuals or transgender identities dismissed as either a medical or psychiatric pathology. Gender Identity Disorder is listed in The DSM-IV-TR, which implies a psychological pathology, however individuals with intersexed conditions have been excluded (APA 2000). It would seem therefore that the gender variant community has been effectively divided into two classifications by the scientific and medical community; either a candidate for sex reassignment surgery or mentally ill. The gender variant community has mobilized, organized, and become motivated. While many in this community have continued to seek sex reassignment surgery and hormone treatment, there appears to be a shift from attempting to pass or fit into society's strict gender binary of masculine or feminine. Hill (1997) noted that many transgender persons prefer to identify themselves as transgender and do not wish to pass in mainstream society.

This paper explores the transgender community from early biblical references to contemporary time. Nature and nurture at examined as possible causalities. Because of the prevalence of the transgender, it is likely that counselors will encounter at least one transgender person seeking services (Ettner 1999), therefore the implications for counseling are reviewed.

CONTENTS

INTRODUCTION

During the past several decades there has been significant movement within the transgender community as evidenced by political activism and organization. "Realizing that they lack civil rights and suffer from severe discrimination and social ostracism, members of the gender minority are actively forming a social movement to end this discrimination." (MacKenzie, 1994 p. 146). There is a raised consciousness within this community as social and support groups have increased in numbers. Action groups, clubs and organizations have contributed to the transgender activism. Chat rooms, web sites, and Internet resources have contributed to greater awareness, support and education for both the individual and for groups. Television and radio talk shows have illuminated this community as a whole, while empowering the individual to grow in self-confidence and self-affirmation. The saturation of news media in reporting hate crimes committed against members of the transgender community have further mobilized and inspired this movement.

Without question, the transgender have become more visible, more organized and more active in today's sociopolitical world. However, they continue to struggle for self-identity and to fit into mainstream society. In an effort to fit into society's narrowly defined binaries of sex and gender (male/female or masculine/feminine), many transgender persons transform themselves through hormonal and or reassignment surgeries. In order to make this transformation using hormonal or sex reassignment surgery, an individual was required to seek counseling, (which involved a thorough evaluation and assessment), and adhere to a rigid set of procedures defined in The Standards of Care, developed by Harry Benjamin,

International Gender Dysphoria Association (Meyer et al. 2001). A candidate for hormonal therapy or sex reassignment was required to receive counseling for one year and to obtain letters of recommendation by qualified mental health professional. The person was also required to live as their desired gender for one year. It is easy to understand why someone seeking to change their anatomical sex to match their gender would view the psychiatric and medical professional with a great deal of suspicion, and many viewed the health care professional as gatekeepers or regulators. Many others are simply not interested in fitting into our binary gender society, but have adopted total self-acceptance.

Feinberg (1998) advocated that transsexual persons should come out and identify themselves as transgender. Hill (1997) noted that the majority preferred to identify themselves as transgender and did not want to reedit their biographies or to pass in mainstream society. Transgender activist Feinberg (1998) declared, “we are oppressed for not fitting these narrow social norms, and we are fighting back” (p. 5).

The current attention appears to have shifted from using hormones and/or surgical procedures to allow the transgender to fit his or her gender, to affirming the uniqueness of the individual. Many transgender today seek “to define themselves rather than asking or allowing themselves to be defined by professionals”, and thereby “do as little or as much as they wish to their bodies” (Denny 1997, p 37). The International Bill of Gender Rights, developed at the 1993 Conference on Transgender Law and Employment Policy, specifically stated the individual’s right to “freedom from psychiatric diagnosis and treatment”. Members of this community have a long history as victims of social, political and economic repression and discrimination. Through organization and activism, they

currently seek the same freedoms, justice and equality enjoyed by members of the majority binary gender community.

The problem areas for counselors are numerous. In writing this paper, I found a poverty of professional discussion, information and treatment recommendations regarding the transgender person. The most obvious question that arises is whether or not counselors have the awareness, knowledge and skills, and are adequately prepared to deal with members of this complex population.

Gender is all that we are, all that we do. In our society only two genders are recognized, masculine and feminine. Likewise there are two birth sexes (excluding intersex), male and female. One cursory examination of a newborn baby, and the child's sex can easily be discerned by the absence or presence of genitals. Males behave like males, and females behave like females. However, there are some biological males that identify as females, and conversely, some females that identify as males. For most of the population, living within the norms and expectations of society as relates to our assigned sex is not an issue. We fit in, so to speak. We are what society expects us to be in our role as male or female. But for many living in this strictly binary sex/gender society and attempting to pass or fit in, there are monumental problems and issues to include severe and chronic emotional stress and psychological issues.

These individuals are said to have a Gender Identity Disorder, or more commonly referred to as Transgender. Transgender persons are those who discover their gender identity, (that is the self-sense of being a male or female), in conflict with their anatomical sex (Mallon 1998). Novelist Leslie Feinberg (1996), in answer to the question,

"are you a guy or girl?" quipped, "the answer is not so simple, since there are no pronouns in the English language as complex as I am…" (p ix). In a later publishing Feinberg (1998), observed, "our lives are proof that sex and gender are much more complex than a delivery room doctor's glance at genitals can determine, more variegated than pink or blue birth caps" (p. 5).

Traditionally constructed boundaries defining binary gender categories leave people identifying as intersex, transsexuals or transgender identities dismissed as either a medical or psychiatric pathology. Gender Identity Disorder is listed in The DSM-IV-TR, which implies a psychological pathology; however, individuals with intersexed conditions have been excluded (APA 2000). It would seem therefore that the gender variant community has been effectively divided into two classifications by the scientific and medical community, either a candidate for sex reassignment surgery or mentally ill. Such classification contributes to the stereotype of a gender variant person as being socially deviant. Because the gender variant persons do not conform to the hetero-normative expectations of contiguous sex and gender categories as exclusively male or female, they have been pathologized by the greater society.

There are differences between gender, sex and sexuality, although our society does not make concrete distinctions. However, since the three are so closely intertwined, it is difficult to consider one without considering the others. What does a lesbian look like or a male homosexual? Without visible cues, it would be impossible to recognize a person with a different sexual orientation. However, one's gender identity as an expression is a visible cue and one that society uses as clues into a person's sex-gender-sexuality.

Even visible cues can be misleading. Transgender persons have a gender identity that is incongruent with their biological sex, yet because they are perceived as being homosexuals, they are frequent targets of homophobic assaults. Additionally, they are diagnosed by the medical and psychiatric community and given labels such as Gender Identity Disorder or Gender Dysphoria simply because they have a more fluid notion of gender. These reactions are based on beliefs that one's gender and sexuality are determined by one's biological sex.

Gender theories such as Essentialism and Social Constructionism rely on the argument of nature and nurture as etiology for the intersex, transsexual and transgender, whose identities develop in spite of their physical biology and often in opposition to their gender socialization.

The social perception that sex-gender-sexuality is linked is a fallacy (Diamond 2000; Dreger 1998; Kessler 1998; Fausto-Sterling 2000). Research in the past decade has spawned theories which argue against the traditional sex-gender dualism (Fausto-Sterling 2000; Califia 1997; Burke 1996). Research is also offering theories explaining the differentiation between sexual orientation and libido from gender identity (Sedgwick 1990). Sexuality may be an expression of gender, but it is not determined by it. Accordingly, while gender may well be an expression of one's biological sex, it is not always the case; and gender identity should not be mistaken as biologically determined (Haynes and McKeena 2001; Fausto-Sterling 2000). As stated earlier, in our society, there are only two sexes, male and female, and two genders, masculine and feminine. This perspective leaves no room for other gender

identification, or variant expressions of gender that fall outside the binary categories of male and female.

For individuals whose gender identity is congruent with their biological sex, identity may not be particularly salient. However, individuals whose gender identity is inconsistent with their biological sex will almost certainly face resistance and opposition to their identity and expression. Such encounters may be traumatic and confusing.

Transgenderism, Transsexuality and Intersex conditions have received attention from scholars investigating the nature of sex, gender, and sexuality, but not all academic research has been constructive or helpful to those claiming these identities (Cromwell 1999). Scholars frequently treat these identities from a theoretical viewpoint to demonstrate the social construction of gender rather than as a lived experience and as a site of systemic erasure and resistance (Feinberg 1996; Califia 1997). Gender variance is a major theoretical and conceptual focus for creating interdisciplinary perspectives on sexuality and the social roles as well as medical processes that result in the erasure of transgender, transsexuals and intersex lives. Medicalization hides these identities at birth through often times, multiple surgeries. The psychiatric community applies diagnoses of Gender Identity Disorder. The medical and psychiatric community recommends treatment protocols that alter the body. For many, shame and secrecy are eminent.

This purpose of this project was to create an increased awareness of this often underserved population of the transgender, made up of females and males whose world is not so black and white, or pink or blue. These are the people who know or suspect the answer to the question, “are you a guy or girl?” But, the answer given is in contradiction to their physical bodies.

Chapter One defines the terminology and conceptual framework associated with this population, and will briefly report on the history of the transgender community.

Chapter Two reviews a brief history, thereby providing a better understanding of the transgender movement, especially during the nineteenth and twentieth centuries.

Chapters Three and Chapter Four will consider nature and nurture as possible causalities by exploring influences of genetics, biological and cultural influences. A brief review of the Psychosocial, Social Constructionism and Essentialism Theories is examined to develop a better understanding of constructs.

Chapter Five looks at the life of a transgenderist. A physically normal male, born XY, and raised during the formative and impressionable years as a female, awakes in middle age to yearnings of becoming a female. The interplay of nurture and activational hormones are evident in this individual, as is her determination to affirm her identity.

Chapter Six is a discussion of clinical issues and the implications for counselors. Specifically, the following will be discussed: (a) Implications for counselors, (b) Gender Identity Disorder as the presenting issue, (c) Co-morbid issues, and (d) Countertransference.

Although there is a paucity of counselor specific, practical information and recommendations for treatment of the transgender, there is a wealth of information on the history of the transgender movement. Much valued information has been gathered from the fields of anthropology, sociology, and psychology. The medical and scientific literature was used to explore the genetics and biology of the transgender; but the most revealing and perhaps the most valuable was the information gathered from publications authored by members of the transgender community.

CHAPTER 1

DEFINING GENDER AND THE TRANSGENDER

Is it a boy or is it a girl? One cursory examination at the moment of birth and a child's sex is assigned based on the presence or absence of a penis. From that moment the child is propelled down a life long road saddled with societal norms and expectations. Blue for males, pink for females. Fire trucks and wagons for boys, dolls and kittens for girls. Males should behave as males and females should behave as females, all according to our strict binary Western culture. And so it goes for the individual's lifespan. For the majority of our population, this does not present a problem. I am anatomically a male, (or female), I feel like a male, (or female), and my role or behavior is consistent with what males, (or females) do. Therefore, I am in harmony with my sex, my identity, and my role as male or female.

For some, they know with conviction the answer to the question, "are you boy or girl?" But to give an honest answer would be in contradiction to the reality of the bodies with which they were born. Some will suffer in silence throughout life; others will struggle to bring their bodies and how society treats them into alignment with who they know they are. Still others will accept their identity and attempt to fit into a narrow-minded society who only recognize male and female with respective identity and role. Often regarded with suspicion and curiosity; often subjected to humiliation and name calling; often suffering violence; often enduring open and blatant discrimination; these are the people of our society who see themselves, and are seen by society as neither male nor female, but as something more like a

third gender. Because gender identity is multidimensional and there are only two designated categories of gender, some people clearly will not fit into either designated category; and, coming to terms with their gender incongruence and expressing that to others can be a daunting experience (Gagne, Tewksbury, and McGaughey 1997).

Who are these people? This community includes cross dressers (transvestites), pre and postoperative transsexuals, intersexed persons and those who are not interested in passing society's norms. There are many labels for persons with non-traditional gender identities. A few of the terms used to describe this population are trans person, transgender, gender variant, and gendered dissonant. Some of the other terms used to identify members of this community are gender-bender, gender-trash, gender-queer, gender-outlaws, third gendered and transsexual lesbians.

This chapter will define the commonly used terms associated with this diverse and emerging community. For the purpose of this paper, and for brevity, the terms transgender, transgender persons or transgenderist will be used for the entire gender variant community. According to Lombardi (1999), the term transgender was originally used to differentiate between those seeking surgery because of gender incongruence, and those not pursuing surgery. Currently the term is accepted to include all persons whose gender identity or expression is incongruent with their anatomy regardless of surgical intent (Bullough 2000).

The term transgender is sometimes used as a less offensive synonym for transsexual. One obvious reason is that it removes the conceptual image of sex in transsexual an implication that transsexuality is sexually motivated, which of course it is not.

A problem that arises with the use of the term transgender is that it may cause confusion between the person who is transgender and the person who is transsexual. Another problem is that some transsexuals reject the term transgender as identification for themselves, because it marginalizes their identity, their history and their very existence. Another argument is that transsexuals view transgender as the breaking down of gender barriers, in that transsexuals usually identify themselves as men or women, (just not as they were assigned at birth), and transgenders do not identify as either male or female.

The term transsexual implies a reference to a process of chemical or surgical modification. Certainly this process does not make a person capable of reproduction after the transition. For this reason, some feminists contend that the transsexual's transition is merely cosmetic, and they are not changing their sex at all, therefore the use of the term transgender is more appropriate. The strong argument presented by the feminist group is that being able to reproduce is what distinguishes men from women; therefore a transsexual woman looses any claim of identification or association with other women.

The terms sex and gender are frequently used interchangeably however, medically and scientifically, they are not synonymous. Sex is defined by the gonads or potential gonads. Sex is also a legal term and is usually assigned at birth based on external genital appearance. In the case of an intersexed infant, one sex may be chosen over another with the good intentions of making an easier life for the individual in terms of socialization and rearing.

In our Western dualistic culture, there can only be two birth-sex possibilities, male or female. According to Cassell (1997), this perspective is known as the biblical norm of sex.

Therefore, when we refer to birth sex, we are referring to the sex as defined by a person authorized to make such determination based on a visual recognition of the genitals. The only way to interpret the genitalia is within this biblical norm and thus as either anatomically male or female (Cassell 1997).

While sex is physical and therefore easily discernible, gender is an intangible, psychological quality that cannot be measured or observed. Webster's (2002) defines gender as, "the fact of being a male or a female human being, especially with regard as to how this affects or determines a person's self-image, social status, goals, etc." Not surprisingly, sex is listed as a synonym Many documents have completely eliminated the word sex and in its place the word gender appears. Because these two words are so often used interchangeably, there is confusion. The Encyclopedia Britannica Online (2001) defines gender as, "an individual's self-conception as being a male or female, as distinguished from actual biological sex. For most persons, gender identity and biological characteristics are the same. There are however, circumstances in which an individual experiences little or no connection between sex and gender…" Perry (1988, p.8), stated that "gender is defined here as the cultural construction of femininity and masculinity as opposed to the biological sex (male or female) which we are born with." Goffman (1979, p.1), defined gender as "the culturally established correlates of sex", while Weiten (1997) referred to gender as "culturally constructed distinctions between masculinity and femininity." Possibly the best definition is that of Dr. Benjamin (1966), who writes, "Gender is the nonsexual side of sex. As someone once expressed it: Gender is located above and sex is located below the belt."

How important then is one's gender? In answer to this question, Bornstein (1994,) wrote, "There is most certainly a privilege to having a gender. Just ask someone who doesn't have a gender, or who can't pass, or who doesn't pass. When you have a gender, or when you are perceived as having a gender, you don't get laughed at in the street. You don't get beat up. You know which public bathroom to use, and when you use it, people don't stare at you or worse. You know which form to fill out. You know what clothes to wear. You have heroes and role models. You have a past", (p. 127).

There can be no question that gender and one's anatomical sex are two distinct elements, each developing at different times in different parts of the person. Gender may well be the most basic thing, the foundation if you will, of our personality make-up. If gender is the foundational block of who we are, what we are and how we behave, what is gender identity?

Gender Identity in its simplest term is our classification of ourselves as male or female, boy or girl; a person's private, subjective sense of his or her own sex. Money et al., (1955), coined the term gender identity and defined it as: "The sameness, unity and persistence of one's individuality as male, female, or ambivalent, in greater or lesser degree, especially as it is experienced in self-awareness and behavior; gender identity is the private experience of gender role, and gender role is the public expression of gender identity, while gender role is defined as everything that a person says and does, to indicate to others or to the self the degree that one is either male, or female, or ambivalent; it includes but is not restricted to sexual arousal and response."

As stated earlier, for most individuals congruence between their biological sex and their gender identity is not an issue. But for those with a sense of difference between their anatomical sex, (male or female) and what they recognize themselves to be, (masculine or feminine) can be confusing and many seek answers of causality. Money (1995), described this phenomenon with the term Gendermaps, defined as an entity, template, or schema within the mind and brain that codes masculinity and femininity and androgyny. This map or coding imprint is established very early in life through an interaction of nature and nurture. Money (1995) believes because this gendermap development is highly influenced by hormones from the developing fetus, sex and gender identification is closely matched. But like most aspects of being human, there are no guarantees. As a result, an individual may as early as the age of four find themselves aware of being caught between having the anatomy of one sex but being equipped with a gendermap much more typical of an individual of the opposite sex.

Since gender identity is the subjective sense of one's own sex, it cannot be proven or displayed to others. It is as real as one's physical sex, yet in the case of the transgender, it is just not recognized in our culture. When a person's psychological dynamics are incongruent with their anatomical sex, that person is termed Gender Dysphoric. These individuals are often confused, uncertain, or disorganized in their concepts of themselves as males or females. They often exhibit behaviors that appear to conform to societal norms and expectations, but many will have unclear or unstable gender identities and lack appropriate gender role behaviors.

While later chapters will present the etiology of gender identity in more detail, I feel that a brief address of the subject at this point will afford a better understanding. The formation of gender identity and the acquisition of culturally prescribed gender role behaviors are complex and understanding of the processes is limited. Money and Ehrhardt (1972), and Money and Lamacz (1989), established that outcomes in this area are powerfully determined by learning--that is by adapting to a host of psychosocial forces that are normally effective in shaping a person to be psychosocially male or female.

The argument for psychosocial influences is strong in determining gender identity and role, however there is evidence from both human and animal studies that show biological and genetic factors are also importantly involved. When considering the incidence of transgenderism in light of strong societal rejection, the role of psychosocial and biological/genetic influences offers insight into why some individuals remain strongly driven to adopt variant behaviors despite the condemnation and negative consequences related to them. It is easy to conclude that they have very little choice in the matter.

Gender variant individuals have been described either by themselves or others as falling into three distinct groups: cross-dressers, (transvestites), transgenderists and transsexuals.

Transvestism (Tvism), is a term probably first used by the German sexologist, Doctor Magnus Hirschfeld , in his published book, Die Transvestiten, (Benjamin 1966). He used it to describe a group of people who habitually and voluntarily wore clothes of the opposite sex. This group consisted of males and females who were heterosexual, homosexual, bisexual and asexual preferences. Although transvestites, (cross dressers), are included

within the umbrella of the transgender community, an important distinction is made. Cross dressers are individuals with a desire to wear the clothing of the opposite sex, but in general do not have gender incongruence. Most transvestites are males with male gender identities, male gender roles, and heterosexual orientation who dress occasionally in women's clothes for purposes of sexual arousal, anxiety management, or self-soothing. A common cause for periodic cross-dressing derives from the use of women's garments to console the man against the dreaded loss of the mother; i.e., it assuages separation anxiety, (Bradley 1985, pp. 175-188). Although many may fantasize about becoming a woman, there is congruency between their sex, their gender identity and their gender role.

Transsexuals are men and women whose gender identity more closely matches the other physical sex. Often described as being trapped in the wrong body, transsexuals have a strong desire to rid themselves of their primary and secondary sexual characteristics and live as members of the other sex. They often seek to permanently change their bodies to match their personal gender identity, through sex reassignment surgery, hormones, or both. Transsexuals may display an unrelenting and high degree of gender dysphoria from an early age, or they may come to the full realization of their gender dissonance in early adulthood. Cross-dressing or a sense of being a transgenderist is likely to be a phase for those not acting on their feelings until much later in life. Transsexuals are also described as being pre-op (plan to have the operation and are on hormones), post-op (have had the operation and are on hormones, or non-op (do not plan to have the operation and are on hormones). In all cases, the transsexual lives the lifestyle of his or her self-perceived gender.

Virginia Prince coined the term transgender in the 1970s. In its original meaning, it provided a contrast with the term transsexual, and was used to refer to someone who did not desire hormones or surgical intervention to change his or her sex. It was also used for those identifying as neither male nor female, but considered themselves to fall somewhere between masculine and feminine. These individuals feel that the gender assigned at birth, (based on physical appearance of their genitals), is a false or incomplete description of them. They may or may not have had sex reassignment surgery and/or hormonal treatment, and may or may not have any interest in doing so.

Transgenderist are men and women who prefer to steer away from their gender role extremes and perfect an androgynous presentation of gender. They incorporate elements of both masculinity and femininity into their appearance. Some may see them as male, others as female. They may live part of their life as a man, and part as a woman, or they may live entirely in their new gender role but without plans for genital surgery. A newer term is gender queer, which refers to the mixing of qualities traditionally associated with masculinity and femininity. It can also refer to the in between sense associated with transgender or transgenderism.

Another category of gender variant individuals is the intersexed. Intersexed individuals are also known as hermaphrodites, and refer to defects in sexual development that result in dual or ambiguous sexual anatomy. The word hermaphrodite has its origin in the Greek language. Hermes, in Greek mythology was known as a messenger of the gods, the patron of music, the controller of dreams or the protector of livestock; and Aphrodite, was the goddess of sexual love and beauty. These two gods parented Hermaphroditus, who

became half male, half female when his body fused with the nymph Salmacis, resulting in one being possessing physical traits of both sexes, (Grumbach and Conte 1998).

Although the anatomical presentation can be varied, a hermaphrodite usually displays both sexual organs at birth. Intersex is also an umbrella term used for the three subgroups, all with some mixture of male and female characteristics.

Fausto-Sterling (2000) referred to the three groups as herms, (the true hermaphrodite), merms (male pseudohermaphrodite), and ferms (female pseudohermaphrodites). The true hermaphrodite possesses one testis and one ovary. In some cases the testis and ovary grow separately but bilaterally; in others they grow together in the same organ, forming an ovo-testis. It is not uncommon for one of the gonads to produce either sperm or eggs, and androgen or estrogen. The pseudohermaphrodites possess two gonads of the same kind and have the male (XY) or female (XX) chromosome makeup. However, the chromosome makeup does not match their genitalia and secondary sex characteristics. The merms (males) have testes and XY chromosomes, and they also have a vagina, clitoris and sometimes develop breasts. Ferms (female) have ovaries, XX chromosomes, and may have a uterus, but they also may have partially masculine external genitalia. In the absence of medical intervention, they can have adult size penises, grow beards, and develop deep voices.

Myth or reality? According to Harvey (1997), Plato allowed Aristophanes the opportunity to speak on the concept of the power of love. Aristophanes says, "…for one thing, the race was divided into three; that is to say, besides the two sexes, male and female, which we have at present, there was a third which partook of the nature of both, and for which we still have a name, though the creature itself is forgotten. For though hermaphrodite

[now called intersexed], is only used nowadays as a term of contempt, there really was a man-woman in those days, a being which was half male and half female…The three sexes, I may say, arose as follows. The males were descended from the Sun, the females from the Earth, and the hermaphrodite from the Moon which partakes of either sex…" (p. 32).

Is there a third sex, third gender? It is evident from mythology and history of the early Greek culture that they believed in this concept. Herdt (1996) believes this concept of third sex/third gender has been lost between the early Greco-Roman era and present day. In answer to the question, we know that there is a population of individuals living in Western culture and elsewhere whose birth sex by all rights should be defined as other than male/female in spite of our strict dualistic perspective of only two sexes, two genders.

Adhering to the biblical norm of sex, a baby born with multiple genetalia or atypical genital anatomy presents problems for the medical community. For years a baby born with genital abnormalities was surgically sexed, often without the parents knowledge that their child was intersexed and without their consent. Terminology such as nondominant genitalia or micro phallus is often used to remove the stigmatization of intersexuality. The well-meaning aim of the medical community is to assist the baby physically and psychologically to fit in, but once again fit into society's norms of either male or female.

Nature as causality is discussed in a later chapter, so only a brief explanation will be given here as to the flexible gender identity of the intersexed. Some consider themselves to be both male and female, while others believe that hermaphroditism is a unique third gender and they are neither male nor female. In the case of Congenital Adrenal Hyperplasia (CAH), the XX female fetuses' exposure to the hormone androgen results in the genitalia being so

masculine that male sex is mistaken at birth. The female would have ovaries, so the gonadal sex would be in agreement with a female gender identity. Because of the exposure to androgen the brain bias may be more male, and the gender role is typically more masculine, with rougher play and preference for male activities. In the case of Androgen Insensitivity Syndrome (AIS), virilization of the male fetus does not take place, and the fetus continues to develop as female. At birth, the XY males have external female genitalia and appear to be normal females. The vagina is short and the baby has no ovaries or uterus. The gender identity and gender role are incongruent with the biological sex. Typically this person would have a female gender identity.

Fausto-Sterling (1992) has suggested there should be at least five categories of sex, i.e., males, merms (male pseudohermaphrodites); herms (true hermaphrodites); ferms, (female hermaphrodites), and females. Subscribing to the notion that sex is multidimensional and complex, a reasonable theory then is suggested that gender is also more than the accepted two categories of masculine and feminine. In looking at gender as binary categories, we see a description of either/or. You are either masculine or you are feminine. If viewed as a binary continuum, it allows for someone to be a blend of both masculine and feminine, and thus a third category of androgynous. If androgynous in gender identity and expression, one would be less masculine that someone whose identity and expression is masculine, and less feminine that one whose identity and expression is feminine. Thus gender identity is better understood if it is viewed on a continuum. For example, Eyler and Wright's (1997) "nine-point continuum" (p.8), labels gender identities along a continuum as follows: (1) Female, (2) Female with Maleness, (3) Gender Blended (female predominating), (4) Other

ungendered, (5) Ungendered, (6) Bi-gendered, (7) Gender Blended (male predominating), (8) Male with Femaleness, (9) Male. This scale is especially useful in developing a clearer understanding of the multiple identities; avoiding confusion of the terminology; and in assisting the client who presents with uncertain gender issues in terms of creating an increased sense of awareness of their gender identities and roles.

This chapter has defined some of the more common terminology associated with this diverse and emerging population. Transsexuals, Transvestites, Intersexed and Transgender were discussed as being members of this community. Gender was discussed in terms of being varied and complex, with multiple identifications. The next chapter will present a brief history of the gender variant progression.

CHAPTER 2

A BRIEF HISTORY

The concept of cross-dressers, transsexuals, intersexed and transgender is not new. Much evidence of gender variance can be found in records almost from the beginning of time and spanning all cultures. Because the descriptive terminology has been created in modern times, inferences must be made in interpreting available information.

One of the earliest references to gender variance can be found in the Bible. The following passages are taken from the King James Version of the Bible:

> Speak unto Aaron, saying, Whosoever he be of thy seed in their generations that hath blemish, let him not approach to offer bread of his God. For whosoever man he be that hath a blemish, he shall not approach: a blind man, or a lame, or he that hath a flat nose, or anything superfluous, or a man that is broken footed, or brokenhanded, or crookedbacked, or a dwarf, or that hath a blemish in his eye, or be scurvy, or scabbed, or hath his stones broken. Lev. 21:17-20. And, He that is wounded in the stones, or hath his privy member cut off, shall not enter into the congregation of the Lord, Deu.23:1.

Stones as mentioned in the Bible is defined as testicles. Could this be construed as being emasculated? If so, one could therefore easily conclude the passages are referring to transsexuals who, as have been discussed desire to be women so much that they alter the appearance of their bodies through hormones and surgery. The most common type of sex reassignment surgery, (SRS), is the transition from male to female. During this procedure the penis is cut off and turned inside out to form a neo-vagina. The scrotum is split down the middle, the testicles and prostate are removed and the scrotum is formed into the new labia. Another term for men who have been emasculated by cutting and referred to often in the Bible is eunuch. Inference may also be made to the intersexed. Drawing once more from the

King James Version of the Bible, Jesus addressed his disciples regarding marriage:

> For there are some eunuchs, which were so born from their mother's womb: and there are some eunuchs, which were made eunuchs of men: and there be eunuchs, which have made themselves eunuchs for the kingdom of heaven's sake. He that is able to receive it, let him receive it. Mat 19:12.

The King James Version of the Bible offers yet another inference, this time to cross dressers:

> The woman shall not wear that which pertaineth unto a man, neither shall a man put on a woman's garment: for all that do so are abomination unto the Lord thy God. Deu. 22:5.

There are also numerous descriptions of transsexualism from classical mythology, classical history, the Renaissance, and nineteenth century history, plus many sources of cultural anthropology (Green 1969). The Greek Goddess, Venus Castina, responded with sympathy and understanding to the yearnings of feminine souls locked up in male bodies (Bulliet 1928 p. 13). The story is told of Tiresias, a Theban soothsayer who was walking on Mt. Cyllene and came upon two snakes coupling. He killed the female and was punished for his action by being changed into a woman. Sometime later, he was reflecting on his new form and made the comment that a woman's pleasure during intercourse was ten to man's one, and he was changed back into a man as an additional punishment (Green 1969).

In Greek and Roman history, there are several accounts of men so discontent with their gender role that they amputated their genitals. The Jewish philosopher Philo wrote, "expending every possible care on their outward adornment, they are not ashamed even to employ every device to change artificially their nature into women…some of them so craving a complete transformation into women, they have amputated their generative members." (Masters 1966). The Roman Emperor Nero is said to have killed his pregnant

wife in a fit of rage. Nero supposedly searched for someone whose face closely resembled his dead wife's, and chose a male ex-slave named Sporum. Nero then ordered his surgeons to transform Sporum into a woman, and they became married. Heliogabalus, another Roman Emperor was reportedly married to a powerful slave and performed the tasks of a wife. It was reported that he took great delight in being called mistress, wife and Queen of Hierocles; and offered half of the Roman Empire to the physician who could transform him with female genitalia (Bulliet, 1928).

French history also records a number of gender variant individuals. King Henry III, who wished to be considered a woman, appeared before his Deputies dressed as a woman. King Henry III was referred to as Sa Majeste, which means her majesty. The Chevalier d'Eon dressed as a female rival of Madame de Pompadour as a mistress for King Louis XV. The King appointed the Chevalier to a position of trust as a diplomat and sent him to Russia on a secret mission disguised as the niece of the King's agent. He later returned to Russia to complete the mission dressed as a man. After the death of King Louis XV, he lived permanently as a woman (Green 1969).

Gender variant behavior and identity from several cultures is well recorded in anthropological studies. One subgroup of India's culture is known as the Hijra. The Hijra, either born with ambiguous genitalia or castrated at birth are eunuchs and are reared from childhood as neither male nor female. Because they have no testes and must strictly adhere to their custom, their gender role is female. However, they are afforded a prominent and unique status as a separate subgroup. They have a distinct role in society and are considered mystical. Their existence has been recorded for centuries (Green 1969). There are reports of

tribes in Africa and New Guinea where male individuals are raised for several years in a female gender role, only to switch back to a male gender role at the time of puberty. Even the North American Indians had "men who dressed themselves in the clothes and performed the duties of women…" (Westermack 1917). Berdache is a term applied by the early colonists to North American Indians who behaved like women. The term is considered derogatory and has been replaced by the word "Two Spirit" (Feinberg 1996, 21). Berdaches in the Yuma culture married men, and performed women's functions. The Yuma tribe also had females who dressed like men, married females, and performed male duties. Tewa Indians identify as women, men and kwido, although their New Mexico birth records recognize only males and females (Jacobs and Cromwell 1992). In Africa, intersexual deities and sex/gender transformations have been documented among many tribes. In Brazil and Haiti cross-dressing is practiced in ceremonies. Male-to-female shamans have been reported in Argentina, Chile and Venezuela. In all Asian societies, transgender identities and practices have been documented (Feinberg 1996).

Transgenderism has obviously always existed in some form and across all cultures. However, it was not until the 1800's that sexologists began the classification of what they called the "sexual perversions" (MacKenzie 1994). Dr. Richard von Krafft-Ebing, a German began studying the prevalence of gender divergence among the homosexual population, and coined the term gynandry to describe the phenomenon. Dr. Krafft-Ebing's research led to a description of what he called "metamorphosis sexualis paranoia", meaning that a homosexual believed himself or herself to be one of the opposite sex. Krafft-Ebing also thought that homosexuality was a delusion and a mental illness. There was confusion among sexologists

due to an attempt to categorize sexual deviations. Cases that by today's standards would be defined as transsexual, were placed in the categories of homosexuality, sexual perversion, eonism, androgyny, psychic hermaphroditism, and transvestisim. Within these categories were the sub-categories of cross-dressing, effeminateness, congenital sex inversion, antipathic sexual instinct, transmutatio sexus, transformation of sex and metamorphosis sexualis (MacKenzie 1994). In seeking treatment, prevention and cures, Kraft-Ebbing held that transgenderism and cross-dressing were symptoms on the road to insanity and a sexual abnormality. Transgenderism and cross-dressing were considered deviant and dangerous behaviors and presented a problem to the established norm of heterosexual behavior. Transgenderism and cross-dressing were also seen as a threat to the gender binary. Transgenderists and cross-dressers were frequently treated with cold baths and intellectual retraining; and the legal consequences included expulsion from universities, institutionalized and in some instances, death.

In seeking the etiology of transgenderism and cross-dressing, many sexologists believed the symptoms the same as homosexuality that is, congenital, hereditary, or acquired. Krafft-Ebing strongly believed in the congenital theory, that transgenderism was the result of glandular, endocrine based or some physiological abnormality. In his attempt to prove his theory, he performed autopsies on deceased transgenderists, and also measured the hips, pelvises, skulls, faces, and ears of the living for comparisons.

Heredity as a cause of transgenderism was investigated during this period. Theories that transgenderists and cross-dressers had inherited a sexual perversion from insane parents or relatives were stressed. Consequently, transgenderist were warned not to marry or have

children. Because it was theorized that transgenderism and cross-dressing were incurable, prevention was stressed and included instructions to the transgenderists not to masturbate or succumb to homosexual desire. Above all else, heterosexuality was encouraged (Krafft-Ebing 1922, p. 450). In cases of acquired transgenderism and cross-dressing, they were instructed to masturbate to excess or to be seduced by an invert or another transgenderist. Other treatments were the use of hypnosis and recommendations for marriage. For those categorized as antipathic sexual inversion, described as, "men in women's garb and women in men's attire who psychically consider themselves to belong to the opposite sex," Krafft-Ebing advised hypnotherapy and often in conjunction with hydrotherapy (Krafft-Ebing 1922, p. 457).

Also in the mid 1800s, Karl Ulrichs, a German lawyer and advocate of homosexual rights, refuted the notion that same-sex acts were crimes against nature. Ulrichs opined that male homosexuality was the result of a feminine soul in a male body and that female homosexuality was the result of a masculine soul trapped in a female body. Ulrichs argued that "love directed towards a man must be a woman's love" and as such must not be considered a crime against nature (Kennedy 1980-81, pp. 105-07). Ulrichs believed that individuals who cross-dressed or expressed the gender role of the opposite sex were expressing their true spirit. Ulrichs also believed that homosexuality was genetic or inherited.

The first real pioneer in the field of transgender issues was Doctor Magnus Hirschfeld. Hirschfeld was the first to systematically describe and work with cross-dressers and transgenderists. He considered the transgender and transsexual person to be a form of

intersexed along with homosexuals. Dr. Hirschfeld was openly gay and a cross-dresser who devoted his life to the study of sex and gender. He was well known to fight for the rights of cross-dressers and transgenderists, and was successful in getting the Berlin police to issue permits allowing transgenderist to cross-dress and cross-live (Katz 1976). Dr. Hirschfeld was the first to describe transgenderism as he coined the terms transvestism and transsexualism. In 1910 he wrote a two volume monograph entitled, Die Transvestiten. In it he described the biographies of several gender variant individuals who would likely be classified as transsexuals. Dr. Hirschfeld founded the Institute fuer Sexualwissenschaft, (Institute for Sexual Science) in Berlin, Germany, which became the first clinic to serve the transgender on a regular basis.

Dr. Hirschfeld argued that transvestism could be distinguished from homosexuality and other groups of sexual deviations. Hirschfeld suggested separate categories of cross-dressers or transvestites. Instead of looking at gender, Hirschfeld based his categories on sex behavior. The categories included asexual transvestites, narcissistic transvestites, bisexuals, homosexuals and heterosexuals. The term transvestite was used to describe transgenderists, cross-dressers and transsexuals. It was not until many years later that the term transsexual began appearing in medical literature.

Hirschfeld, interested in a surgical solution to his cases, began working with a Vienna physician, Eugen Steinach. Steinach had over forty years experience in gonadal experimentation in attempts to treat sexual disorders including homosexuality and transvestism. Steinach was the first to suggest that the sex glands contained secretions that

made men act like men, and women act like women. Many years later, androgens and estrogens would be discovered.

The first complete male-to-female sex change operation was performed in 1931, and it was performed based on the recommendation of Hirschfeld. Doctor Felix Abraham, who worked at The Institute for Sexual Science, performed the operation. The patient underwent castration nearly ten years before having a penectomy and construction of an artificial vagina.

The Nazis raided the Institute for Sexual Science in 1933. Hirschfeld's entire transvestite records were burned, his clinic destroyed and Hirschfeld was severely beaten and left for dead by the Nazis. He escaped to France and attempted to rebuild another clinic, however in 1935, he died.

Havelock Ellis, another sexologist, was the first to make a distinction between individuals who simply enjoy dressing as members of the opposite sex and individuals who desire to live as or become members of the opposite sex (MacKenzie 1994). Ellis disagreed with Hirschfeld's categorization of transvestites. Ellis argued that the act of cross-dressing was a behavior that freed the transvestite from their social disguise. For those who believed they were born into the wrong body, the act of cross-dressing validated their feelings. Ellis used the term aesthetic inversion to categorize the two types of cross-dressers and transvestites. The most common type was described as being confined mainly to the clothing of the opposite sex, and the less common described as the cross-dresser or transvestite identifying with and having a real sense of belonging as a member of the opposite sex. The

parallel of Ellis' categorizations of cross-dressers and transvestites and today's transsexuals and transgenderists is striking.

The contrast of ideologies among the early sexologists is clear. Krafft-Ebing viewed cross-dressing and transgenderism as a path to moral insanity, with no differentiation being made between the types of cross-dressers. His theory appears largely influenced by the psychoanalytic theory that viewed cross-dressers and transgenderists as homosexuals. Treatment of the cross-dresser and transgenderists was focused on a medical cure. Conversely, Hirschfeld and Ellis viewed cross-dressers and transgenderists as different categories, recognizing a difference between transgenderists and transsexuals. Both Hirschfeld and Ellis strongly advocated for legal reform and public tolerance for transgenderists and cross-dressers.

One of Hirschfeld's students was Harry Benjamin, who made significant contributions to sexology in general and transsexualism in particular. Benjamin was born in Berlin and had close connections to sex researchers in Europe. He met Hirschfeld in 1907 when he was still a medical student. His involvement in transsexualism and transvestism was inspired by the work of Hirschfeld. Encouraging his work also was Dr. Eugen Steinach, who as previously mentioned had experience and knowledge in the secretions of the sex glands and their effects on the person. Benjamin developed an interest in the newly breaking developments of endocrinology. He arrived in the United States in 1913 and joined the Neurological Institute of Columbia University and concentrated on the study of endocrinology. By 1949, Dr. Benjamin was sympathetically treating transsexuals with hormones in San Francisco and New York. Dr. Benjamin was best known for his work with

transvestites and transsexuals, having rejected the notion that transsexuals were either mentally ill or poorly adjusted homosexuals. He emerged as a leader in the field and published a groundbreaking book, The Transsexual Phenomenon (1966), the first comprehensive treatment guide for the transsexual. In 1979 a group of professional created the Harry Benjamin International Gender Dysphoria Association (HBIGDA), and created a standard of care (SOC) to ensure that only appropriate candidates could obtain surgery. Among the characteristics of a good candidate was adherence to a traditional, heterosexual feminine or masculine role. According to the standards, a candidate must first undergo psychotherapy before he or she can undergo hormone treatment, and must complete the real life experience of living full time as the desired gender. Many transsexuals lauded the standards, while social and political shifts created controversy. Some transgender people felt they should not have to jump through hoops to obtain medical treatment, and others oppose the traditional gender role requirement. Because of this controversy, the standards have been relaxed and the International Conference on Transgender Law and Employment Policy have declared that, "Persons have the right to express their gender identity through changes to their physical appearance, including the use of hormones and reconstructive surgery."

Two significant events in the 1950s increased awareness of transsexualism and transgenderism in America. First, was the news of an ex-marine returning home after a sex change operation; and secondly, Harry Benjamin received funding from the Erikson Foundation for transsexual research.

George Jorgensen, a former United States Marine traveled to Copenhagen, Denmark and had sex reassignment surgery. On December 1st, 1952, the New York Daily News broke

the story with the headline: Ex-GI Becomes Blonde Beauty. The new Christine Jorgensen was certainly not the first person to undergo SRS, but her sex change surgery illuminated the path for the emergence of transsexualism.

A second major event was when Harry Benjamin presented a paper on transsexualism at a medical conference, and used the term transsexual to describe a person who felt trapped in the wrong body. The use of the term by the media not only popularized the term, but also caused it to be implanted in the minds of Americans.

As a result of the Jorgensen publicity and the recognition by the medical community of Benjamin's announcement of a population who felt trapped in the wrong body, public awareness increased as transsexualism moved from relative obscurity to the public spotlight. Jorgensen and Benjamin had created an awareness of not only a distinct category, but also a distinct identity. Even though transsexuality was more prevalent in the 1950s and 1960s, it remained a mystery to the general public. Its occasional venture into the public's eye was still marred by sensationalism and incredulity. Due mainly to the Jorgensen publicity, the number of sex reassignment surgeries grew dramatically, as transsexuals now knew reassignment surgery was available.

In America, surgeons were fearful to perform sex reassignment surgeries, (SRS). SRS was not a medically recognized diagnosis, and could therefore be seen as being a crime, subjecting the surgeon to both criminal and civil liability. It was not until 1958 that a group of doctors performed feminization surgery on an intersexual woman at the University of California at Los Angeles. Reid Erikson was born a female and transitioned to a male under the supervision of Harry Benjamin, and founded the Erikson Educational Foundation for the

study of transsexualism. Johns Hopkins University, on a grant from Reid Erikson, started the first Gender Identity Clinic. In 1965, Phillip Wilson successfully underwent the first SRS surgery in the United States and became Phyllis Wilson. Over the next few years more universities opened gender clinics, and in 1969, the first private practitioner, Dr. Stanley Biber, began performing SRS. Transsexuals seeking services from Dr. Biber, were expected to conform to strict criteria before having SRS (Meyerowitz 2002).

Benjamin was among the first to recommend sex reassignment as the only effective treatment for transsexuals and was seen as a gatekeeper into the transsexual milieu (Califia 1997). Rather than propose a theory of causality, Benjamin admitted he did not understand the etiology of transsexuality. He did subscribe to the theory of imprinting as one such possibility and also suggested the possibility of prenatal hormonal influences (Benjamin 1964). Benjamin gave some degree of credence to early childhood conditioning, but remained opposed to simple theories of transsexuality. He rejected psychoanalytical theories as causality, postulating instead a constitutional existence of gender variance.

Benjamin (1964) did not view the transsexual's desire for sex reassignment surgery as a psychosis. He outlined a common sense approach of motives: the sexual motive (the desire of a normal woman to have sex with a normal man), the gender motive (the desire to live in the sex of preference, even if no intimate or romantic relationship is possible), the legal motive (to end the fear of being exposed or arrested for impersonating a woman), and the social motive (the desire of a genetic male with a feminine physique to end the harassment and embarrassment he experiences from other people who cannot tolerate his difference).

As mentioned earlier, for most of the Twentieth Century the psychoanalytical model was used as both explanation and treatment for the gender variant, in spite of the fact that psychoanalytic therapy was not successful in changing the transgender person. It is interesting to note, that in the case of an intersexed person, the system views it as right-mind/wrong-body, and deals with it as a medical issue by using surgery to correct the body. However in the case of a transgender person, the system views that phenomenon as wrong-mind/right-body and deals with it as a psychological issue. Perhaps that is the reason why Gender Identity Disorder continues to be listed in the Diagnostic and Statistical Manual of Mental Disorders, (DSM IV- TR) American Psychiatric Association (2000).

In 1979, the Harry Benjamin International Gender Dysphoria Association (HBIGDA) was formed, and its standards of care (SOC) adopted. The SOC outlined specific criteria for diagnosis and treatment. While the standards authorized medical treatment, it did not allow for surgery without having met certain requirements, i.e., recommendations from two licensed psychologist or psychiatrist prior to surgery. The SOC were guidelines for diagnosis and treatment, they were not legally binding. Thus during a decline in activism by transsexual advocacy organizations, psychoanalyst again raised concerns objecting to transsexual surgery.

Doctors in private practice discovered a lucrative opportunity and began to specialize in SRS, therefore with fewer restrictions and the increase availability of surgery, the numbers of people undergoing SRS increased. Also during the 1970s and 1980s, new activist emerged from the ranks of the transgender. New organizations were formed, peer counseling

was offered, and change was advocated at all levels of government. It appeared that the cloak of secrecy had been lifted as transgender themes began to appear on television and in movies. On radio and television talk shows, transgenders spoke to large audiences. During this period, the Erikson Educational Foundation had suspended most of its operations; Harry Benjamin and Christine Jorgensen had died; and while it may have signaled the end of one era, the emergence of the contemporary transgender movement in the 1990s, suggested a rebirth of the transgender movement.

During the 1990s, transsexual activist joined with transgenders, cross-dressers, intersexed, and any others who crossed traditional gender boundaries. New organizations were formed ranging from radical to conservative groups. The new activist insisted that HIBGDA revise its standards and include transgenders in its deliberations. Gay rights groups were petitioned to include transgender people in their political efforts. Violence, brutality and assaults of the transgender were vigorously protested. Activist advocated for inclusion of the rights of transgender people in antidiscrimination legislation. Conferences were organized for free expression of gender variance, they published newspapers and magazines in order to organize community and share information. The Internet allowed new opportunities to reach many people who may otherwise have been isolated.

Web sites and chat rooms have opened up the opportunity for transgender persons to communicate and support each other. The increased media attention and Hollywood movies of transgender persons have been enabling in term of increasing confidence and affirmation. Brandon Teena, a female-to-male transgender person was brutally raped and murdered after two male acquaintances discovered that he was biologically female, and became the focus of

the media and a popular film titled, Boys Don't Cry (Pierce 1999). Tyra Hunter, a pre-operative male to female transsexual was a passenger in a car, which was hit by another vehicle. When emergency personnel arrived, they first tried to rescue Hunter, but when discovering non-female aspects of her anatomy, one rescuer stated "this ain't no bitch," and another said "look, it's got a cock and balls." Instead of administering treatment, the emergency personnel stood around joking about her anatomy and Hunter died (Hampton 1995). Leslie Feinberg (1998), noted author and lesbian was refused treatment by a physician in a hospital emergency room. The publicity surrounding these and other hate crimes against members of their community has served to organize and motivate the transgender.

Many in the transgender community reject terms such as gender dysphoria, transvestic fetish, and gender identity disorder because the terms are perceived to pathologize and dehumanize gender variant persons. Because the medical and psychiatric professions have served as gatekeepers in the gender transition process, many transgenders view them with suspicion. Rather than conform to the strict requirements of the SOCs mentioned earlier, many transgender persons now seek to "define themselves rather than asking or allowing themselves to be defined by helping professionals, and thereby do as much or as little as they wish to their bodies" (Denny 1997, p. 37). During the conference on Transgender Law and Employment Policy in 1993, the International Bill of Gender Rights specifically included the right to "freedom from psychiatric diagnosis and treatment" reflecting the desire of many transgender not to have to conform to a prescribed regimen dictated by the medical and psychiatric professionals (Meyer et al. 2001).

People who will not or cannot meet expectations and requirements of their society are rejected by it, often with discrimination, aggression and violence. For all of us, existing within our society requires a balancing act between who we are and what society expects. The transgender must achieve a balance between brain, body and the expectations of society. Hormones and surgical intervention may allow some transgenderists to successfully pass without detection. However, others are not as successful. Many cannot afford the high cost of SRS, while for others it may be a matter of basic body morphology, which makes their attempt to transition more noticeable. Transgender activist have advocated that members of this community identify themselves as transgender and in doing so, "begin to write oneself into the discourses which have been written about us" (Stone 1991, p. 299). Hill (1997) noted that the majority of transgender preferred to identify themselves as transgender and did not want to "reedit" their biographies or to pass in mainstream society." Bockting (1997) noted that by affirming their identities as either transsexuals or transgender persons, persons with nontraditional gender identities could alleviate shame, isolation and secrecy that often accompany attempts to pass as a desired gender. Leslie Feinberg (1998) wrote, "we are oppressed for not fitting these narrow social norms and we are fighting back" (p. 5).

To summarize, transgender and its variations is an umbrella term used to describe people who do not fit into traditional categories, and includes transsexuals, transvestites or cross-dressers gender queers, intersexuals and other gender variant persons. A transgender person is someone whose gender identity or expression of gender does not fit the conventional expectations of masculinity or femininity. Gender identity is one's internal sense of being either male or female, and for most people there is no conflict between gender

identity and physical sex. Transgender people grow up questioning their gender identity, which differs from their physical sex.

Transgender people have been part of every culture and society in recorded history; however, they have only recently become the focus of medical science. Many researchers believe that transgenderism is caused from complex biological factors and are fixed at birth, and this theory affirms what the transgenderist already knows, that being transgender is not a choice.

Through research and experimentation with hormones, early pioneers paved the way for hormonal and surgical intervention that successfully changed the lives of many transgender people by matching their anatomical sex with their gender identity.

Because of financial constraints or body morphology, many transgender people have elected not to have SRS, while many others have affirmed their unique identities of being transgender and are simply not interested in fitting into our mainstream society.

In the following chapter, I will discuss the idea that gender is influenced by biological factors. To begin this discussion, it is necessary to define the terms sex and gender. Sex is a biological term referring to the functional differences between males and females and their reproductive potential. Genes in chromosomes determine a person's sex. Male and female are biological or legal terms, referring to one's physical anatomy. Gender is a psychological term that refers to our reaction and awareness of our biological sex, and is determined by biological, psychological and sociological factors, the latter of which will be presented in chapter four. In referring to a person's gender, we use the terms masculine and feminine.

The chapter will also discuss the effects of hormones on the development of the brain and behavior.

CHAPTER 3

THE ARGUMENT FOR NATURE

Gender development, specifically as it relates to gender identity, is an emotional and highly controversial issue. Professionals from the fields of medicine, psychology, sociology, biology, theology, endocrinology and others have varying views and theories regarding the etiology of gender variance. The debate of nature vs. nurture continues. Many maintain that gender identity is the result of the nurture we receive as a child. The nurture position holds that we are psychosexually neutral at birth and that socialization is responsible for the development of gender, (Money and Ehrhardt 1972). Still others assert that gender identity is influenced with biological factors in our nature. Thus, biological influences may be both genetic and environmental in the sense of biologically active environmental influences such as uterine environments, exposure to chemicals and exposure to infectious agents. An assertion of the nature view is that prenatal exposure to hormones, or the lack thereof, influences the development of gender identity, (Breedlove 1994).

The purpose of this chapter is to examine the genetic and biological determinants. This chapter is not intended to provide a review of Biology 101 in terms of the processes of reproduction and development. However, in order to have any discourse on gender identity, a foundation must be laid upon which to build the argument that gender identity may be strongly influenced by nature.

Coon (1997), discussed gender in terms of five dimensions, (1) genetic sex, (2) gonadal sex, (3) hormonal sex, (4) genital sex, and (5) gender identity, while Benjamin

(1966), identified nine, “concepts and manifestations of sex”, (1) chromosomal, (2) genetic, (3) anatomical, (4) legal, (5) gonadal, (6) germinal, (7) endocrine (hormonal), (8) psychological, and (9) social. While there is a variation of the concepts, both agree that it begins at the moment the male’s sperm enters the female’s egg, (ovum). The human sperm or egg cells, called gametes, contain twenty-three chromosomes each. When the sperm and egg unite during fertilization, the offspring will have a total of forty-six chromosomes in each body cell. Twenty-three will be received from the female and twenty-three will be received from the male. The twenty-third pair, known as sex chromosomes carry genetic codes that determines sex. Males have an XY twenty-third pair and females have an XX twenty-third pair. Two X chromosomes initiate development of a female; however for a male embryo to develop, something has to be added, and that something is a Y chromosome from the father. On one end of the Y chromosome, there is a region thought to contain a gene know as TDF, (Testes Determining Factor), that starts the process of the embryo becoming a male. This region of the Y chromosome is called the SRY, (Sex determining region of the Y chromosome). According to Dworetzky (1995), the Y chromosome has the effect it does because it is carrying the gene that determines gender. Sinclair et al. (1990), reported that, “the actual gene responsible for creating ‘maleness’ is sometimes absent from the father’s Y chromosome or present on the father’s X chromosome, causing rare occurrences in gender. Since it is only the male who can contribute the Y chromosome, the gender of the offspring is determined by the father’s sperm.”

The physical differences between male and female have been divided into two sexual characteristics, primary and secondary. Primary sexual characteristics refer to the sexual and

reproductive organs themselves: the vagina, ovaries, and uterus in the female, and the penis, scrotum, and testes in males. The secondary sexual characteristics appear at puberty in response to hormonal signals from the pituitary gland. In females, secondary sexual characteristics involve the development of the breast, broadening of the hips, and other changes in body shape. Males develop facial and body hair, and the voice deepens. These changes signal readiness for reproduction. Reproductive maturity is especially evident in the female menarche, the onset of menstruation. In The Transsexual Phenomenon, Dr. Benjamin (1966), viewed primary sexual organs as testes and ovaries, because they are directly concerned with reproduction. According to Dr. Benjamin, the secondary sexual organs are the penis, scrotum, prostate, masculine hair distribution, and a deeper voice in the male. The female characteristics are the clitoris, vulva, uterus, vagina, breasts, a wide pelvis, female voice, female hair distribution, and the usual feminine mental traits, described as shyness, compliance, emotionalism, and others.

All humans start off with the same basic body plan, (Gould 1991). For the first six weeks of gestation, there is no difference between a genetically female and a genetically male embryo, (Coon 1997). The SRY gene on the Y chromosome causes the fetus to release TDF, which turns the undifferentiated gonads into testes. Once testes have formed, they release androgens, (testosterone), and anti-mullerian hormone, also known as Mullerian Inhibiting Hormone, (MIH). Prior to the release of TDF, the developing fetus has two tiny structures, the mullerian and wolffian ducts, and two small undifferentiated gonads, neither testes nor ovaries. In the absence of TDF and testosterone, the gonads form into ovaries and the mullerian duct forms into the female internal sex organs. The mullerian duct then

disappears and the external sex tissue becomes the labia majora, clitoris, labia minora and clitoral hood. With the influence of testosterone and MIH, the gonads become testicles and the wolffian duct forms the male internal sex organs. The mullerian ducts dissolve and the external tissue develops into the penis, scrotum, penile sheaths and foreskin. Here an important point is made; the embryo will develop female external genetalia unless it is exposed to dihydrotestosterone, regardless of the genetic sex.

What do we know and what are the influences of genetics in terms of gender expression? First, we know that genes in chromosomes determine sex. Secondly, we know that genetic sex is fixed and unchangeable (Benjamin 1996). We also know that traditionally a typical female has XX chromosomes and a typical male has XY chromosomes, but we also know that there are many other combinations of chromosomes, each resulting in abnormalities that can have an effect on a person's gender identity. In rare cases there are females born who have XY chromosomes, and males born who have XX.

One variant combination is XXY, resulting in forty-seven rather than forty-six chromosomes. The condition resulting from this combination is known as Kleinfelter's syndrome. Because of the Y chromosome and its components, fetal development is that of a normal male. They are sterile, may have development of breast tissue, have rudimentary testes and penis, little or no facial hair and may be retarded (Dworetzky 1995). Another trisomy of sex chromosome twenty-three is the Supermale. This syndrome occurs when the fetus has XYY sex karyotype. In this abnormality, (forty seven rather than forty six chromosomes), the fetal development is that of a male. The extra Y chromosome has been linked to excessively aggressive and antisocial behavior. Gender identity is essentially

masculine, and they are also typically bisexual or paraphilic, with little impulse control (Dworetzky 1995). A female receiving a single X, but not receiving a second X, is said to have an XO sex karyotype. Because of disjunction in her parent's sex chromosome during meiosis, the fetus would develop Turner's syndrome. In this chromosomal abnormality, the person would have forty-five instead of the normal forty-six chromosomes. The resultant individual is born with female genetalia, but ovarian development is atypical. These females are characterized by having external organs that approximate females, skin flaps on the back of their necks and are sterile. Having had no influence of testosterone, they never exhibit tomboyish behaviors (Dworetzky 1995). Gender identity is usually feminine, but because of their appearance, infertility, and awareness of their genetic profile, some may question or feel confused about their gender role. Another chromosomal abnormality is a condition where tissues of different genetic makeup occur in the same organism called Mosaicism. These persons have an XX/XY sex karyotype and may present with the anatomical features of either sex or as intersexed, (characteristics of both sexes), (Reiner 1999). This condition is known as hermaphroditism. Gender identity of both masculine and feminine is clearly apparent in the intersexed person. While some think of themselves as both male and female, others consider themselves to be in a unique third gender and reject the notion that they are either male or female.

There are still other conditions that have their origins in the prenatal stage and which may ultimately affect a child's gender identity. Altered hormonal levels alter phenotype progression, thus the brain bias towards one sex may be in dissonance with the genetic makeup of a fetus, or even with its external genetalia (Reiner 1996). If a female fetus is

exposed to high levels of cortisol produced by its own adrenal gland, a condition exists known as Congenital Adrenal Hyperplasis, (CAH). Another term for this condition is called female pseudohermaphroditism.

The higher levels of androgenic hormones, results in a female with an overly large clitoris, (clitoromegaly) resembling a male penis. Both the gender role and the gender identity of the child are controversial. If the child is raised as a male and given male hormones at puberty, the individual develops as a normal male, but sterile. If the infant is surgically corrected to female and given female hormones, there is greater than fifty percent chance of the person being lesbian or with a transgender expression. Females with this condition have ovaries, so gonadal sex would be congruent with female gender identity, however the gender role is more typically masculine, with preference for traditional male dress and activities.

Still another hormonal abnormality is Androgen Insensitivity Syndrome (AIS). In this condition, mutations in the gene encoding for the androgen receptor can reduce or eliminate the ability of the receptor to bind to the androgen causing androgen insensitivity. There is a normal amount of testosterone in the XY sex karyotype fetus, but the cells of the fetus are unable to respond to it because of dysfunctional androgen receptors (Breedlove 1994). In this case, nature's default of developing a female continues. Genetically XY males develop female external genetalia, and are accepted as females at birth. However, when menses fail to begin, they are identified as males. These individuals are feminine in gender identity and orientation, and they are attracted to and marry males (Money et al. 1984). According to Breedlove, (1994), theses feminine characteristics could equally be the result of absence of androgenic stimulation of the nervous system or of psychosocial forces at work in

development. Other characteristics include a short vagina, and they have no uterus or ovaries. During puberty, the un-descended testes produce testosterone that is converted to the hormone estradiol. The influence of this hormone allows for the development of female secondary sex characteristics.

Another congenital disorder is called pelvic field defect. This disorder leads to gross abnormalities of the abdominal organs, and in a boy, a missing penis. Doctors have frequently recommended that these XY boys be raised as girls and undergo surgical sex reassignment. The popular view was that a boy without a penis could not live a normal life as a boy, and would be better off if acculturated as a girl. For the infant male, this meant castration because he was born with testicles, but without a penis. Physical evidence of testicles means of course that the child had been exposed prenatally to normal levels of testosterone. Reiner (2000), found that despite surgical sex reassignment and attempts by the child's parents to rear the child as girls, most rejected their assigned sex role and insisted that they were boys. A viable conclusion of this study is that prenatal exposure to androgens does in fact lead to male behaviors and a male gender identity.

To further illustrate the effects of hormones as a determinant of gender identity the well-publicized case of John/Joan is discussed. Money and Ehrhardt (1972), reported on the case of an XY baby boy, one of a pair of identical twins. The child was born in 1965, named John, and approximately one year later had surgery for routine circumcision. During the procedure, the child sustained an injury to his penis caused by an electro-cautery needle. Through mechanical malfunction or doctor error, the penis was virtually destroyed.

Doctor Money at the time of John's surgical castration was on staff at Johns Hopkins Hospital, where the world's largest clinic for the study of intersexual conditions had been established. Money's research and studies were largely focused on intersexed children and adults with identical genital ambiguities and chromosome structure, and who had been reared as members of the opposite sex. Money observed that all of the intersexed that were studied, they were well adjusted psychologically, regardless of whether they were raised as male or female. Money considered this fact as evidence that an intersexed child's gender was developed according to the way the child was raised, and not because of biological makeup. According to the view of Money the children were born psychosexually undifferentiated. In The True Story of John/Joan, Colapinto (1997), quoted Money's assertion, "in the light of hermaphroditic evidence it is no longer possible to attribute psychological maleness or femaleness to chromosomal, gonadal or hormonal origins…The evidence of hermaphroditism lends support to a conception that, psychologically, sexuality is undifferentiated at birth and that it becomes differentiated in masculine or feminine in the course of the various experiences of growing up."

At twenty-two months the child (John) was surgically castrated, at Johns Hopkins Hospital and renamed Joan. Following the castration, a chromosomal test confirmed that the twins were in fact identical. At the time of castration, Joan was given a cosmetic exterior vagina, with a full vaginal canal planned when the child's body was closer to full-grown. Money (1972), posited that a person's genital appearance was crucial to how one learns a sexual identity, and that Joan's psychological sex change could not be complete until her physical change was complete. Also strict instructions were given the parents that they were

not to talk about the operation, ever tell their child the whole truth, and to raise her as a girl. In spite of the parent's efforts to steer the twins in opposite sexes, Joan displayed masculine behaviors. From refusing to wear makeup, wanting to shave like her dad, to playing with boy's toys, and involvement in tomboyish activities, Joan's behavior was unconventional for a girl. In an interview conducted in adult life, Joan revealed that by the age of kindergarten she knew there was something different, and that even her teachers knew that there was something different. Teacher's reported that "Joan's interests are strongly masculine", and "there is nothing feminine about her." Throughout childhood and adolescence, Joan's attraction was for girls. Joan fiercely resisted further surgeries and often pretended to take prescribed estrogen pills. At age fourteen, during an appointment with an endocrinologist, Joan refused to remove her gown for a breast examination, and forcefully told the clinician she did not want to be a girl. The decision was made to tell Joan the truth about who she was and all that had happened to her.

Once the story was revealed to Joan, her life changed dramatically. She immediately changed her name back to John and began male hormone treatment, followed by surgery to complete her metamorphosis back to a boy. His breasts were surgically excised and a rudimentary penis was constructed. Eventually, after overcoming numerous social, emotional and psychological obstacles, John married a woman who already had three children.

Money's Theory postulated that: (a) Individuals are psychosexually neutral at birth; (b) healthy psychosexual development is dependent upon the appearance of one's genitals; (c) doubt should not be allowed as to sex of assignment; and (d) do not change sex after two years of age.

In his criticism of Money, Doctor Milton Diamond, University of Hawaii, (1997) argued, "…that an individual is born with prenatal biases with which he or she will interact with the world." Diamond went on to say that, "John's case is evidence that gender identity, and sexual orientation are largely inborn and that while rearing may play a role in helping to shape a person's sexual identity, nature is by far the stronger of the two forces, so much so that even the concerted 12-year efforts of parents, psychologist, psychiatrists, surgeons and hormone specialists could not override it", (Colapinto 1997).

The case of John/Joan presents compelling evidence that genetics and gonadal hormones have very powerful effects on the development of gender and behavior in human beings. It is well established as fact that both androgens and estrogens affect behavior throughout development, from early prenatal life through adulthood. High levels of testosterones and other androgens that are present early in development promote the development of male characteristics and inhibit female characteristics. Estrogen plays an important role in development and maintenance of female characteristics, and their effect on the brain extend beyond the prenatal and postnatal periods.

As stated, hormones have powerful effects on the development of the brain and behavior from early prenatal life through adulthood. Organizational effects refer to the effect of hormones during early development and activational effects refer to the effects of hormones in the adult. Evidence suggests that exposure to hormones during a critical period, (infancy) organizes the way behavior is activated by hormones in adulthood.

A better understanding of the effects of hormones can be had by reviewing experiments with rodents. When male rats were castrated in infancy, they became demasculinized and feminized. When female rats were treated with testosterone during infancy they became masculinized and defeminized. During an experiment, the male rat was castrated at birth and given an injection of estrogen as an adult. The rat exhibited lordosis (a female rat's sexual response), when placed with a male rat. When a male rat was castrated at birth and then as an adult was placed with a female rat that was in heat, the male rat would not mate with her. During yet another study, a normal adult male rat was injected with estrogen and placed with a sexually vigorous male rat. The male rat injected with estrogen did not exhibit lordosis.

One study revealed that if a female rat was injected with testosterone during infancy and again in adulthood, she would show male sexual responses by attempting to mount a female rat in estrus, (heat). The same study showed that if a female rat is injected with testosterone during infancy and again in adulthood, she will not exhibit lordosis when placed with a normal male rat; and, if a female rat is injected with testosterone in adulthood, she will not exhibit male sexual behavior.

Conclusions of this study are obvious. Hormones organize the brain development. Testosterones establish male circuits (maculinization) and inhibit defeminization (female circuit); and, in the absence of testosterones, brain circuits are feminized and demasculinized. It is evident then that adult sex behavior depended on whether or not the brain was organized by gonadal hormones during the first few days after birth.

According to Phoenix et al., (1959), behavioral and brain changes that occur as a result of high or low levels of gonadal hormones that are present early in development are considered organizational in that the hormones make permanent changes in the brains wiring. Arnold and Breedlove (1985) assert that hormonal effects extend beyond early development and may continue to affect behavior at later periods because of permanent changes in the brain. Interestingly, later hormones do not produce long lasting and permanent changes, but rather activate neural systems that were organized early in life.

Evidence has shown that early exposure to testosterone affects the external genetalia and adult behavior. An important question is whether or not testosterone also affects the brain. According to Gorski (1980), the brains of females and males are different and the difference is caused by exposure to androgens during a critical period of development.

Studies using non-human species have shown that gonadal hormones play a major role in the development of sex differences in behavior and in the brain (Arnold and Gorski, 1984; Breedlove, 1994). Regions of the brain involved in sexual behavior, the hypothalamus, show sex differences and changes with excess or reduced levels of masculinizing hormones. In rodents, an area of the hypothalamus called the sexually dimorphic nucleus of the pre-optic area is much larger in males than in females (Gorski 1980).

A question that arises is simply, “what does the research and studies tell us about the transgender?” First, it has been established that hormones play a significant role in one’s behavior, from early development to adulthood. Secondly, hormones do alter and affect brain changes.

In a study at The Netherland Institute For Brain Research in Amsterdam, detectable differences were noted in the brain of transsexuals at autopsy. Specifically, the hypothalamus an area responsible for sexual behavior. Research revealed that the genetically male transsexual had a female brain structure. An area of the hypothalamus was similar in male to female transsexuals and genetic females. In another study, Zhou, et al., (1995) reported, "the possible psychogenic or biological etiology of transsexuality has been the subject of debate for many years. Here we show that the volume of the central subdivision of the bed nucleus of the stria terminalis (BST), a brain area essential for sexual behavior, is larger in men than in women. A female sized BST was found in MTF transsexuals. The size of the BST was not influenced by sex hormones in adulthood and was independent of sexual orientation. Our study is the first to show a female brain structure in genetically male transsexuals and support the hypothesis that gender identity develops as a result of an interaction between the developing brain and sex hormones." D.F. Swabb (1995), a co-author of the study noted, "this research shows that transsexuals are right. Their sex was judged in the wrong way at the moment of birth because people look only to the sex organs and not to the brain."

Much of the research presented strongly suggests that biology contributes and influences individual differences in masculinity and femininity. Genetic and hormonal abnormalities offer evidence that early exposure to hormones has influences on sex type behaviors. Studies of testosterone levels offer suggestions of sex differences. Animal experiments give evidence that prenatal hormones create differences in behaviors of males and females. Human experimentation as the result of a surgical accident as in the case of a

genetic male baby castrated and reared as a female, showed that prenatal exposure to testosterone produced a masculine gender identity and male typical behaviors. The research has shown that both prenatal and adult hormone levels, especially androgens, are related to individual differences in masculinity and femininity.

It would be reasonable after reviewing the foregoing to conclude that gender identity is a product of nature; that genetics, chromosomes and hormones are the determining factors in gender identity; that transgenderism is the result of brain changes due to alterations in sex hormone levels. Without question there is ample evidence to draw such a conclusion. However, in seeking to better understand the gender identity phenomenon, it is necessary to look beyond the argument of nature as the only etiology, and to investigate the external environmental experiences. Are social factors capable of overriding hormonal influences? In other words, can gender role behavior and environmental experiences have causative influence on hormonal production and response? The following chapter will discuss the ongoing argument for nurture and the interplay between nature and the social/environmental experiences.

CHAPTER 4

THE ARGUMENT FOR NURTURE

In the preceding chapter, the influences of nature on gender identity were discussed. Genetic commands inscribed in sex chromosomes determine if the person will be male or female. Presence or absence of hormones leads to the differentiation of the genitals; and, hormones play a major role in the development of sex differences in behavior and in brain structure, and are directly related to the individual differences in masculinity and femininity.

It may be said from the preceding chapter that the way gender is actually shaped depends upon the organism's internal environment, that is the interaction between genetic makeup and the presence or absence of the hormone androgen. But what about the environment after birth? The biological theory has not addressed the social environment as a cause of sex differences in behavior or as a cause of individual differences in masculinity and femininity.

This chapter will discuss the physical and social world, the crucial environmental events, that affect gender identity. Biologically, sexual identity may refer to the XX vs. XY chromosome pairs, or it may refer to the external genitals. However, psychologically, it refers to three issues. The three issues are: gender identity, (our inner sense of whether we are male or female), gender role, (behavior patterns that society deems appropriate for each sex), and sexual orientation, (choice of a sexual partner). Gender identity, gender role, and sexual orientation are the most important determinants of a person's social existence.

Gender roles penetrate all facets of social life. When a human being enters the world,

the first question asked is, “is it a boy or girl?” When the answer is given, the gender typing begins and the infant is propelled along one of two totally different social paths. The stereotype is very simple. The infant is dressed in either pink or blue; plays with either dolls or fire trucks; the adult woman’s place is in the home, while the adult male goes to the work place. Society has very different expectations about what the two sexes should do; and society also has very different concepts of what the two sexes should be. Aggressive, tough, emotionally restrained are expectations our culture has for the male. Expectations for females are greater submissiveness, emotional expressiveness, and more interest in people than in things. These gender role stereotypes have an effect on the way we perceive people, including newborns and infants.

In a study, mothers of newborns were asked to participate in an experiment on “how children play”. The mothers were introduced to a six-month old baby, little Joey or little Jane, and asked to spend a few minutes playing with the child. The six-month old child was dressed as a boy or girl regardless of its actual sex. Results revealed that the mothers’ behavior depended upon whether they thought they were playing with Joey or Janie. If they thought they were playing with Joey, they gave him a rattle or play hammer. When handling Joey, they tended to bounce him about and were more physically vigorous. If the mothers’ thought they were playing with Jane, they presented her with a doll. When physically handling Jane their response was much gentler and less vigorous (Smith and Lloyd 1978).

Children soon behave as parents expect them to. Starting at about age one and one-half, children begin to show gender-typed differences, and by age three they prefer different toys and play with peers of their own sex (Huston, 1983). When young children play with

toys that are judged to be inappropriate, their parents are likely to express disapproval. This is especially true for fathers who oppose any such behavior from their sons. Girls appear to have more latitude. A girl can easily be a tomboy with no such reproach, but a boy who is a sissy is laughed at (Langlois and Downs 1980).

The most dramatic examples of the effects of social factors in the determination of gender identity come from the studies of children who at birth were declared to be of one sex, but who were later reassigned to the other. This sex reassignment sometimes occurs when the newborn is a hermaphrodite, with reproductive organs that are anatomically ambiguous so that they are not exclusively male or female. In such cases, parents and/or physicians decide to reverse the initial sex assignment. Corrective surgery is undertaken, the sex is officially reassigned and the child is raised accordingly. The results suggest that if the reassignment occurs early enough the child adjust to a remarkable degree. It becomes a he or she, in part because this is how other people regard it (Money and Ehrhardt 1972).

One such case involved a child that was genetically male. It had a male's XY chromosome pair and testes. However, the external genitalia were more similar to a female's than to a male's. At birth the child was pronounced a boy, but the decision was reversed seventeen months later, at which time there was corrective surgery. According to the parents, there was an immediate change in the way the child was now treated. Even her three-year-old brother reacted differently and showed a "marked tendency to treat her much more gently. Whereas before he was just as likely to stick his foot out and trip her as he went by, he now wants to hold her hand to make sure she doesn't fall" (Money & Ehrhardt 1972, p. 124).

In sharp contrast is the previously discussed case of Joan and John, two normally born male identical twins, one of whom suffered a surgical accident at the age of seven months, followed by sex reassignment surgery. This case seemed to provide an excellent demonstration that gender identity is not a simple function of one's chromosomes. But on follow-up, the twin reared as a girl had developed various problems with her sexual identity by the time she reached age thirteen. Diamond (1997) strongly asserts that gender identity depends on the biological organization of the individual's nervous system and cannot be refashioned by social factors, even in infancy. Still others feel the issue is unresolved, considering that the difficulties of the twin raised as a female are by no means uncommon in young adolescent girls (Ruble 1984).

The extent to which social factors can override the individual's biological makeup is not clear, but there is evidence that constitutional factors play a role. The evidence comes from a series of studies of girls who were exposed to high levels of male hormone in the womb. At birth, many of these girls were hermaphrodites, with ambiguous external genitals. After appropriate surgery, they were raised as females. But follow-up studies showed that the excess androgen during pregnancy had some long-term psychological effects. When compared to a control group, the androgenized girls were more likely to be tomboys during childhood. They chose trucks over dolls, loved to participate in energetic team sports, preferred functional slacks to feminine dresses, and had little interest in jewelry or perfume. As adolescents, they looked forward to a future in which marriage and maternity were subordinated to a career (Money and Ehrhardt 1972; Money 1980; Ehrhardt 1984).

Social factors are evidently of great importance in shaping our sense of being masculine or feminine, and they shape our behavior accordingly. There are essentially three main theories of socialization to consider as determinants of gender identity. Social learning theory, psychoanalytic theory and cognitive development theory all have strong arguments.

Is gender identity learned? Biological theorists posit that behavioral differences of gender are innate. Social learning theorists argue that gender behaviors are learned. Bussey and Bandura (1999), believe that the differing behaviors of men and women can be explained in terms of well-understood principles of learning such as classical conditioning, operant conditioning, and modeling. Classical conditioning is thought to occur when a neutral conditioned stimulus is paired with a second unconditioned stimulus. In the study of Pavlov's dogs, salivation was produced by the sight of food, (unconditioned stimulus). The unconditioned stimulus was then paired with a bell, (conditioned stimulus). After learning, the dogs automatically and involuntarily responded physiologically to the bell only.

Mischel (1966), noted that classical conditioning helps explain why "labels like 'sissy,' 'pansy,' 'tough,' or 'sweet' acquire differential value for the two sexes" (p.61). When a boy is called sissy or pansy, the words are usually associated with events that trigger shame or disgust. Consequently, the boy will not want to behave in such a manner as to have those words applied to him. Engaging in activities such as playing with dolls, playing house or dressing up as a female would not be appealing because of prior conditioning to have horrible feelings about any such activities.

When a person's voluntary behaviors are molded by either rewards or punishment, operant conditioning is thought to occur. One view of the social learning theorist is that boys

and girls are systematically rewarded or punished throughout life for different kinds of behavior. If a male child is rewarded for dressing in mom or sister's underwear, shoes, dresses, etc., what will be the effect on his gender identity or gender role? Conversely, if a female is consistently punished for engaging in girlish activities, how will this affect her gender identity? In theory, the behavior will be reinforced or extinguished based upon rewards or punishment.

Modeling is a third social learning theory. Children learn to behave sex appropriately by observing and imitating the behaviors of others. They learn to be boy or girl by imitating same-sex parents, friends, brothers or sisters, and media figures. Mischel and Grusec (1966), suggest that children are most likely to imitate people who are powerful and nurturing, and who control rewards in their lives. This would obviously imply that boys would imitate their fathers and girls would imitate their mothers. The explanation for gender identity is perhaps stronger in the modeling theory. Generally when boys imitate other boys and girls imitate other girls, they learn sex differences. It stands to reason that parents, siblings and other models will have varying degrees of masculinity and femininity, therefore the boy or girl will vary in their own degree of displayed masculinity and femininity, based on their learning.

According to the view of the social learning theorists, sex drive has very little to do with gender role behaviors, identity and to a lesser extent the anatomy. The penis and vagina are relevant only in determining whether a child is a boy or a girl in the parent's eyes. From this point on, differential rewards and punishments do the rest (Mischel 1966). Parents guide sons and daughters into different sex appropriate social molds most probably because of various reinforcers, which act to maintain a particular social structure, an apprenticeship for

the roles they will adopt as adults. It appears that this theory would portray the learning of gender identity as a passive process, based on a series of rewards and punishment. But, masculinity and femininity is not just a matter of genes, hormones and social conditioning. Gender Identity is how we view ourselves.

In the theory of cognitive development, Kohlberg (1966), asserts that children's conception of gender are critical in motivating them to behave in masculine or feminine ways, and that these conceptions develop with the child's mental development. By age two or three, a child can correctly identify his or her sex, and understand that people are either male or female. Kohlberg (1966), argues that once a child develops a stable gender identity, (boy or girl), and stable gender categories for all others, (male or female), they begin to identify with and prefer others of their own sex. During this period, the child doesn't realize that gender is defined by genital differences. They recognize gender more by the types of clothing, hair lengths, and the types of play. Many children will often state that they could be the other sex if they wanted to simply by changing their clothing, hair style, etc. Kohlberg (1966), posits that children older than seven continue to develop gender concepts, for example, "women are nicer and more gentler than men," and "men are more violent than women". By categorizing themselves, Kohlberg (1966), suggests that children acquire stereotypical masculine or feminine behaviors. In social learning theory, the child behaves as a boy or girl for the sake of being rewarded. Kohlberg (1966), theorized that it is not rewards that make the boy masculine or the girl feminine, rather it is identifying oneself as being male or female that makes masculine or feminine activities rewarding.

According to the cognitive development theory, sex differences are an inevitable consequence of identifying oneself as masculine or feminine. In our society, men and women behave differently; consequently once boys realize they are boys and girls realize they are girls, they will want to behave as other boys and girls.

While Kohlberg's (1966), theory does not directly address individual differences in masculinity and femininity, another cognitive development theory by Jerome Kagan (1964, p. 4) does. Kagan (1964) asserts that boys and girls decide how masculine or feminine they are by comparing themselves to other boys and girls behavior. If a boy observes his behavior is similar to that of most other males, he will decide that he is masculine. If a girl observes that her behavior is similar to that of most other girls, she will decide that she is feminine. Absent from this theory is an explanation as to why some boys behave either more or less like other boys and why some girls behave either more or less like other girls in terms of masculinity and femininity.

In considering an explanation, it would appear that we have made a full circle back to the biological determinants of gender identity. Is gender identity molded by genes, hormones and brain structures, or by conditioning and social learning? Whatever the answer, Kohlberg's (1966), theory indicates that gender self-labeling will accentuate such differences, while Kagan's (1964), theory suggests that children compare their own behaviors with those of their same sex, and determine how masculine or feminine they are. Swann (1966) theorized that once children develop these self-concepts, they act in ways that are consistent with their self-concepts.

Social learning theory is based on cultural forces that make a girl or boy fit into a sex specific gender role and thus shape or creates a gender identity. Cognitive development theory holds that through cognitive development the boy or girl will have an emerging self-concept that includes a gender identity as masculine or feminine, and the boy or girl will attempt to live up to their self-concept.

The founder of psychoanalysis, Sigmund Freud (1856-1939), was probably the first psychologist to inquire as to how males and females develop masculinity and femininity. According to Freud's psychoanalytic theory of gender identity, the basic mechanism is identification. The child models himself or herself on the same sex parent in an effort to become like him or her. In Freud's view, identification is the end product of the Oedipus conflict, which reaches the culmination at about age five or six. The little boy is unable to cope with the mounting activities aroused by his sexual longings for his mother and his resentment of his father. He therefore represses both incestuous love for his mother and hate for his father. His renunciation for his mother is only temporary. He begins to identify with his father in an effort to win favor and, in the hope that he will gain the mother's sexual love, (if I am like my father, she will love me). By this process of identification, thought to be unconscious, the boy begins to incorporate many aspects of his father's personality, including those that pertain to gender roles. According to Freud, the female goes through essentially the same phases. The process unfolds more or less analogously to the male: love of father, jealousy of her mother, increasing fear of her mother, eventual repression of the entire complex and finally, identification with her mother (Freud, 1925, 1933).

From the psychoanalytic theorist's view, masculinity and femininity are the inevitable outcomes of biological givens. The events that occur during the Oedipal period determine gender identity, an identity that is thought to remain stable throughout life.

Discussion of social learning theory, cognitive development theory and psychoanalytic theory has provided a foundational argument for the on-going controversy of the cause for gender identity, nature or nurture. Gender identity can also be discussed in terms of the location of gender, within the individual (essentialism) or within social arrangements, (social constructionism).

In its simplest explanation, essentialist theorists say that men and women are just made that way. This is an easy theory to accept because for the majority of our population, there is a direct relationship between the genitals and gender identity. An interesting thought becomes, "how did the essentialist determine the sex of an individual born intersexed?" Initially the presence or absence of a penis was the determining factor. As medical science progressed, examination of the gonads became the determinant, but currently medical technology allows for microscopic examination for the absence or presence of the Y chromosome as the arbiter of a person's sex. Essentialists argue that gender differences are encoded in the body's chemistry and that brain structures account for most of the differences between men and women. As previously discussed, neuroscientists have indeed found differences between specific important areas of female and male brain structures. Essentialists hold to the belief that hormones play a large part in explaining the differences in gender identity.

One belief of essentialism is that observations of behavioral differences must reveal essential sex differences (Bohan 1993). Essentialism portrays gender as a resident within the individual and linked to that person's sex. The theories about sex differences present those differences as qualities of individuals that exist in all situations and are separable from the social and cultural. For those psychologists who subscribe to this theory, there is an assumption that the sex differences between male and female are biological in nature. Essentialists also use cross-cultural similarities as further evidence to lend support to the argument for universal sex differences. From the essentialist's point of view, those similarities are used to support the argument that there are essential qualities associated with sex. Gender is thus seen as a characteristic of individuals, most likely caused by biological factors.

Does the theory of essentialism offer proof positive that transgender people have no real claim to their identity? Perhaps not, but it can offer as an explanation that if the locus of gender is not in the genitals or the chromosomes, then reasonably, the transgender person must be the man trapped in a woman's body or the woman trapped in a man's body as they have claimed for years.

Social constructionism denies that there is any natural basis for gender identity, therefore refuting any rational cause for transgenderism. According to the social constructionists, transgender people are free to express themselves as they choose, recognizing that all gender expression is valid and only the conventions of society stand as obstacles to their free expressions. For some it means society can modify certain

conventions as it deems appropriate and acceptable. For others it means simply to live and let live.

In challenging the social constructionism theory, one must seek answers to the questions, “why does gender identity even exists?” and “why would some (transgender people) choose to express themselves in ways that does not conform to the norms of a greater society?” Social Constructionism spawned several sub-theories that may provide a greater insight.

Performance Theory holds that we are taught to perform gender, or that we do gender rather than have a gender. According to this theory, we are taught a set of gender behaviors that have become so ingrained as habit that we forget that we are merely acting them out. This theory would have you believe that transgender people have been improperly instructed. This theory has found application in behavior modification therapy for children, by not allowing children to express gender that is different from society’s norms.

Oppression theory, another sub-theory of Social Constructionism, states that transgender people are very much in control of their faculties and have made a rational decision to avoid societal restrictions on desires they experience. One thought within the oppression theory is that male-to-female transgender people are too ashamed to live openly as gay men and therefore have to pretend to be women in order to express their innermost desire for same sex relations.

Social Constructionism fails to provide a rational explanation for the transgender phenomenon, positing instead that society took the biological differences and instilled in them an artificial behavior difference. What is obviously absent from the theory of. Social

Constructionism is the evidence from studies of behavior in sexually dimorphic animals, which could not have been socially constructed. Neither do these theories offer explanation for the stable cultures of variant gender identities globally and throughout history.

Reverting for a moment to the argument for nature, it is well established that hormones play a significant role in one's gender identity, not only pre and post natal, but throughout the entire lifespan. Recalling from the previous chapter that behavioral and brain changes occur as a result of high or low levels of gonadal hormones that are present early in development and make permanent changes in the wiring of the brain, opens the question of the interaction between the brain and environmental influences. Arnold and Breedlove (1985), presented evidence that the action of sex hormones can still cause both permanent, morphological changes to the brain and long term behavioral changes. They also suggested that there are critical periods past the neonatal stages during which the organism is most receptive to these changes. The evidence presented suggested that environmental factors can affect sensitivity and response patterns of the hormonal system and because of the changes in hormonal functioning can have effects throughout the life span.

If changing environmental demands increase or even obstruct secretions of hormones, then it could be reasonably concluded that human experiences, and the meanings given these experiences by the individual, play a role in the development of hormonal production, and thus suggest an explanation for the transgender phenomenon.

As stated earlier, a transgender person is one whose physical sex is unambiguous, and whose gender identity is unambiguous, but whose sex and gender does not match. The belief

that gender is necessarily linked to chromosomes or the anatomy; and that all males are masculine and all females are feminine, challenges the very existence of the transgender.

Seyler et al. (1978), investigated the way in which female-to-male transgenders processed the hormones in their bodies. His study determined that female-to-male transgender responded differently to experimentally administered progestins, (a synthetic hormone often used in birth control pills), than did either average females or average males. Further studies of male-to-female transgender found that after administration of estrogen to average females and average males and also to male-to-female transgender persons, the transgender subjects responded dramatically as evidenced by their levels of testosterone being lower than that of average females studied.

The studies indicated that transgender persons do process their hormones in an abnormal way. Seyler et al. (1978) further observed that the changes observed in estrogen responses are acquired due to either psychological or other disturbance. psychological state is known to influence the gonadotropic function. It would seem logical then that gender role behavior along with environmental experiences would have an influence on hormonal responses. Money and Ehrhardt (1972), posited that social factors might be capable of overriding most, if not all prenatal influences. If this is true, then hormonal abnormalities might be seen to be the result of chronic social abnormalities. In this way, the interaction between the two would function as a loop. If positive, the hormonal system and the environment would reinforce each other. If negative, the environmental experience may be able of overriding prenatal influences.

In the long term, everyday social interaction may be strong enough to be of greater importance than hormones in shaping behavioral sex differences, as the reinforcement of behavior and constant feedback has an effect on hormone levels. The endocrine glands without question have a controlling influence on gender identity, but only because of the strong interaction with the organism's social and environmental experiences, being mediated by the brain.

Is the etiology of transgenderism nature or nurture? Sternberg (1993) argues that the influences of nature and nurture are both fully involved in gender-related behaviors, attitudes, and feelings. Money (1987), opines that it is not possible to determine how much of a particular trait or behavior is influenced by biological versus social factors. Benjamin (1966), summarized by saying, "…Our genetic and endocrine equipment constitutes either an unresponsive, sterile, or a more or less responsive, that is to say, fertile soil on which the wrong conditioning and a psychic trauma can grow and develop into such a basic conflict that subsequently a deviation like transsexualism can result. To express it differently, our organic sexual constitution, that is to say, the chromosomal sex, supported and maintained by the endocrine, form the substance and the material that make up our sexuality. Psychological conditioning in early life would determine its final shape and individual function. The substance is largely inaccessible to treatment. The function alone would be the domain of psychotherapy."

Thus, in answer to the question posed, it appears that nature and nurture interact with each other in such complex and dynamic ways that both have an influence on gender identity and roles.

Just how strongly does nurture influence gender identity? In the following chapter, the life of a middle-age transgender person is discussed, and the play of hormones, (organizational and activational), are considered as influences of gender identity.

CHAPTER 5

NARRATIVE OF A TRANSGENDERIST

In the chapter on Argument for Nature Chapter 3), I discussed two different effects that hormones have on sexual behavior. Organizational effects refer to the effects that hormones have during early development, and Activational effects are said to be to the effects that hormones have in adulthood. A point was made that early exposure to hormones does not have a permanent effect on behavior; rather it suggests that early exposure may affect how the adult reacts to hormones. And, in the previous chapter, I discussed that changing environmental demands may increase or obstruct the production or the secretion of hormones from the standpoint that our experiences and the meaning we give to those experiences may play a role. Thus, I concluded that gender identity and gender role might be the result of a complex and dynamic interplay of both nature and nurture.

This brief chapter will report on a discussion with a male-to-female transgenderist. There appears to be sufficient evidence from this account to give credence to the interaction of nature and nurture in influencing gender identity and gender role.

I met Carla while interviewing another transgenderist. Carla is anything except what one would imagine a MTF transgenderist to be. She is estimated to stand at least six feet tall, and her estimated weight is two hundred pounds. Her frame is rather large and her build is very athletic. Carla has large hands and a grip that most men would envy. Good naturedly, she laughed at my astonishment of her appearance and easily joked about her days of college football, where she was named most valuable player for three consecutive years. Carla's

presence would easily dominate a boardroom; her speech is a low baritone, and her eye contact is steady, unwavering and almost intimidating, until you see a sparkle when she expresses humor.

When we met, Carla was casually dressed in a sweat suit and wearing what appeared to be an expensive and stylish hairpiece. She was accompanied by her wife of nearly twenty-seven years. Together, they have three children ranging in ages from eighteen to twenty-two years of age. Carla explained that all of the children knew of her new identity. She spoke sadly that the two eldest children, both females, opted to live with maternal grandparents, and have disowned her and there has been no contact for the past nine years. The youngest child, a male, continued to live at home and has entered college just this year. Carla and her wife spoke of the years of counseling, "for all involved." Her eyes and voice revealed the emotional pain of not having her entire family, but she quickly added, "I am a much happier person, and I deserve that."

Carla was born a biological male, in a rural city in the south. Her father was in the military and out-of-country when Carla was born. Carla had four older sisters and in her words, "a strong, domineering mother." She remembers from a very early childhood being told repeatedly, "that she should have been born a girl", and "we don't have enough money to buy little boy clothes." Carla remembers quite vividly being dressed up in her sister's clothes and having long blonde hair. Her eldest sister in particular influenced her mother not to cut Carla's hair. At the age of four, Carla remembers, " a house full of people and my Mother crying for days." Although too young at the time to comprehend the meaning of the

event, she can recall the “men in uniforms and the soldiers shooting the rifles.” The father whom she never met was killed in the line of military duty, and Carla still wonders if her life would have been different had her Dad raised her.

Shortly after the death of her father, Carla’s mother found it necessary to find a job, leaving the rearing of Carla and her younger sisters to the two eldest sisters, but primarily to the oldest. Carla has memories of being dressed daily in female clothing and being told that he should have been born a female. She remembers taking baths with her older sister and not understanding why her sister didn’t have the same body as she did. Until the first grade, Carla’s only playmates had been her sisters, usually playing with girl’s toys and playing girl games. Just prior to entering the first grade at age six, Carla’s mother cut her hair and purchased boy’s clothes. Carla described her first grade as exciting and fun. “At first, I was shy and backwards, but it didn’t take me very long to begin playing and hanging out with the boys; and I was so proud of my clothes and the fact that I had short hair just like the rest of the boys.” Carla described her school years as, “the best years of my life, because I could hang out with the guys and play rough and tumble games. I still remember my very first fight with the class bully. I was trying to protect a girl and stood right up to him. I got my butt kicked, but I was so proud of myself.” “When I got home my sister scolded me and told me that girls shouldn’t fight. I became so mad, that I left the house screaming, “I am not a girl”, over and over. To make up for calling him a girl, her sister allowed Carla to spend the night, to sleep with her and to dress in one of her gowns. Carla recalls, “I loved the feel of my sister’s gowns and other undies, and to this very day, I still derive pleasure from wearing those things.” Sleeping with her sister and wearing her gowns and other items became the

norm for Carla until as she recalls around the age of eleven or twelve. Carla also remembers other things that occurred while sleeping with his sister. She remembers waking up several times unable to breathe, only to find that her mouth was being pressed against her sister's breast, or waking and realizing that, "my sister was playing with me down there"; and on one occasion waking to find that my sister was using my hand to stimulate herself." Carla goes on to say "don't misunderstand, I enjoyed all of it without understanding why, but I knew it was wrong, especially when my sister started being extra nice to me and begging me to keep our secret."

Carla recalls on one occasion at approximately twelve or thirteen being home alone. "My sisters were at their friends house playing, my older sister was with her boyfriend, and my Mom was working. I decided to play dress up, so I took a bath, put on my sister's panties and bra. I found a pair of heels and put them on also. By then I was really getting into it, and decided I needed makeup. Just as I was putting on my mom's makeup, the door opened and standing there was Mom with this weird look on her face. Her look changed from surprise and astonishment to anger, and she started screaming and throwing things at me, and calling me names like slut and whore and queer. There were also words like insane and crazy. She started beating me, first with her hands and then with a belt. She wouldn't allow me to get out of those clothes. She painted me up with lipstick and eye make-up, and I had to sit in a chair in the middle of the room until my sisters came home. They all laughed at me and called me names and I was totally humiliated. There I was, crying, ashamed, humiliated and they were all laughing and calling me names, all except my oldest sister. She came over and

put her arms around me and held me close. I can still remember her softness and her smell. After Mom left the house for a date my sister came into my room and held me while I slept."

Shortly after this incident, Carla went to a nearby city to live with his maternal grandparents. According to Carla, her grandfather was exactly what she expected a man to be, "he was kind, considerate, and understanding. He also spent a lot of time with me. We played football, went on hunting and fishing trips, and he always found the time to listen to me and give me guidance." Carla recalls the rage when she confided to her grandfather about her childhood. "He was furious, and as I told him every detail as well as I could, you could just see his temperature rising. We (my Grandmother and I) thought he would explode. He immediately drove to my Mom's house and let Mom and my sisters 'have it'. Then he drove to a county judge whom he knew and started the proceedings to transfer custody."

From age thirteen until age eighteen, Carla lived with his grandparents. "I tried to forget as much as I could about my childhood and was successful until around age thirty-seven." Carla speaks about her life from the moment of moving in with her grandparents as being the most normal years of my life. In her male identity and role, Carla played and excelled at sports throughout high school and college years. "I was always athletic and the girls really seemed to seek me out in high school and college." Carla denied any misgivings or doubt about his sex, gender identity or gender role during those years. He spoke emphatically, saying, "I was a male, I had all the right equipment, I knew who I was, I loved girls, and I never doubted it." Carla declined an offer to play football professionally, opting instead to follow his father's path by accepting a commission in the Armed Forces. It was

during his commissioning ceremonies that he met his first love and they were married shortly thereafter.

Identifying as a male officer in the Armed Forces, Carla's career seemed to skyrocket. All fitness reports were excellent. Assignments were given for accelerated career progression. Promotions came at the bare minimum required time in grade. The events and memories of a bad childhood had been relegated to an inactive file in the mind. During this time, Carla and his wife had traveled extensively and had added three children to a happy and successful marriage.

Carla's wife recalls at age thirty-seven, Carla became withdrawn from the family. "Carla had just received orders for a deployment and was due to leave in two weeks. We always had a very open marriage. Communication was excellent. We routinely held family meetings where we would discuss anything and everything that related to the family. Carla would sit at those meetings and just stare off into space." Carla would reveal much later that for some unknown reason, he had begun having thoughts and feelings relating to his childhood, in particular questioning his gender identity. Explained Carla, "I was terrified. I was having thoughts and feelings that had not surfaced in years. I mean, what if I suddenly started behaving as a female around a bunch of macho men? I have always been in total control of myself, and now I was having these strong feelings that I am a girl." The feelings became so intense and so frightening that Carla sought the help of a psychiatrist in a nearby city. With only two weeks left before deployment, Carla requested a waiver based on humanitarian reason, and thus ended a promising career. With only five years remaining in order to retire, Carla reluctantly accepted a desk job to protect his retirement.

For obvious reasons Carla attended sessions with the psychiatrist for well over five years, involving his entire family for most of the time. Carla's wife stated that for her the experience was terrifying. "Right away I began to blame myself, asking what I did or did not do to cause this. I would go to sessions by myself and just cry for the whole period because I thought initially that it had to do with my own sexuality. I was prescribed antidepressants and anti-anxiety medication and couldn't understand why I had to take them. We had always had such a beautiful, romantic life. Our sex life was great, and I never once entertained the notion that Carla was interested in anyone else or had ever been unfaithful."

Carla successfully completed her term of service in the military and was given an honorable discharge with an earned twenty-year retirement. Said Carla, "those last five years were the worse. I had to really work to suppress my feelings and behaviors. I could feel the woman inside and she wanted out." Carla was discharged at the age of forty-two and began living full time as a woman. Prior to discharge she had done an adequate amount of research on transgenderism and found the direction to pursue. Carla also went to the expense of having extensive testing done, and it was determined that Carla was a perfectly normal XY male, with normal levels of testosterone. Carla recalls a physician prescribing a testosterone patch, but the feelings did not diminish. Carla repeatedly told her physician and wife that she felt strongly she was in the wrong body.

It was shortly before Carla's discharge from the military that her eldest daughter moved away, and a short while later, the next eldest daughter moved away. Carla has had no contact from either since her decision to live full time as a woman. Of the three children,

Carla's son appears to be the most well adjusted and accepting, often jokingly calling Carla, "my second Mom."

Carla was on a regimen of hormones for nearly two years, but discontinued them because of side effects and economics. At the age of forty-nine, she plans to resume the hormonal treatment, but says she will not have sex reassignment surgery. According to Carla, I don't have to have invasive surgery to become who I want to be. I, and my wife accept me as I am. Carla's wife agrees, saying, "I am perfectly happy with who she is and who she has become. When she was on the hormonal treatment, her voice had begun to change and of course her breast were beginning to develop. But those things aren't important, it's who is inside that is"!

Near the end of the interview, Carla asked me if there was anything at all that I would like to ask? After a review of my notes, I asked Carla about her sexual orientation. Carla seemed to ponder the question and then replied; "I know that many people equate transgenderism with homosexuality. That's why my daughters left home, because they thought their dad had become a homosexual. But, I can say with all honesty that I have never had a same sex relationship, nor have I ever had those thoughts. I am very much attracted sexually to females, especially my wife, always have been and hope I always will be. I am told that it [sexual orientation] may change once I have a build up of hormones, I don't know. For some of my transgender friends it has, for others it has not. I am not able to perform sexually as I once did, but we still have a very satisfying sex life." I then asked Carla's wife if she would care to comment on her feelings being married to a female. She replied, "as I told you earlier, I am perfectly happy the way things are. I didn't marry Carla

for sex only. I married the person, and I married for better or for worse. We have had a happy, satisfying twenty-five year marriage and as long as Carla continues as she has, we will endure another twenty-five years. Do I feel as though I am having a lesbian relationship? No way"!

What does the interview tell about the development of gender identity? To recapitulate, Carla was born a perfectly normal XY male. We cannot speculate on the levels or the timing of hormones, but based on Carla's report, I feel safe to assume that both were normal. We do know that as a developing organism, Carla endured what Benjamin (1966) referred to as, "…psychologically harmful influences in childhood, so-called conditioning." Having a dominant mother, the absence of a male role model, and the influence of four sisters, coupled with having to wear girl clothes and play girl games would meet the criteria for imprinting. The childhood experiences would also fit the social learning theory, in that gender typing is the result of a combination of observational learning and reinforcement. Absent from early childhood until age thirty-seven is any degree of gender dysphoria normally experienced by the transgender person. As early as the first grade, Carla recognized and was comfortable in a male identity role. Carla was never perplexed about sex and gender incongruency, that is, not until some thirty-seven years later, which brings into question the organizational effects of hormones, (early development) and activational effect of hormones, (adulthood).

Dr. Simon Levay (1993), argues that there are genetically determined differences in the brain's hormone receptors, and that brain receptors for hormones play a significant role in gender development. Seyler et al. (1978), in his studies found that transsexuals process the

hormones in their body in abnormal ways, and that psychological state is known to influence gonadotropic functions. Even Benjamin (1966) alluded to psychological causes.

An inference could easily be made that human gender role behavior and the environmental experiences might influence hormonal production and response. But why did it take thirty-seven years later to realize there was a woman inside? In the case of Carla, and considering a psychological component, one hypothesis is that Carla created within an artificial person who met the goal of being normal so as to fit in; and in doing so denied her real female self until it was no longer possible to suppress the true self.

The debate will continue to rage between nature and nurture, and whether gender identity is the result of biological, environmental or psychological factors, or a combination of two or more. We do know that gender identity is established early in life, possibly prenatal, and there are no methods known that have proven effective for changing it. We know that biological sex can be changed. We know that gender expression is quite flexible for some, more rigid for others. We know that most people feel strongly about expressing themselves in ways that is consistent with their gender identity, and experience discomfort when they are not allowed to do so.

In any event, because of my interviewing Carla and others, I am better able to view the development of gender identity as a complex and dynamic interaction of both nature and nurture.

CHAPTER 6

COUNSELING ISSUES

This chapter will discuss clinical issues and treatment of the gender variant client. As previously noted, the term transgender was originally used to differentiate between those seeking surgery because of gender incongruence, and those not pursuing surgery (Lombardi 1999). Currently, the term is accepted to include all persons whose gender identity or expression is incongruent with their anatomy regardless of surgical intent (Bullough 2000). Transgender and all its variations is used in this chapter for all people with nontraditional gender identities, which include pre-and postoperative transsexuals, cross-dressers or transvestites, intersex persons and those not interested in meeting society's norms and expectations of gender roles.

Research conducted Doctor and Fleming (2001) examined cognition and behavior of transgenders in order to identify components of transgenderism. A 70-item questionnaire was given to 455 transvestites and 61 transsexuals, all born biological male. The questionnaire identified five factors: transgender identity (feelings of masculinity or femininity, role (body adornment and social behaviors), sexual arousal (excitement due to wearing women's apparel) androallure (sexual, social, and affectionate encounters between transgender person) and pleasure (non-sexual feelings of enjoyment, happiness or relaxation due to cross-dressing) (Doctor and Fleming, 2001). Their conclusion was that transgender cognition and behavior was multidimensional and complex and that there existed fundamental elements of transgender thought and behavior with respect to role and identity

that overlap in transsexuals and transvestites (Doctor & Fleming, 2001).

There is no dispute that gender identity is a powerful determinant in a person's sense of self (Ekins & King 1997). Gender identity is a fundamental sense of self and is more than just anatomy. Expression of gender comes in the form of body adornment, role in society, role in family, selection of occupation, attitude, and mannerisms (Ekins & King 1997). Once a gender is adopted there are behavioral expectations that are relegated to that gender (Bullough 2000). Gender behavior that is not totally congruent with the rules and expectations of society in which a person lives may be met with negativity (Bullough 2000; Bandura 1977; Ekins & King 1997).

The statistics reported on the prevalence of gender variant persons are widely varied. Bullough (2000) suggests that approximately 10% to 15% of the world's population is gender incongruent. Conway (2001) reports there are currently 32,000 to 40,000 postoperative transsexual women in the United States alone or 1:250 males, while medical authorities quote a prevalence of 1 in 30,000 for MTF transsexualism and 1 in 1000,00 for FTM transsexualism. Research by Dr. Anne Fausto-Sterling (2000) conservatively estimates that one in 100 babies born in the United States present intersex conditions at birth. Efforts to estimate the prevalence of gender variant persons have been problematic because such efforts are based on persons requesting surgical reassignment of their sex and would therefore be considered transsexuals (Ettner 1999). With the prevalence of transgender persons estimated from a range that varies from 3% to 5% to a range of 8% to 10%, it is likely that mental health providers will encounter at least one transgender client during their career (Ettner 1999).

Transgender persons present the mental health professional with a variety of issues, needs and goals beyond those related to sex reassignment surgery (SRS) (Cole et al. 2000). Some issues facing the transgender person include: frustration, cognitive dissonance, anger, loneliness, shame guilt, disclosure, relationships, family, and secrecy (Cole et al. 2000). Specific health issues, both physical and mental are particular to the transgender community (Dean et al. 2000). Increased levels of stress and depression within this community are associated with the negative perception of the transgender status (Dean et al., 2000). Perception of self (self esteem) is also at risk because of the stigma attached to gender incongruence. Gagne et al. (1997) cited fear of discovery and abandonment as issues faced by those who are gender incongruent. Dean and colleagues cited low self-esteem, fear of discovery, and feelings of shame related to being transgender as barriers to care (Dean et al. 2000). Prejudice and discrimination caused by the stigma of the label "transgender" promote ridicule and isolation (St. Claire 2000). It is argued that the stigma attached to behaviors that are incongruent with anatomy is the foundation for issues surrounding fear of discovery, secrecy, and fear of abandonment (Dean et al. 2000; Wilson 1998). Revisiting Bandura's Social Learning Theory, (Bandura 1977) offers insight as to the transgender person's perception for the need of secrecy about their gender status. According to Bandura, behavior that is not congruent with the assigned anatomical sex receives negative reinforcement from society. Another barrier is the ignorance of the needs of this community by medical and mental health care providers (Dean et al. 2000).

Having a perception of self (gender identity) that contradicts the gender assigned at birth, and taking part in activities that are not consistent with one's physical sex, creates

separate public and private selves that threaten a person's ability to maintain an integral self-image (Ekins & King 1997). Gagne et al. (1997) observed that it may take years for a person to come to terms with his or her gender identity and resolve differences between the public self and the private self. Those who are gender incongruent face obstacles that may inhibit expression of their perceived gender. Issues of discrimination, shame, support, and lack of adequate health and mental health care may delay coming to terms with a gender identity that is incongruent with physical self (Dean et al. (2000). Other factors that may bring about distress and impairment in gender variant persons are fear of discovery, abandonment and discrimination, all of which influence behaviors of secrecy and isolation (Gagne et al. 1997; Lombardi 1999).

Research by Dean et al., (2000) suggests that this group experiences some of the same struggles as other stigmatized minority groups, such as homosexuals and persons with HIV/AIDS. Internal perception of self and external appearance causes dissonance, and together with the stigma attached to gender incongruence, may be the cause of distress in this population (Dean et al., 2000; Lombardi, 2001). Self-esteem, shame, abandonment, and discrimination should not be interpreted as evidence of pathology, but should instead be considered a result of the social definitions of gender division and a person's non-conformity with those divisions (Dean et al. 2000).

According to Gagne et al. (1997) the transgender person faces two battlefields, one internal and one external. The internal conflict of coming to terms with feelings of incongruent gender identity, deciding whether or not to act on these feelings, and then trying to find a way to fit into society may be the true issues faced by this population (DeAngelis

2002). Externally, being unable to dress, act, and live as one desires creates another set of barriers to expression of gender identity. Still another set of barriers for those who are gender incongruent, is not being able to participate in those same activities because of shame or fear. Both can result in dissonance, anxiety, low self-esteem, and possible decreased enjoyment in life (Dean et al. 2000).

Problems of invisibility have plagued transgender populations for centuries (Feinberg 1996). Having been excluded from historical accounts and pressured by members of the medical and mental health establishments into concealing circumstances surrounding their gender and birth sex from public knowledge, these individuals suffer shame and secrecy (Dreger 1998; Fausto-Sterling 2000; Diamond and Sigmundson 1997). The cost for invisibility is harsh: sexual assignment surgery on infants (Kessler 1998), absence of legal protection against discrimination (Namaste 2000), and diagnoses of mental disorders. Even more severe is the cost of being visible resulting in hate crimes.

Our society has intolerance for sexual orientations that do not conform to the heterosexual standard; and while it is not their sexual identity that makes these individuals visible, it is the expression of their gender identity. Social prohibitions against transgenders combined with pervasive stereotypes about the kind of person that would undergo SRS, force many to live a life of stealth. In the case of a postoperative transsexual, identifying as such may imply a continued pathology, thus it is far simpler not to identify as a transgender or associate with the transgender community.

Distress or impairment is often a controversy between members of the transgender community and the medical and mental health providers who care for them. When the

original diagnosis of Transsexualism appeared in the DSM III-R in 1987, the essential features included persistent discomfort with one's assigned sex and at least two continuous years of interest in changing one's body, (APA 1987). In 1994 the diagnosis was removed from the DSM-IV, leaving Transvestic Fetishism and Gender Identity Disorder (APA 1994). Today, the DSM-IV-TR describes Transvestic Fetishism as a male cross-dressing in women's attire for the purpose of sexual gratification. There are clinical criteria that these behaviors cause "clinically significant distress" (APA 2000, p.575). According to the DSM-IV-TR, Gender Identity Disorder has two components, both of which must be present in order to make the diagnosis. There must be persistent cross-gender identification and there is discomfort about one's assigned sex (APA 2000, p. 576).

The diagnosis of Gender Identity Disorder is one criterion that must be met before Sex reassignment Surgery (SRS) will be recommended (Wilson 1998). In addition to the two criteria mentioned, there "must be evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning" (APA 2000, p. 576). The necessity of making a diagnosis puts mental health care providers in the position of gatekeepers for transgender persons because the assessed degree of distress and impairment will determine their candidacy (Bolin 1988). The transgender person seeking candidacy for surgery feel they need to adopt a script of extreme behavior in order to receive hormonal treatment or to be considered for SRS.

Hyper-femininity and hyper-masculinity coupled with distress have been conceptualized as stereotypes created by care givers and used as criteria for care (Bolin 1988).

Bolin stated that, “Caretaker-client interaction is fraught with dishonesty, distrust, and hostility that undermine the benefits of the therapeutic encounter (Bolin 1988, p.65).” According to Bolin (1998), not all male to female transgender persons are hyper-feminine, and not all female to male transgenders are hyper-masculine. But these two extremes have been used for benchmarks for the diagnosis, treatment and care for some in the transgender community. Bolin noted that effective therapy cannot take place in such a climate, and that transgender persons should not have to hide nor exaggerate aspects of self in order to receive medical or mental health services (Bolin 1988).

Wilson (1998) found that not all transgender persons experience extreme distress or impairment because of their gender incongruence. Some have learned to cope and function within the gender identity bounds created by society. In a study conducted by Prince and Bentler (1972) of members of a heterosexual cross-dresser support organization, 504 cases disputed assignment of distress or impairment to those who cross-dress. Results suggested a high degree of educational and vocational success by group members as well as a great deal of self-acceptance.

Lombardi (1999) conducted a study with similar results. The study asked 46 college-educated, married, upper-income, transgender male to female persons to complete a questionnaire. The depression measure component (Center for Epidemiologic Studies Depression Scale) was been used in a National Survey of Family and Household (NSFH) in the United States in 1999 (Lombardi 1999). When the results of the Lombardi study were compared with the results of the NSFH research, transgender persons did not significantly differ in areas of distress and depression (Lombardi 1999).

Treatment issues for the transgender go beyond assisting gender dysphoric persons in their transition or adjusting to their new gender, but include the possibility of affirming a unique transgender identity (Bockting 1997). Cole and colleagues reminded mental health professionals that providing mental health care to transgender persons is not limited to those transgender persons seeking SRS (Cole, Denny, Eyler, & Sammons 2000).

When providing mental health care to the transgender person, it is crucial that counselors build an adequate knowledge base of understanding transgender issues. Acquiring information regarding the historical, political and psychological contexts in which the transgender person lives is essential for positive outcomes of counseling. Biographies, autobiographies, general texts, periodicals published by transgender organizations and some popular movies allow for cultural exploration and provide valuable insight into this emerging and diverse population. Familiarization with historical and sociopolitical events, the politicization of the transgender movement and an increased awareness of the ever evolving consciousness of the transgender community will be helpful in developing understanding and establishing a therapeutic relationship with the transgender client.

To further develop counseling skills and knowledge, it is necessary to be aware of the local, state and national support networks for transgender persons. Lombardi (1999) noted that the greater the social network, the greater the opportunities for members to talk about gender issues with each other. Parlee (1998) reported that the growing sense of community serves to challenge the pathologizing medical community and the violence and discrimination. Another knowledge base to develop is for referrals to medical establishments

regarding hormonal and SRS, and support services such as HIV prevention and testing, sexual assault prevention and other medical services.

Not all transgender persons have the same notion about gender identities and many in fact do not identify with the transgender movement. Even though there have been efforts to build coalitions between subgroups within the transgender community, differences and tension exists (Bornstein 1998). In a study of transgenderist for example, most desired to refigure their bodies in such a way as to pass as women. Only a minority expressed a desire to live as a transgenderists and to break out of the traditional binary gender (Gagne & Tewksbury 1998).

Many transgender persons view the medical and mental health establishment with distrust and suspicion. Many (if not all) have endured discrimination and negative stigma. For these reasons Bockting (1997) recommends that counselors use a client-centered approach. Crucial skills include empathy, acceptance, positive regard, listening and validation of feelings. Another protocol that is helpful the narrative therapy approach (Laird 1999). The client is able to tell their own stories unburdened by prior assumption of the therapist about sex and gender. During this process, cultural narratives regarding heterosexism and gender are deconstructed. Ettner (1999) proposes that counselors who work with transgender persons must possess cognitive flexibility or a directive, holistic approach. Laird recommended adopting an "informed not knowing" stance in which the counselor leaves "behind her own cultural biases and pre-understanding to enter the experience of others" (Laird 1999, p. 75).

Transgender persons seek counseling for a variety of issues including mood disorders alcoholism and other drug abuse, inability to function at work or school, physical abuse, fetishism, and anxiety (Denny & Green 1996). Transgender persons may feel isolated, ostracized from family and friends, have feelings of depression and low self-esteem. They may experience financial, social and legal discrimination. Transgender persons may lack knowledge about risks of HIV/AIDS, safe sex and other sexually transmitted disease. They may lack knowledge of risk of sexual assault. Male-to-female transgenders are especially vulnerable because of their lack of experience with sexual advances by biological males.

More important than a knowledge base of understanding transgender issues in a therapeutic setting is the therapist's attitude towards the transgender client and community. Counselors should rethink their beliefs and assumptions about gender, sexuality and sexual orientation, and adapt a more positive approach when counseling members of this community. Medical and mental health establishments have pathologized the transgender community, and counselors need to be sensitive to this issue. Counselors have communicated reductionistic either/or messages, such as counseling clients out of SRS because of somatically inappropriate body types, facial features and so forth (Ettner 1999). Gagne et al., (1997) conducted a qualitative study of MTF transsexuals and found that the majority reported having been in counseling and were pressured by their therapist to come out to others and appear as women. Fagan, et al. (1994) reported that there are still incidents of counselors who adamantly believe that transsexual people are homophiles but cannot accept their sexual orientation.

When counseling the transgender person, counselors should increase their awareness of the possibility of countertransference. Counselors should be increasingly aware of their subjective feelings and inner experiences as they interact with their transgender clients in a therapeutic setting. Countertransference is when the therapist, during the course of therapy, develops positive or negative feelings towards the client. For example, many MTF transgender persons gravitate toward female therapist. This may be the cause of therapist availability in a specific area or it may be a function of the preponderance of women in the profession. Bolin (1988) suggested that MTF individuals feel that genetic females serve as the optimal role models of experience. The client's need and desire to develop a female gender identity may tap into the therapist's own unresolved issues of dependency, narcissism and internalized gender constructs. Before providing advice to the client on gender presentation, the therapists would be well served to examine her underlying values and perceptions of femininity. The therapist should not impose her personal translation of female gender attributes onto the client by being directive when the client experiments with hairstyles, make-up or clothing.

A concern in providing therapy to transitioning individuals involves the therapist's conception of gender including fantasies of his or her own possible gender/sex change as well as the gender/sex change of the client. During the real life test or cross-living period in the transitioning process, the therapist's internalized gender values will most likely be found to influence the client. The therapist has to ensure that his or her value system does not interfere with the client's choice of gender expression, even though the choice may seem inappropriate to the therapist.

Only about 6% of all diagnosed transgender persons who start the cross-living process will proceed with SRS (Stinger 1992). Although many begin the transitioning process the majority will elect hormones but keep their genitals in tact. Others have raised concerns of undue importance being placed on SRS. In any event, the decision must be reached by the client without any interference from the therapist. The transgender person may have second thoughts of SRS and desire the therapist to dissuade them from proceeding. The therapist must always be accepting, without condoning.

Because SRS is not reversible, the client and the therapist should gather as much information as possible, primarily that the client may make a well informed decision, free from any influence or interference from the therapists. In the case of a MTF, inquiry must address the complete removal of the testes and the effects of hormones. While some post-operative individuals feel happiness and a sense of well-being, others may experience loss of libido. Some will come to the realization that despite surgery, they will still not be considered members of the opposite sex or gender (Bornstein 1994; Stuart 1991). The post-operative individual may also develop hatred for body parts that cannot be changed, such as hands or feet (Denny 1991). Additionally, the fear of being detected by the public may re-intensify because the external appearance will remain the same even when the person is fully clothed. Based on the client's emotions and circumstances, androgyny may be an acceptable solution. But to open this up to the client may require an examination of the therapist's biases in terms of gender and sexuality.

Some people have serious moral compunctions about changes of sex, and others have their own about gender identity with which they have yet to deal. However, transgender

persons have a right to treatment and people who are transgender and have no specific issues about their gender identity have the right to expect treatment on the issues for which they have requested it. Therapist should treat the transgender client on the presenting issue free of any moral qualms or prejudices. If a transgender person seeks counseling, the therapist must not explore the client's gender identity unless it's the client's desire to do so.

CONCLUSION

The purpose of this project was to increase a greater awareness and understanding of the transgender community. In accomplishing the objective, the evolving definitions were defined and a review of the history surrounding this diverse population from early biblical times to present day was made. The influences of nature and nurture were examined as possible etiologies, and it was concluded that the complex and dynamic interaction of both nature and nurture determine gender identity. Interestingly a discovery was made that gender identity is more than our society's strict gender binary of masculine and feminine. Gender, as seen on a continuum is multidimensional, and there are degrees of masculinity and femininity in each person. An interview with a transgender who was born a male but raised during very formative and impressionable years as a girl lends credence to the theory that environmental experiences may be able of overriding prenatal influences. And finally I discussed counseling the transgender.

If the transgender community (transsexuals, transvestites, intesex and transgenders) has been marginalized as they claim, would framing a collective identity that all members can embrace, diminish or displace identities that a greater society wishes to recognize in the transgender? Possibly. But only if the medical and social definitions and categorizations that divide them are dismantled; and, when members of the transgender community shake loose their invisibility, divisions, and self-imposed isolation.

GLOSSARY

Cross-dresser. An individual who dresses in clothing that is culturally associated with members of the other sex. Most cross-dressers are heterosexual and conduct their cross-dressing on a part time basis. Cross-dressers cross-dress for a variety of reasons, including pleasure, relief from stress, and a desire to express opposite sex feelings to the larger society.

Drag King. Individuals who identify themselves as lesbians and who cross-dress for entertainment purposes in lesbian and gay bars.

Drag Queen. Individuals who identify themselves as gay men and who cross-dress for entertainment in lesbian and gay bars.

Gender. Gender refers to culturally constructed distinctions between masculinity and femininity.

Gender bender. Refers to a person who openly, brazenly and flamboyantly flaunts society's gender conventions by mixing elements of masculinity and femininity.

Gender dysphoria. A psychiatric term used to refer to an individual who feels an irrevocable disconnect between their physical bodies and their self-sense of gender. The term is offensive to those in the transgender community because it pathologizes the transgender due to its association with the DSM-IV.

Gender identity. Refers to a person's self-sense as man or woman, transgender or other identity.

Gender outlaw. Refers to individuals who transgress society's rules and laws of gender. one who challenges gender roles.

Gender queer. Refers to individuals who challenge both the gender roles and sexuality regimes, and who see gender identity and sexual orientation as overlapping and interconnected.

Gender trash. Slang term used to describe the way that gender variant individuals are often treated in a transphobic society.

Gender variant. Refers to individuals who stray from socially accepted roles in a given culture. Hir. A pronoun used by some individuals who identify outside the male-female spectrum, instead of his or her.

Intersex. Formal term is hermaphrodite. Someone who considers themselves to be in between the sexes. The term can refer to a person who is born with sex chromosomes, external genetalia, or an internal reproductive system that is not considered by society's norm for either male or female. However, some sex and gender diverse people not born with obvious physical differences may also use the term to describe themselves. The intersex movement seeks to halt pediatric surgery and hormonal treatments that attempt to normalize infants into the dominant male and female roles.

Metagender. A person who identifies as neither male nor female. Such a person also does not identify as being both male and female, or as neutral. This is a new term that refers to a gender identity outside of any current definitions.

Queer. Once considered as slang and offensive, the term has been reclaimed by members of the gay, lesbian, bisexual and transgender communities, and refers to those individuals who transgress culturally imposed norms of heterosexuality and traditional gender. Those who identify with the term "Queer", use it as a symbol of pride and affirmation of their difference and diversity.

Queer theorist. An individual, normally an academician, who uses feminism, psychoanalysis, post-constructionism and other theoretical schools to critically analyze the position of gay, lesbian, bisexual, and transgender individuals in cultural texts.

Sex. Not to be confused with gender, this term refers to the cluster of biological, chromosomal, and anatomical features associated with maleness and femaleness in the human body.

Sexual orientation. Refers to the gender that a person is emotionally, physically, romantically, and erotically attracted to. Examples of sexual orientation include homosexual, bisexual, heterosexual, and asexual. Transgender and gender-variant persons may identify with any sexual orientation, and their sexual orientation may or may not change after transition.

Sexuality. The state or quality of being sexual. Sexuality is a broad term that refers to a cluster of behaviors, practices, and identities in the social world.

She-male. Someone who identifies as between male and female, or as both male and female. The term generally refers to people born as a biological male who later takes on the appearance of females, sometimes through hormones, surgery or both.

Sie,s/he, or zie. A pronoun used by some people who identify outside the male-female spectrum, instead of he or she.

Trans. A term referring to cross-dressers, transgenderists, transsexuals and others who

permanently or periodically dis-identify with the sex they were assigned at birth.

Transgender. Refers to a variety of behaviors, expressions, and identifications that challenge the bipolar gender system in a culture. Transgender is used as an umbrella term in reference to a variety of differing gender identity categories, which include transsexual, drag king, drag queen, cross-dresser, transgenderist, bi-gendered, and others.

Transgender lesbian. An individual, regardless of biological sex, who identifies as both transgender and lesbian. This could include male-to-female transgenders who are sexually attracted to women, or to biological females who identify as lesbians and who often pass as men, or who identify to some degree with masculinity or with butch.

Transgenderist. This term was coined by Virginia Prince and refers to an individual who dis-identifies with their assigned birth sex and lives full time in congruence with their self-sense of gender identity. Although some transgenderists may opt for hormone therapy, most do not seek or want sex reassignment therapy.

Transphobia. The fear and hatred of all those individuals who violate, transgress or cross over the dominant gender categories in society. Transphobic attitudes lead to discrimination and oppression against the trans communities.

Transsexual. Refers to an individual who strongly dis-identifies with their birth sex, and who wishes to use hormonal, surgery or both as a way to align their physical body with their self-sense of gender identity.

Transvestite. Refers to cross-dressers, or individuals who have an internal drive to wear clothing associated with a gender other than the one that they were assigned at birth. Cross-dresser is preferred because of the psychiatric, clinical and fetishistic connotations, of the word transvestite.

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