Notes on Gender Role Transition

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T NOTE #13

Potential Therapeutic Errors When Using Binary Based Terminology to Explain the Gender Variant Condition

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Five of the most common terms used when working with people struggling with gender issues are "**gender dysphoria**," "**Gender Identity Disorder**," "**female-to-male**," "**male-to-female**," and "**sex change**." Because these terms are based on a male/female binary norm, they may not be apt descriptors of people who are gender variant. Or worse, if taken literally they could lead to practitioners misdiagnosing the condition, clients misinterpreting their situation and both client and practitioner having unrealistic expectations for treatment outcome.

In this paper I will try to explain why I find the above mentioned phrases awkward or inappropriate and, where possible, offer suggestions for alternative terminology.

GENDER DYSPHORIA-- The term, in my opinion is wrong on two accounts. Firstly, everyone I have ever treated with sex/gender dimorphic feelings believed that their gender or inner sense of being male or female or the combination thereof is simply that, a sense of being male or female. I have yet to hear anyone complain that their physical sex is "right" and their sense of being male or female is "wrong". The complaint is that their inner sense of being male or female or a combination thereof is inconsistent with their physiology. The idea of changing this critical element in the pantheon of elements that compose the essence of who they are is anathema to them. Some individuals find their gender identity so truthful that they turn the phrase "gender dysphoria" on it head and use "gender euphoria" to refer to their sense of gender identity.

Secondly, "Dysphoria," defined by Marriam-Webster's Collegiate dictionary as "a state of feeling unwell or unhappy," or in the American College Dictionary as "a state of dissatisfaction, anxiety, restlessness, or fidgeting" is simply too soft a word to describe the angst most clinicians see on intake with this population. At best it may be an apt descriptor for individuals who, despite strong evidence to the contrary, are making an extraordinary effort to convince themselves that they are sex/gender congruent. These individuals make life decisions such as getting married and having children not only because

they may find it appealing to have a spouse and have children but with the added hope that this activity will ease or erase their obsessive cross gender thoughts. Although there may be instances where these special efforts succeed, (i.e. the incongruity is mild) the more likely outcome is a realization they have actually made matters worse. Typically, at time of presentation these individuals report that either their lives are in ruin, or they are very afraid that if their gender variant condition was to become known they would loose all that they cherish and be ostracized from family, friends and the ability to support themselves. High anxiety and deep depression with concurrent suicide ideation is common. One of the most extreme cases I have treated was that of a 50 year old genetic male, married and the father of 3 grown children with an international reputation as a scientist who reported to me that the reason he finally sought out treatment for his gender issues was because the number of times he found himself curled up in the corner of his office in the fetal position muffling his cry was increasing. That is not dysphoria, that is pure misery.

GENDER IDENTITY DISORDER (GID) --This term was introduced into the lexicon with the publication of the DSM IV (1994). It replaced the venerable descriptor, "Transsexualism."

According to the authors of the "Interim report of the DSM-IV Subcommittee on Gender Identity Disorders" (Bradley, et. al. 1991), the primary reason for creating the new term was to combine in one place the various DSM III-R (1987) diagnoses of Gender Identity Disorder of Childhood, Transsexualism, and Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type. The authors were also concerned that the term Transsexualism had taken on the singular definition of referring to someone who had decided to transition from one gender role to the other via hormonal and surgical procedures. Clearly a limiting term especially where children were involved. They go on to state in the paper's abstract that the term Gender Identity Disorder allows "the concept of a spectrum of gender dysphoria rather than discrete levels of symptoms". I believe that this was a valuable and insightful contribution to an evolving understanding of what it means to diagnose and treat someone who has a gender issue. However, I believe that the time has come for us to use our new found experience in working with this population and move closer to what it is clinicians are really treating when a gender variant individual enters our office.

In the eight years that Gender Identity Disorder has been in the lexicon, it has shown to have both aided and abetted the treatment of gender variant people. On the plus side, the severity of the term has lent a significant level of medical authenticity to the gender variant condition. Individuals so diagnosed, have used it to justify everything from transitioning on the job to keeping their marriages together to getting insurance coverage for treatment.

On the negative side, referring to a gender variant condition as a mental disorder has given fuel to those who feel that since it is classified as a mental disorder it should not be treated by physical transformation. Another unfortunate unintended consequence is that it often keeps gender variant people from seeking help. This applies especially to genetic males who are presenting for treatment. The median age of the individuals I have been working with has been rising

regularly and is now 47. We know from talking to adults who report a life long history of not disclosing the condition to their family and peers that they actively started hiding the condition in earliest childhood. Often resorting to overt lies and ultra secret cross gender activity to guard and protect themselves from scorn and disdain imposed by a binary gendered world. Obviously, this is not a healthy environment for any child to develop in. That more adults presenting with gender issues are not more psychically scared or more neurotic, is a testament to the strength of human nature.

Although GID may sound descriptive of the problem to those who have their sex and gender nice and neatly congruent, it is often considered offensive to those who have a different life circumstance. Referring to some people's gender consciousness as being ordered or disordered has until now come largely from those outside of the gender variant experience. After working with over 400 individuals with sex/gender dimorphic feelings over the last 24 years, I have come to believe that if there is any disorder to be treated in these individuals, it is one of anxiety. An anxiety that builds over years of physiological deprivation --an inability to produce sufficient cross-sex hormones-- combined with sociological --and sometimes even self-- gender expression deprivation brought about by strict enforcement of rigid dress and behavior codes.

It seems to me that the treatment plan delineated in the Standards of Care has it right. Indeed the administration of cross-sex hormones after a period of differential diagnosis, educational psychotherapy, encouragement in the exploration of cross-sex behavioral expression and in some cases, surgery, has been found to significantly reduce anxiety, elevate depression and improve the quality of life for a significant number of these individuals.

Perhaps it is time to consider renaming the phenomenon. I repeat here as I have else where (Vitale, 2001) that the condition be referred to as Gender Expression Deprivation Anxiety Disorder (GEDAD). GEDAD is not only less stigmatizing, it helps both the therapist and the individual to understand the real issues involved. Another advantage is that it leads away from the erroneous thinking that one can psychotherapeutically "correct" or "cure" a client's gender identity. A "correction" has yet to be shown to be possible in individuals with a significant level of variance from the more absolute male/female norm.

Considering the transsexual phenomenon as simply a natural variation of gender identity encourages both the therapist and the individual to work toward attaining an anxiety free resolution that is authentic yet compatible to acceptable gender expression within a binary based gendering system.

MALE-TO-FEMALE AND FEMALE-TO-MALE

Clinicians and gender variant people use these terms routinely. Often reduced simply to MTF and FTM respectively they have become an accepted shorthand by virtually everyone who is interested in the subject. As handy as the phrases have become, I would like to remind the reader that they are merely descriptors of a general direction of transition, not some concrete start to finish process. As much as clinicians and perhaps even most of the people who present for the first time with gender variant issues may wish, clinicians do not actually

take men as most men apparently understand themselves to be and help them become women. Nor do clinicians take women as most women apparently understand themselves to be and help them become men. Gender role transition is a life long process that starts near one gender pole and progresses ever closer without completion toward the other.

Rather then simply changing men into women and women into men something more profound happens during transition. Post treatment individuals who are busy going about their daily lives routinely report transition as a being a life saving experience. Empirical studies continue to show a significant absence of regret (Phafflin). If you talk to long term post transition individuals (25-30 years post-op) outside the clinical setting, it is clear that the "no regret" being referred to in the studies does not necessarily refer to having attained a definitive attachment to one or the other poles of a binary sexing system. Instead, it means that through hormonal and/or surgical intervention they have moved from a place they intuitively knew as wrong to a place that feels authentic.

In my opinion, the administration of cross sex hormones is the key agent in the enterprise. Not only do they help the individual attain the desired secondary sex characteristics, cross sex hormones seem to have a gender confirming maturation effect on that portion of one's sense of being male or female that until then had apparently been suffering hormonal deprivation. Beyond hormones, we have sex reassignment surgery. Although surgery opens up new possibilities regarding relationships and gender role social status, it still does not delete their gender variant status. The implication here is that there is room between the binary poles for significant satisfaction as long as the individual is given appropriate medication, surgery and space to define themselves.
For most of us who have been through the process and have rebuilt our lives, being truly male or truly female becomes a moot point. A condition I suspect is common to non sex/gender dimorphic individuals as well. It is common to hear from individuals who have undergone sex-reassignment surgery, some of which were treated as long as 25 years ago, that they have come to realize that they will always remain in the middle ground of the gender spectrum. But importantly, this continues to be far, far better then what their life was like prior to transition.

SEX CHANGE
Lastly-- the term "Sex Change" is also misleading. Technically sex is defined by chromosomal composition at the time of conception. Obviously, no amount of hormonal manipulation or surgery will ever change that. When you combine this with the fact that there is a spectrum of chromosomal variations possible at conception resulting in various intersex conditions, using a binary sex descriptors as positive markers is in reality only relativistic.

Although the term "sex change" is rarely if ever used in professional circles, it is common in the lay press. This indicates to me that there is a large gulf between what specialists in the field of gender issues understand about sexual assignment/reassignment and that of the lay world. I suggest that the term "gender role transition" be used instead. I first heard the term "gender role transition" used three years ago by Rebecca Auge Ph.D. during a peer supervision group. After discussing

it in great detail with her, I have since adopted it and encourage others to do so as well.

CONCLUSION

It is clear that the descriptive language regarding gender issues is evolving. Significantly, much of the gender variant philosophy and associated new language is coming from professionals who are currently experiencing the 'as lived' condition. Unlike in the past, the new speak does not emphasis or even hint at pathology, disability or disorder. Instead the new speak is characterized by its inclusiveness and declaration for a full healthy life.

The clinical advantages of using less negative and more aptly descriptive terminology not only help in the psychological recovery of the individual, it helps those around the client to accept the condition and--thereby the client-- upon his or her reentry into society in the new gender role. Outside the therapy office, therapist must continue to expand their and society's definition of sex/gender expression beyond the current binary sexing system to be more inclusive of the full range of human gender variant possibilities.

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upon this information as a substitute for consul with a qualified mental health professional.