APPENDIX B

TRANSGENDERED BEHAVIOR AND DSM IV

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Background

Transgenderism is a socio-legal-behavioral term referring to individuals who express feelings and behaviors that are discordant with recognized gender, based on anatomic sex. Most commonly, this term includes the following subgroups: transvestites (i.e., males who cross-dress; there is no female counterpart); transsexuals (i.e., individuals, both male and female, who are dissatisfied with their anatomic sex and desire to change to the opposite sex, often living full time in the new role, taking hormones, and pursuing sex reassignment surgery); and transgenderists (i.e., individuals similar to the transsexual, both male and female, who are dissatisfied with their anatomic sex, often living full time in the desired role and taking hormones, but not desiring sex reassignment surgery and instead electing what is coming to be called the "non-surgical option").

While the term "transgenderism" is relatively new, the phenomenon described is well-recognized throughout the history of man.[1] Early efforts to describe transgendered behavior have fallen on the field of medicine, likely because this phenomenon involved nonusual or atypical behavioral manifestations of the human condition, and such was considered in the realm of medicine and psychiatry. Hirschfeld[2] was one of the first sexologists at the turn of the century to detail cross-dressing behavior and coined the term "transvestite." Half a century later, Benjamin[3] studied aspects of transsexualism, culminating in his classic book on the subject. And, in 1980, the Harry Benjamin International Gender Dysphoria Association was formed and Standards of Care were developed to guide professionals in working with transgendered individuals.[4] Specifically, minimal criteria are offered for determining how and when to recommend such interventions as hormone therapy and sex reassignment surgery for those seeking these treatments. Further, methods for ongoing follow-up are provided too.

Along this historical pathway, the American Psychiatric Association also recognized this behavioral condition. And, with the current Diagnostic and Statistical Manual - Fourth edition (DSM-IV) two primary types are identified.[5] First, transvestic fetishism (formerly transvestism, also referred to as heterosexual cross-dressing) is listed under the Paraphilias, or sexual deviant behaviors. This category also includes pedophilia, exhibitionism, voyeurism, and other prominent sex offending problems. And second, gender identity disorder (formerly transsexualism, also referred to as gender dysphoria) stands alone with its own classification. This phenomenon can be seen at various developmental stages and so can be diagnosed at childhood, adolescence, or adulthood. The former is described as a disorder that involves recurrent fantasies, urges, and behaviors involving cross-dressing. For such a diagnosis to be made, according to DSM-IV criteria, such activity must also produce distress or impairment in social, occupational, or other important areas of functioning. The latter disorder involves a strong and persistent cross-gender identification and discomfort with one's anatomic sex, often beginning in the early developmental years and evolving over time to include a desire to alter oneself through hormones and surgery. Again, such a diagnosis is made when these feelings produce distress or impairment in social, occupational, or other important areas of functioning.

Controversy, however, surrounds the way transgendered behavior is described in DSM-IV. For some, the APA's diagnostic criteria are too limiting and do not take into account variations that exist which do not fit into the specified categories. Similar concerns have arisen within the membership of the Harry Benjamin International Gender Dysphoria Association, the primary association of professionals working in this area. Also, some transgendered consumers and activists feel that a psychiatric description of this condition is stigmatizing. A recent article in *Esquire* Magazine describes the increasingly visible "transgender movement" and the concerns these individuals have about this issue.[6] Yet, the same article points out that those protesting appear to be in the minority, with the vast "silent" majority of transgendered individuals simply wanting to pursue desired medical therapies, blend into society, and live in quiet anonymity.

This poses an interesting question: to what extent is transgendered behavior psychopathological? Is there some research to suggest that perhaps such behavioral states are not psychiatrically disordered, per se?

Contemporary Research

In a recent work by Brown, a psychiatrist and gender specialist, the area of transvestism or heterosexual cross-dressing is extensively reviewed.[7] He points out that various treatment approaches used to "cure" adults of this behavior (e.g., psychotherapy, aversion techniques, pharmacological agents) have been abysmal failures, with none resulting in permanent behavior change. Rather, most cross-dressers enjoy their behavior, coming to the attention of mental health professionals only when a crisis arises (e.g., a spouse discovers and will not accept such behavior, feelings of guilt and shame develop associated with cross-dressing). Brown notes that current views of transvestism are based on such clinical cases of individuals in distress. Surveys of large groups of individuals drawn from social and support networks of cross-dressers, however, indicate no sense of distress but rather self-satisfaction and feelings that such activities are fulfilling and enriching aspects of their adult lives.[8] Also, the psychiatric profession views cross-dressing behavior as associated with sexual arousal, often with masturbation accompanying the activity. Yet, the above-mentioned surveys suggest another motivation. For many, the desire to cross-dress, while often starting out with accompanying sexual activity in the early phase, evolves over time to where non-erotic pleasure is a predominant motivator (e.g., expressing one's feminine side, providing a sense of calmness and relaxation, being able to network socially with friends around such behavior).

Such observations suggest for many cross-dressers there may not exist a psychiatric disorder, per se. That is, there may be a number of people out there, as yet undetermined in size, that have largely gone unnoticed by mental health professionals. For these individuals, there would seem to be no significant social, legal, or occupational problems that have been encountered, hence no need to be described as a psychiatric problem. From Brown's perspective then, cross-dressing behavior could be seen as compatible with mental health rather than mental illness.

Cole and his colleagues in Galveston have likewise surveyed a primarily transsexual population.[9] Over 400 individuals presenting with a self-diagnosis of transsexualism were evaluated extensively, addressing such areas as hormonal/surgical treatment, and histories of substance abuse, mental illness, genital mutilation, and suicide attempts. In addition, a subgroup of individuals completed the MMPI, a standardized personality inventory commonly used in the field of psychiatry. Results suggested that less than 10% evidenced problems associated with mental illness, genital mutilation, or suicide attempts. This 10% figure is noteworthy, according to the authors, as recent estimates from the National Institute of Mental Health (NIMH) regarding the American population in general suggest that up to 25% may have identifiable psychiatric symptoms suggestive of diagnoses such as anxiety disorders, depression, drug and alcohol abuse, and personality disorders.[10,11] In light of this, it would appear that the sample studied had an incidence of mental illness no higher than that found in the general population. Additional findings indicated that those completing the MMPI demonstrated profiles that were notably free of psychopathology according to both Axis I (i.e., major clinical syndromes) and Axis II (i.e., personality disorders) criteria as set forth in DSM-IV. The one scale where significant differences were observed was the Mf scale, a measure of masculinity - femininity. Here the profiles of the male-to-female subsample, and to some extent the female-to-male subsample, appeared more "normal" when examined from the perspective

of the desired sex rather than the anatomic sex, suggesting better comfort and adaptation in the new gender roles. In summary, this study offered support to the view that transsexualism is usually an isolated diagnosis and not part of any general psychopathological disorder.

Those studied by Cole and his colleagues had presented to a gender clinic for medical assistance in achieving their desired goals of successfully living as men or women. Over two-thirds were undergoing hormone reassignment, suggesting a commitment to the real-life process. And virtually all of the individuals were seeking to pursue sex reassignment surgery, hence the reason for coming to this medical clinic. Only a handful were considering the non-surgical option (i.e., living as transgenderists, taking hormones of the desired sex, but not wanting to pursue surgery). Such an option, as noted earlier, is relatively new and has not been extensively studied by gender specialists who have traditionally viewed hormones and surgery as the usual outcome sought by individuals. For indeed, it is the consumers who have raised and pressed the issue of "why do you think I would go to all this trouble if I did not want to complete the process" (i.e., surgery).

It is important to remember that the Cole et al. findings noted above are not without critics as some studies have found opposite results. Specifically, Pauly [12] has noted a significant incidence of mood disorders in gender dysphoric individuals, and Levine[13] has reported on notable Axis II pathology in this group (i.e., DSM-IV criteria for associated personality disorders). These varied findings suggest a need to conduct further surveys of large groups of transsexuals, addressing issues of self-satisfaction, social-familial problems encountered, and evidence of symptoms suggestive of mental illness.

Towards the Future

These recent studies suggest that an expanded view of transgendered behavior may be in order. Frankly, one should not be surprised in this regard. After all, knowledge regarding other human conditions has evolved with time and closer examination. The study of transgendered behavior is relatively recent with most research coming in the last several decades. The conceptualization of such behavior has been based, as noted, on clinical samples of individuals in distress (e.g., feeling guilty, discovered by spouse or children) or who are seeking specific medical therapies (e.g., hormones, surgery). Much of this professional literature portrays transgendered individuals as having additional associated psychopathology. Now, it appears that this may not always be the case. However, this does not rule out the existence of individuals with problems who certainly can benefit from psychiatric intervention, but this may not be a characteristic of the group as a whole. Clearly there is a need for additional empirical research around the variations of transgenderism in order to revise understanding of this human condition as well as ways to intervene and assist where indicated. Perhaps one direction worth considering would be to consolidate all variant subgroups under one classification, transgenderism, thus reflecting the continuum of this human condition and also eliminating one of the major criticisms of cross-dresser groups about being identified with the "sexual perversions" or paraphilias.

Medical involvement in some fashion will likely remain in place, particularly for those electing

the option to pursue hormone therapies and surgery. After all, a period of evaluation is practical and judicious when contemplating interventions of this nature. The Standards of Care recognize the importance of this fact and were clearly developed to be of benefit to the consumer, professional, and payor of services. No form of medical treatment is simply provided "on demand" without an interactive component between professional and consumer, exploring both potential risks and benefits. For example, if hormone medications were so safe and simple, why does the FDA not assign these to over-the-counter status? Research clearly indicates, however, that there can be risks to this form of treatment and so medical involvement with follow-up is warranted to ensure safety for the consumer.[14] Another issue to remember too, and a very practical one at that, is pointed out by Pauly[15], where he notes that tremendous gains have been made over the years in getting insurance carriers to recognize transgendered behavior as a legitimate, reimbursable expense for a medically recognized condition. With Standards of Care and identified diagnostic criteria, major battles have been won in this regard. In many cases, coverage has gone beyond the medical-surgical expenses to include speech therapy, electrolysis, and other recommended interventions. Eliminating such guidelines could return a consumer's coverage for professional expenses to one's own out-of-pocket capabilities. Instead of trying to eliminate medical involvement, the important point here is that both consumer and professional need to work together and, in the case where it seems like there is not a good match, then either should be free to go elsewhere.

So, one should not be quick to downgrade or abandon the current Standards of Care. Along with "clinical judgment" and experience they serve to help an individual come to understand himself/herself and develop a tailored plan to move toward better adjustment and self-acceptance. They are, however, not written in stone and, indeed, are subject to change as new information comes forth. (Such is a common practice in medicine and psychiatry as various illnesses and behavioral states are revisited and approaches to intervention and management are revised.) The Fourteenth International Symposium on Gender Dysphoria, sponsored by the Harry Benjamin International Gender Dysphoria Association, is set for this fall in Germany, and the entire Standards of Care will be reexamined and updated.

Some, however, are likely still to criticize such groups as HBIGDA for "medicalizing" and "profiting" from transgenderism. Yet, one could certainly level similar criticism at other professionals such as the lawyers, electrologists, speech therapists, and fashion consultants, to name but a few who have come along as well. On the other hand, it is important to note that many others (i.e., the "silent" majority referred to earlier) are openly thankful that various professionals, and even multidisciplinary teams, exist to help work through the myriad of issues associated with coming out. These individuals seem less concerned with the politics of transgenderism and are more focused on seeking medical interventions to assist with establishing a new and satisfying life, a choice that certainly should be respected. Sadly, reports continue to surface from some who run into professionals untrained in this area who show disinterest or disgust in transgenderism, or who unscrupulously and unethically try to provide services when, in fact, they are learning at the literal expense of the consumer.

Finally, in view of the research noted previously, efforts must continue toward demystifying and destigmatizing transgenderism. Clearly, inequalities remain, discrimination continues, and

society-at-large still sees such behavior on a continuum from amusing to distasteful. [6] Handling this gargantuan challenge will require planning and coordination, and time. Attitudes will not change overnight. However, positive steps can be taken with more empirical research, as called for here, with consumer groups meeting with and educating professionals from fields such as medicine, psychiatry, insurance industry, state and national government, and with tasteful, well-prepared media coverage and documentaries, not of the tabloid variety. Frontal assaults on these typically conservative groups will not work and predictably will reinforce notions that transgendered individuals are abnormal and flaky at best. Rather than dictating to these groups, it will be important to dialog with them.

In summary, transgenderism is a variation on the human condition and, in light of new thinking and evidence, may not be simply a psychiatric disorder, per se. It appears that individuals can hold down jobs, raise families, establish close relationships, pay taxes, and generally live successfully, with no significant debilitating distress or impairment in functioning. Additional research is needed to explore and verify these observations. In the meantime, however, much has been accomplished with the development of Standards of Care and a growing group of dedicated professionals from various walks of life who appear committed to working with a group that so often has been treated like the lepers of ancient society. And, efforts must continue to eliminate discrimination and stigmatizing attitudes toward transgendered individuals. Rather than simply abandoning and vilifying what has been achieved, attention should be turned to working within the system to educate and improve opportunities for all.

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