

Transgender Psychological and Surgical Perspective

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 - C. Scientific labeling of Transgender Females as "autogynophilic", 'Paraphilics', Homosexual Transsexuals (attracted to males) or non-homosexual Transsexuals (attracted to females) or even as sexual deviants is harmful, degrading and heterosexist that lacks scientific merit
 - D. Reparative Therapy (intended to attempt a change of gender) mandate for gender non-conformant kids is harmful and sends completely the wrong message
 - E. Post-transition Societal Dysphoria results in myriad post-transition issues:
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Transgender Psychological and Surgical Perspective

I am honored to be asked by the APA membership and planning committee to speak with all of you today. And thank you, Dr. Haldeman, for the introduction. I believe this to be an important talk as there is much controversy surrounding transgender issues, some of which I hope to point out in giving all persons within the psychiatric community a bit of direction in this area. I realize that there may be persons in the audience with an extensive background in Transgender issues while there are others who are unfamiliar or are merely curious.... although, these days, it is hard to imagine any psychological practice completely devoid of any trans-exposure.

Though I am not much of a Star Wars fan anymore, I do have to say in amazement that it has been 30 years since the first Star Wars movie was introduced. Last year, while flying from Chicago to Seattle, I had the opportunity to fly with James Earl Jones....at least I *thought* it was him. You know....Darth Vader from the Evil Empire. I knew that he was from Seattle, he is African-American and tall and I thought it had to be him, sitting in first class while I ate peanuts in coach...but I wasn't sure. He had a baseball cap with a big "F" pulled down over his eyes (I thought perhaps the "F" might stand for the Force?). Anyway, the only way to truly find out if it was him, as I think anyone in the room knows, is to hear that voice....the Darth Vader *voice*. So.....and I'm not normally this star-struck, I just kind of followed he and his wife over to the baggage area and hung out near them waiting for the bags to arrive...of course within earshot to ear 'that voice'. Well soon, the bags began arriving and a slight woman leaned over before them and grabbed a bag that must have looked like James Earl Jones' wife's because, next-thing-you-know, "I believe that is OUR bag" you should have seen this poor woman. Her eyes opened wide, kind of like that star fleet commander as he was being choked by Darth Vader himself. Anyway, so I guess the message there is that 'some bags really do look alike'.

I bring the Star Wars analogy in here because there really is a Dark Force that we do face in today's polarized political world and I think it is incumbent upon all responsible professionals to seek truth, however it may conflict with one's sense of internal order and preconceptions. Being transgender is tough to fathom for most persons, the vast majority of whom have had clear and internally obvious gender identities since early childhood. And those gender identities are consistent with the genitalia that they were born with. Understanding the motivations and deeply held inclinations of a transgender person is difficult, especially in this realm, where it is so hard to fathom changing from one gender to another. It is simply unimaginable to most.

What motivates a person to go down a 'Transgender Pathway'? Is it a mental condition? (However, if the distress and misery associated with GID is a result of Society's Discomfort and resulting discriminatory reaction, the DSM itself says it cannot be psychologically-based). Is it inborn or somehow biological? Is it sexual in its origin or are there merely sexuality issues that are altered by the process? What is it that makes a man a man and a woman a woman? Can hormones and plastic surgery come in any way close to what 'God intended' (Quote unquote)? What is life like after surgery? Are the outcomes positive or have we simply created plastic surgery monsters that look one way but act another? How powerful are hormones in regards to physical and mental well-being? And sexual well-being? And where exactly does society play a role in these outcomes? And what role can the psychiatric community play besides pre-transition screening and counseling? Are these post-surgical outcomes men, women or some other unnamed gender? If gender expression is represented by diversity, why is gender itself

simply binary, with only two choices, male and female? Are these completely yin-yang individuals really something *special*, in offering perspective from both sides of the gender divide? Can the keys to unlocking violence and human male behavior be better understood via the insights of transsexuals? Is the transgender movement a cultural flash in the pan or is it here to stay? These are some of the questions I pondered when readying myself for this program and some that I hope to address today with you.

I mention gender and gender expression and would first like to offer a definition for each. **Gender Expression** is the behaviors, the voice, the mannerisms, the clothing, the characteristics that help a person define for the world what they believe their internal (brain) gender to be. **Gender identity** is a person's internal sense of gender. Gender expression is defined by society. Gender identity is normally defined by genetics and genitalia though not in the case of transgender persons. **Transgender** is the umbrella term that encompasses all non-conforming gender expression. It can include **transsexuals** (who feel themselves to physically not be of their natal gender and seek hormonal/surgical care to alter that fact), **cross-dressers** (who are largely heterosexual but who find satisfaction via wearing clothing of their non-biological gender) or **drag queens** (who wear opposite sex clothing, if only to attract the attention of gay males and, in fact, identify as homosexual). There are many similar and varied non-conforming gender expressions in both sexes, whose expression, in my opinion, is nearly equal in incidence, MTF/FTM. Although in our culture, for whatever reason, a slight preponderance of male-to female exists. My work and further discussion today will center upon transgender individuals who seek medical and surgical treatment to effect an alignment of genitalia that is consistent with their non-biological gender identity.

About myself: I am an Ob/Gyn by specialty medical training. I have delivered several thousand babies over 20 years although no longer perform obstetrics. I too am transgender although do not consider that term to apply, instead preferring 'female' without qualification. I practiced medicine for 8 years pre-transition and have practiced for exactly 8 years post-transition. Once, when I was identified as transgender, a woman asked the person who had outed me and said, "why would such a pretty lady want to change into a man?" I officially identify as bisexual though currently am with a female partner. I have been exclusively monogamous throughout my adult life. I have been proposed to on the shores of Waikiki overlooking Diamondhead but remain legally married to my spouse, a woman, who is the mother of my 3 teenage children and is here in the audience today. I have also performed hysterectomy on my ex-boyfriend and have performed genital reassignment surgery in the name of vaginoplasty in converting male to female on another boyfriend, who now goes by the name of Janice. I will not describe personal aspects of my intimate life but, it goes without saying, I have a rather diverse and interesting experience there as well. Oh, besides all that, I am the only current MD in the world who both performs gender reassignment surgery and also possesses a transgender history (with apologies to Dr. Christine McGinn).

About the surgery: Though I continue to have an office in Seattle, all surgery is currently performed in Trinidad, Colorado, a small but wildly supportive Victorian Western town located on the Santa Fe Trail. The hospital is modern and the ancillary care is excellent. Surgery is overwhelmingly successful in aligning patient self-perception of gender identity with physical maleness or femaleness. I perform Hysterectomy and metoidioplasty (but not phalloplasty), and scrotoplasty for FTM's. These are some examples. For TG females, we perform vaginoplasty, breast augmentation, labiaplasty and tracheal shaving and I've included examples of each.

How effective are the main GRS procedures? *Sensation* is assumed to be present with each outcome, with rare exception. Patients are almost invariably *orgasmic*, both for TG females as well as males. Regret is something almost every reporter or interviewer asks of me. In nearly 500 primary MTF procedures, I am not aware of a single case of regret. That said, life is not easy for those undergoing transition. Many continue to see surgical transition as their 'Holy Grail' in finally achieving intimacy, fulfillment and finality in their presentation as the gender they see themselves to be. I had one patient, very large and not overly passable, with a spouse who remained with her through transition, complete her surgical transition with me. Shortly after release from the hospital, she was as happy as any patient I'd known. She left Trinidad on top of the world....an hour later we got a call from the Walsenburg (Colorado) Police Department. Seems they had received a call from a young woman reporting a 'man in the women's room' at the local Carl's Jr. When her situation was explained, she was released but it points out the difficulty for many TG women. Surgery can do only so much. Especially genital surgery...although it remains a critical step in a person's transition, genital surgery doesn't have much effect on the likelihood of finding intimacy or passability. It is still estimated that 60% of post-op MTF's, regardless of quality of surgical outcome, will not to use their new equipment for its intended purpose.

Furthermore, I have personally had two patients commit **suicide post-transition**. The reasons for taking their lives were unclear to some though I have had personal opinions about each. The first was a radiologist, very accomplished, extremely intelligent. Not only did underemployment preclude her finding a job (eventually, she found work with an insurance company in utilization review, a job that kept her completely out of the public eye...not that I've seen any radiologist at the receptionist desk). The second patient came into surgery with huge expectations...seems she had invested most of her adult life savings in surgery and in her post-transition career, a modeling agency named John Powers. Neither person found intimacy, both were rejected by their respective families and both chose to end their lives prematurely. These are the tragedies that I hope to prevent. Lovely people who came into transition with unrealistic expectations but for whom society's cruelty and unfairness ultimately was at least partially responsible for each demise. Nonetheless, at least one study has conclusively shown that there is clear correlation between satisfaction with post-surgical outcome and long-term **post-transition happiness**. This point serves to emphasize that, although cheap genital surgery is available, this isn't an area where a person is necessarily wise to cut costs.

TG males and females overwhelmingly feel themselves to be 'different' at a very early age with strong **cross-gender identification**. In my practice of approximately 500 MTF and FTM reassignment surgeries since 2003, prospective clients were asked this question. To ascertain that this was not a case of suggestion bias, each was asked for specific dating points ("we were living in the blue house in Baltimore only until age 5....I didn't fit in with the boys...my best friends were always girls" or... "my mom died when I was 6....I dressed in her clothes until she passed away", in my case, I was cross-dressed when my mom came in, found me and said "president Kennedy has been Shot" Age 5). Although the study was non-scientific, 94% of pre-op clients reported similar cross-gender identification prior to the age of 7 years old. This suggests, in my opinion, a phenomenon, not of early cross-gender 'imprinting' but of a biological reality that is irrepressible and life long. There need to be studies that ask these delicate questions of self-identifying trans children to see what happens with these earliest

childhood memories and what is reality and what is suppressible or non-predictive. If you take all gender non-conforming behavior rather than narrowing it down to strong, clear cross-gender identification, you will continue to find a diverse outcome, consistent with your diverse inclusion or subjects.

Furthermore, the ongoing psychiatric ambivalence towards transgender persons is harmful and needs clarity. Hack, right wing theories that *obsess upon sexuality* rather than gender identity continue to muddy the waters while demonizing and pathologizing the very transgender persons the psychiatric community alleges to help. This needs to end and very soon. Terms like '*Homosexual Transsexual*' suggest that MTF clients are actually Male Homosexuals who use transition to make sex with men socially acceptable. '*Autogynophilics*' (or "*non-homosexual transsexuals*") supposedly are MTF transsexuals that find sexual fulfillment by imagining themselves to be female. Oddly, there are no analogous right wing theories for the nearly equal number of FTM transsexuals. Worse, when such theories resulted in outrage from transsexual activists, it was the transsexual community that was accused of playing politics. Why would researchers fail to listen to their own client base? It is, to me, completely and utterly baffling.

In reality, what is it to be a man or a woman? In my opinion, the answer is in the power of *hormonal intervention*. If a male-bodied person takes female hormones for long enough and undergoes *genital reassignment surgery*, muscle mass drops, body fat redistributes, breasts develop...even the brain appears female (in a portion of the hypothalamus). That said, there no doubt is some *retained male behavior*...certain behaviors, like speech patterns, are difficult to unlearn, leaving more of a male persona. Then again, that person will assume a remarkably female bodily presence....bacterial composition of the vagina, body 'scent' and chemistry, emotional makeup, it is nothing short of incredible. Not all post-ops will ever be considered 'female' , if only because of their genetic size and prior long-term exposures to testosterone....although many, many post-ops make perfectly lovely women. FTM's, on the other hand, transition in a passing sense incredibly well. Hands remain small, certain behavioral issues might remain, but for the FTM's I've met, fewer than a handful on long-term hormones, ever retain enough 'female' to ever be considered as such. And yes, their chemistry and bodily scents are remarkably and unmistakably male.

The result of such judgmental and inflammatory theories, rather than clarifying the mental status of TG individuals, serves to legitimize discrimination towards TG persons as mentally infirm, perverted or obsessed with sexuality. In reality, few MTF's ever engage in sexual activity. In fact, sexuality for TG females falls considerably down the list of priorities (as is true for natal born females). Sexual fulfillment based upon perceiving oneself to be female seems genuinely absurd..... at least to me. Frankly, I am a busy, professional woman. I like who I am much more than B4, but my status as a woman is not the least bit arousing, on the whole. Rather, sometimes it is a bit of a pain in the behind but it is life now and that is about it. Being sexual in any fashion is about 72nd on my list of priorities. And, if I were to be sexual, I do remember the softness and sensuality of a woman with appreciation but now understand the chemical, musky power of a male and have come to find a shocking exhilaration in such awareness, something that was completely and absolutely foreign to me B4. I do not think that makes me a "homosexual transsexual". Rather, it is my femaleness (and increased sense of smell!) post-transition that makes me aware of these differences and subtleties. Fortunately,

my thoughts are no longer clouded by constant thoughts of sex 24/7, allowing me a clarity that current theorists seem lacking in, still obsessed as they are, by sex.

Besides costing me huge premiums for malpractice insurance, these **unhealthy characterizations of transgender persons** cause enormous suffering within the TG community. As a group, TG men and women remain woefully underemployed, often lack intimacy, are highly prone to depression and suicide, and are brutally victimized by miserable divorce and child custody laws and court-sanctioned biases in favor of non-transitioning spouses. There are even those who liken TG women to those with Body Identity Dysmorphia, likening creation of a vagina (or 'chopping off the penis') to amputation fetishes. These are hateful, ignorant comparisons that serve to perpetuate mistrust and hatred towards trans persons, regardless of fact or outcome. Despite this miserable assessment by the general and psychiatric community, post-op TG persons transition through surgery and come out of it all as a nearly unanimously happier cohort.

As a surgical provider of care, I am subject to double doses of discrimination. Medical Malpractice, for me, is nearly impossible to secure. Despite an absence of any malpractice litigation of providing surgical care to Transgenders in Trinidad, Colorado, I am faced with double digit annual premium increases and relegation to 'surplus line' malpractice carriers. Furthermore, because of the stigma of working with the TG community, I see fewer Gyn clients. I have also been turned down for surgical privileging by both the University of Washington and the University of Colorado. The UW wrote me a letter saying 'it was not within the scope of their mission'. The U of C wrote and said, they were 'concerned about conservative attitudes within their Board of Regents'.

In an ideal world, we would not need the psychological community and would have no need for inclusion of **Gender Identity Disorder** within the DSM. Gender Identity Disorder is the DSM 'diagnosis' that currently describes the **dysphoria** that transgender persons feel by not having their gender expression able to match their gender identity. The fact is, while others disagree, at this time, transgender individuals continue to need a diagnostic category somewhere, whether it be within the DSM or ICD-9, in order to allow treatment. Unlike homosexuality (whose DSM diagnosis was removed in 1980) and needs no medical prescribing in order to live, Transsexuals continue to need 'diagnosis' in order to pursue hormonal and surgical treatment. However, that **dependency** puts transgender males and females at substantial risk for manipulation and opportunism on the part of psychological providers, both in their assessments, their fee structures and their treatment protocols. It calls for fluidity, not rigidity for the sake of both providers (who remain at risk when obstruction is offered) and for clients (who are at risk for depression and impoverishment as a result of non-treatment).

The world, through education, is improving for transgender persons. **Non-discrimination laws** are passing and have been endorsed by current Democratic presidential candidates. These legislative advances will help enormously but will not help much in reality for those who are still viewed as psychologically infirm because of psychological perceptions that have not kept pace with social advance and are buoyed by preconceived agendas of the psychological right wing. The fact is, so long as Transsexualism and gender dysphoria are viewed as anything but biological in origin, human suffering, on the part of the transgender community, will persist. I believe were politics removed from the equation, that a **biological basis for transgender behavior** would and could be established by even a semi-logical review of the

available medical evidence. Until such research is designed, employed and accepted, that viewpoint will still generate controversy, sadly.

The fact is, gender transition is arguably the most challenging path available in the human journey. Those undergoing transition will continue to need the psychological community, at least for the foreseeable future... but not obligatorily. Those providers of psychological care, in turn, need to respect that union with the transgender clients as an equal and dynamic relationship. The transgender calling, rather than being a pathetic pathologic condition is valuable for its many insights into humanity and should be respected as such, as it has been in previous cultures historically. Then again, gender transition remains a minefield whose dangers are not always evident to potential transitioners. Transgender men and women will continue to look to the psychological community for support, for guidance in their surgical, hormonal and emotional well-being and decision-making. Of warning clients of the dangers inherent in transition. Of dashing unrealistic expectations and avoidance of unwise personal choices and opportunistic surgeons and those who promote instant gratification.

On a note of optimism, the rise of **transgender professionals**, those who have themselves lived through transition, understand the nuances of life on both sides. These individuals, those who have weathered employment discrimination, brutal child custody laws, hatred and violence, offer the clearest voice as to where we ought to be going as professionals. I hope only that the psychological community will finally set aside psychological preconceptions and perceptions of mental infirmity on the part of transgender persons. Truly listen to those whose lives hang in the balance of the thoughts and actions of the psychological community.

With that I offer a few bits of advice from my wish list in going forward:

- **Design research that offers insight** into the origins of gender identity, whether in early childhood or prenatal development, as seems obvious from my clinical experience with the transgender undergoing surgery.
- **Promote education and research within Universities** and institutions of higher learning that acknowledge transgender persons and their historical and ubiquitous presence.
- **Drop the politicized hijacking of the psychological approach** to gender dysphoria by eliminating pejorative and disrespectful labeling such as "autogynophilia", 'transvestic fetishism', 'homosexual transsexuals', that serve only to polarize and stigmatize transgendered persons, legitimizing discrimination towards them.
- **Retain Gender Dysphoria within the DSM** but narrow the diagnostic criteria to allow facile, clear inclusion that eliminates inconsistencies and exceptions.
- **Include some sort of Exit Clause** within the diagnostic criteria for Gender Identity Disorder that allows a person post-treatment to adopt 'normalcy' instead of perpetual labeling. For most, once surgical and hormonal therapies are instituted, life is pretty mundane and there no longer exists any remaining 'Identity Disorder'. Again, leaving transgender persons without an 'out' once treatment is completed, leaves the general practitioner with the lingering perception that 'once a mental case, always a mental

case'. This is simply not borne out when examining the many successful careers of post-transitioned TG men and women who move on, without psychiatric contact, to lead healthy and productive professional and personal lives. Though I consider most to be fully men or women (not even TG)

- **Move Gender Dysphoria as a DSM diagnostic criteria.** If anything, it is an identity disorder that has virtually *nothing to do with sexuality*, other than as a consequence of one's gender and, as such, belongs nowhere within disorders of sexuality. Gender is a distinct and separate entity, whose connection with sexuality is ironic and confusing, at best.
- **Eliminate mandatory 'Reparative Therapy' for children (or adults),** designed to assure gender conformity. The world, like gender, is, by definition, characterized by diversity. Why on earth should gender remain the one human characteristic that offers only two distinct choices? Rather, a non-judgmental approach to gender non-conformity is closest to what transgendered persons aspire to and is what will eventually be proven by medical science. Show wisdom and vision and get there now.