



**THE WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH**

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Abstract Book ~ 2007

# 20<sup>th</sup> Biennial Symposium

WPATH 20<sup>TH</sup> BIENNIAL SYMPOSIUM, CHICAGO, ILLINOIS

# Symposium Abstracts

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**Compiled by Tara L. Tieso, MSW, Shellae Mueller, Dr. Bean Robinson, PhD**

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# A Message from the President

**Prof. Dr. Stan Monstrey**

Chicago, September 2007

Dear WPATH Members and Symposium Participants,

It is my pleasure to welcome each and every one of you to the 20<sup>th</sup> International Symposium of the World Professional Association of Transgender Health (WPATH), formerly the Harry Benjamin International Gender Dysphoria Association (HBIGDA).

The two past meetings of our Association have been held in Europe (2003 Gent and 2005 Bologna) and it's good to be back in the United States in this beautiful city of Chicago.

With this 20<sup>th</sup> Anniversary Symposium, our Association already has a long history to look back upon. Still, this Chicago Meeting, which will probably be one of the most important meetings in the history of our Association, is focused on looking to the future, and this is reflected in our program in many ways.

Our Association has changed its name from HBIGDA to WPATH, and this change of name reflects our new vision and our new mission. For the first time ever, a Pre-Symposium on various subjects, featuring 3 different levels of expertise has been organized just prior to our Meeting. Very distinguished keynote speakers will provide information on the newest trends, both in biological sciences and surgery. Also for the first time ever, a plenary session will focus on the evolving field of tele-psychiatry and web-based transgender care. Other very important plenary sessions will be held on the treatment of gender dysphoric children, evidence-based data, the state of the art in gender reassignment surgery, and new directions in our Standards of Care.

The WPATH Symposium offers a unique opportunity to share information and our professional experience in the field of gender dysphoria with other professionals from surgery, psychiatry, endocrinology, psychology, sexology, sociology, counselling, voice therapy and law as well as with clients who have experienced the ignorance and discrimination of society towards transgendered persons.

I want to express my thanks to our staff: Dr. Bean Robinson and Tara Tieso for handling all the many facets of the Society over the past two years, especially in this very intense period of transition from HBIGDA to WPATH.

I also would like to thank Drs. Randi Ettner and Loren Schechter for organizing such a great meeting here in Chicago.

I know that you will find the scientific program exceptionally stimulating and interesting and we are so pleased to see people from all over the world who have joined us here – Welcome to Chicago!



Prof. Dr. Stan MONSTREY  
SM/ad (WPATH.Chicago2007)

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**SYMPOSIUM**  
**THURSDAY, SEPTEMBER 6, 2007**  
**SALONS A - D**

**Welcome and Introduction: Dr. Randi Ettner, PhD**

The opening speech welcomes all the attendees (the number of participants for this Chicago Meeting is at an all time high). The local organizing committee, mainly Dr. Randi Ettner and Dr. Loren Schechter are to be thanked for the efforts they put in organizing this meeting. An overview will be provided on the various speakers and sessions of this symposium as well as on the city of Chicago. Last but not least, information will be given on the strategic planning meeting held in New York in January 2006 which resulted in the development of a new vision and mission statement and also in the transition of HBGDA to WPATH.

**Invited Speaker: Evolution's Rainbow: Diversity, gender and sexuality in nature and people (Dr. Joan Roughgarden, PhD)**

Dept of Biological Sciences  
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The biological theory of gender traces to Darwin's writings on "sexual selection" in 1871. This theory of universal gender norms and family social dynamics now appears both false and unfixable. The empirical generalizations Darwin claimed have been refuted by thousands of exceptions, well-known cases that seemed to fit sexual-selection's explanations do not support the theory when closely studied, and the theory itself contains logical contradictions in light of today's population genetics.

I have proposed "social-selection" theory as a replacement for sexual-selection theory. I will review some aspects of this new approach to the evolution of gender, sexuality, and family social dynamics. The theory of social selection draws on the mathematics of cooperative game theory.

*Joan Roughgarden is a professor of biological sciences and geophysics in the School of Humanities and Sciences and former director of the Earth Systems Program. She joined the Stanford faculty in 1972. Her main research subject is theoretical ecology and evolutionary biology, with continuing field studies of the Anolis lizards of the Lesser Antilles and previous field studies with the barnacle populations of the California coast. Her recent research includes theoretical aspects of the interface between ecology and economics, and the evolution of gender expression and sexuality. She was a Guggenheim Fellow in 1985-86, elected as a Fellow of the American Academy of Arts and Sciences in 1993, and received Stanford's Dinkelspiel Award for service to undergraduate education in 1995. Her 2004 book, Evolution's Rainbow, published by the University of California Press received the Stonewall Prize from the American Library Association in 2005. Her most recent book, Evolution and Christian Faith, was published in 2006 by Island Press.*

**Invited Speaker: Surgery – Overview and State of the Art (Dr. Stan Monstrey, MD)**

In this presentation an overview will be given on where we stand as to gender reassignment surgery, both in female to male and male and female transsexuals. Special emphasis will be given to the residual unsolved problems in these operative interventions. Finally, information will be provided on the different threats related to sex reassignment surgery: diminution of financial means and resources of the National Health Systems, quality control, the continuing dilemma of reconstructive versus aesthetic surgery, multidisciplinary teams, training and research.

**Invited Speaker: The History of Christine Jorgensen (Dr. R.F. Docter, PhD)**

Professor of Psychology (Emeritus) California State University, Northridge  
17162 Sunburst Street, Northridge, CA 91325, (818) 349-9709 [RichDokter@aol.com](mailto:RichDokter@aol.com)

In 1952 Christine Jorgensen became an over-night celebrity when her so-called "sex change" was depicted worldwide in newspapers and newsreels. In order to understand this case more fully, we have written a biography that attempts to distinguish fact from fiction. This study was based on the resources of several libraries, interviews with childhood friends and close relatives, and with the assistance of those who knew her best as an adult. An especially valuable account of her two years in Copenhagen was provided by Jesper Hamburger, the son of her principle physician.

Jorgensen was especially mis-leading concerning the following:

- a) Christine put forth her theory that she was the victim of some vaguely described intersex condition. In some interviews she alluded to findings by her physicians of what she called female tissue. These assertions were not true.
- b) Jorgensen denied a history of childhood cross dressing. This was not true.

c) She frequently misrepresented her 1952 passport as classifying her as a female. This was not true. At that time, US passports did include identification by sex.

d) Christine sought to conceal her complicity in bringing her so-called “sex change” to the attention of the press, claiming the story had been “leaked” by a dis-loyal friend. The true story is more complicated, but there is evidence that she was involved.

e) Following her emergence as a woman in 1952, she was often asked about the effects of two years of female hormones. She greatly mis-represented these facts especially concerning breast development. In 1953 she had virtually no breast development.

f) When responding to the media, Jorgensen never provided an accurate account of the outcome of her three unsuccessful surgical attempts to construct a vagina. Despite these difficulties, she invariably told reporters that she was fully capable of every aspect of female sexuality.

g) In general, Christine was a very well liked person with many friends. Major personality features included interpersonal warmth, exceptional humor, extroversion, focused striving for success, and high level of aspiration. She was an excellent public speaker. However, persistent indications of borderline personality characteristics were also evidenced, including: several intense love-hate relationships, episodes of anger and rejection toward those who had assisted her, and unrewarding efforts to punish supposed wrongdoers through legal initiatives.

Jorgensen never married. She died of cancer in 1989, and is remembered as an influential role model of transsexuality.

*Dr. Docter continues to be active as a gender researcher and clinician serving transgender clients.*

### **Invited Speaker: First Facial Transplant (Dr. Benoit Langelé, MD)**



“Living a new face” :  
an update on the techniques,  
functional results and ethical  
issues  
of the first human face  
transplantation

The first human face transplantation was carried out nearly two years ago now in order to reconstruct the facial appearance of a young woman severely disfigured after a dog bite.

The news of this groundbreaking procedure raised immediately many questions and concerns all over the world, not only in terms of science, about the medical planning and the expected outcomes of this successful operation, but also in terms of ethics, about the potential risks runned by the patient due to the necessity for her to reappropriate psychologically the face graft, and to sustain a life-long immunosuppressive treatment. Nevertheless, immediate impressive results that were shown also induced a new hope for many patients suffering from a wide range of acquired or inborn body defects that could be repaired by similar composite tissue transplantations.

From our present retrospective experience, based on a 22 months follow-up, we may state that face composite tissue transplantation is feasible and that graft rejection can be overcome with a standard immunosuppressive treatment. Furthermore, if careful motor and sensitive nerve anastomoses are performed during surgery, the face graft recovers fully the complexity of its expressive function, and its psychological reintegration deep inside the brain cortex parallels the sensitive recovery taking place simultaneously on the skin surface of the transplant. Finally, even if the surgical procedure is obviously not aiming to restore exactly the previous face image of the recipient patient, the new face that is created recovers a real individual morphology.

All these inaugural data, cumulated with those collected from similar observations made on hand transplanted patients, seem to indicate by analogy that, in the future, other functional composite tissue grafts, like for example penile transplants, may be carried out successfully, although their definitive feasibility still need to overcome a lot of specific technical problems.

### **(GID) - The Dutch Experience**

Schagen, SEE & Wouters FM, Cohen-Kettenis PT, Delemarre-van de Waal HA  
VU University Medical Center, Departments of Pediatric Endocrinology<sup>1</sup> and Medical Psychology<sup>2</sup>.  
PO Box 7057, 1007 MB Amsterdam, The Netherlands.  
[S.Schagen@vumc.nl](mailto:S.Schagen@vumc.nl)

Transsexual adolescents are eligible for suppression of the endogenous puberty by a GnRH-analogue, when they fulfil DSM-IV criteria for GID and have experienced the early, reversible phases of their biological puberty. This is assessed on the basis of their Tanner stage (at least B2/ G2-3) and sex steroid hormone level. Treatment with a GnRH-analogue allows for a balanced decision regarding sex reassignment without the pressure of the development of irreversible secondary sex characteristics. If there are no contra-indications cross-sex hormones will be given from the age of sixteen.

Currently, sixty patients are being treated with a GnRH analogue with a mean duration of 17,9 months (range 0-48 months). In thirty-seven cross-sex hormones were added with a mean duration of 17,6 months (range 0-45 months). By using the GnRH-analogue a decrease in height growth and bone maturation is observed. This decrease in height growth enables us to manipulate patient's height. The administration of high doses of estrogens inhibits growth in tall male-to-female transsexuals, whereas the addition of oxandrolone is used to achieve an appropriate 'male' height. During suppression of puberty bone mass stabilizes, while a catch-up of bone density is observed when cross-sex hormones are started. Still, long-term consequences have to be evaluated carefully.

The effects of this treatment in regard to brain functioning and brain development will be investigated as well. Hereby the focus will be on sex differences between transsexual adolescents and similar aged individuals of both sexes as well as on possible neurobiological determinants of GID by means of structural and functional MRI and family pedigree research.

### **Effects of GNRH Analogue Treatment to Delay Puberty: Effects on Psychological Functioning at 16 Years**

De Vries ALC, Steensma ThD, Cohen-Kettenis P T  
VU University medical center, Departments of medical psychology<sup>2</sup> and child psychiatry<sup>1</sup>.  
PO Box 7057, 1007 MB, Amsterdam, the Netherlands,  
[alc.devries@vumc.nl](mailto:alc.devries@vumc.nl)

At the Amsterdam VU medical centre, adolescents with GID under the age of 16 may be eligible for treatment with GnRH analogues to arrest the development of secondary sex characteristics. Eligibility is assessed in an extensive diagnostic procedure. For a study evaluating psychological and social functioning after GnRH treatment, adolescents who had received GnRH analogues were assessed twice: At their attendance to the gender identity clinic (t0) and shortly before starting cross-sex hormones, usually around the age of 16 (t1). At the moment, 66 adolescents with GID (mean age at first assessment 14,2 years) have been eligible for treatment with GnRH analogues, 32 female-to-males and 34 male-to-females. Thirty-nine of them have started cross-sex hormone treatment subsequently (mean age at start cross-sex hormones; 16,6 years). Twenty-six parents of these 39 individuals filled out a Child Behavior Checklist (CBCL) at both assessments. The Youth Self Report (YSR) and other instruments measuring depressive symptoms, anxiety, anger and self-esteem were also administered. The results were generally favorable. For instance, the mean total problem scores on the CBCL were not in the clinical or sub-clinical range at either t0 or t1. Nevertheless, there was a significant decrease on total problem behavior as well as on several CBCL subscales. These results and the results with regard to the other instruments will be discussed.

### **A Follow-Up Study of Girls with Gender Identity Disorder**

Zucker, K. J., Drummond, K. D., Bradley, S. J., and Peterson-Badali, M.  
<sup>1</sup>Gender Identity Service, Centre for Addiction and Mental Health, <sup>2</sup>Ontario Institute for Studies in Education of the University of Toronto  
c/o , 250 College St., Toronto, Ontario M5T 1R8, Canada; e-mail: [Ken\\_Zucker@camh.net](mailto:Ken_Zucker@camh.net)

This study provided information on the natural history of 25 girls with gender identity disorder (GID). Standardized assessment data in childhood (*M* age at assessment, 8.88 years; range, 3-12) and at follow-up (*M* age at follow-up, 23.24 years; range, 15-36) were used to evaluate gender identity, sexual orientation, and general behavioral problems and psychiatric disorders. At follow-up, 3 (12%) participants were judged to have persistent GID or gender dysphoria. Regarding sexual orientation, 8 (32%) participants were classified as bisexual/ homosexual in fantasy and 6 (24%) were classified as bisexual/homosexual in behavior. The remaining participants were classified as either heterosexual or asexual. The rates of GID persistence and bisexuality/homosexuality were substantially higher than base rates in the general female population derived from epidemiological or survey studies. About half of the participants had clinical range behavioral and psychiatric problems at follow-up. The high rate of behavioral and psychiatric disorder at follow-up was considered in relation to both general and specific risk factors, including the role of social ostracism related to cross-gender identification and a minority sexual orientation.

### **Prediction of Adult GID: A Follow-Up Study of Gender Dysphoric Children**

Wallien, MSC; Cohen-Kettenis – PhD, PT

VU University Medical Center, Department of medical psychology

P.O Box 7057, 1007 MB Amsterdam, the Netherlands; P.T. Cohen-Kettenis, Phone: 00-31-20-444-2550, Fax: 00-31-20-444-3077, [PT.Cohen-Kettenis@vumc.nl](mailto:PT.Cohen-Kettenis@vumc.nl)

M.S.C. Wallien, Phone: 00-31-20-444-3343, Fax: 00-31-20-444-3077, [m.wallien@vumc.nl](mailto:m.wallien@vumc.nl)

In this study we followed children with GID into adolescence and adulthood to find childhood characteristics that predict aspects of psychosexual outcome. In childhood, we assessed a group of 77 children, who are now 16 years or older. Fifty four participated in the study. Twenty-seven percent of the initial sample of children referred to the Gender Identity Clinic still fulfilled criteria for GID at follow-up: one out of five boys and half of the girls. It appeared that the most strongly gender dysphoric group in childhood still was gender dysphoric at follow-up. Extremeness of gender dysphoria was evident from the percentage having a complete GID diagnosis, and the mean scores on the Gender Identity Interview (GII), the Gender Identity Questionnaire for children (GIQC) and the gender items of the Child Behavior Checklist (CBCL). Scores on the GII were a strong predictor for persisting gender dysphoria into adolescence or young adulthood. This study is the first one providing evidence that extremeness of childhood GID is related to persisting gender dysphoria after puberty.

### **Invited Speaker: Symposium on Children and Adolescents (Dr. Peggy Cohen-Kettenis, PhD)**

Schagen, SEE<sup>1</sup>& Wouters FM<sup>1</sup>, Cohen-Kettenis PT<sup>2</sup>, Delemarre-van de Waal HA<sup>1</sup>

VU University Medical Center, Departments of Pediatric Endocrinology<sup>1</sup> and Medical Psychology<sup>2</sup>.

PO Box 7057, 1007 MB Amsterdam, The Netherlands. [S.Schagen@vumc.nl](mailto:S.Schagen@vumc.nl)

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The effects of this treatment in regard to brain functioning and brain development will be investigated as well. Hereby the focus will be on sex differences between transsexual adolescents and similar aged individuals of both sexes as well as on possible neurobiological determinants of GID by means of structural and functional MRI and family pedigree research.

### **Invited Speaker: Children of Transsexuals (Dr. Randi Ettner, PhD)**

Ettner, R. and White, T.

New Health Foundation Worldwide

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Approximately 70% of male-to-female transsexuals who enter treatment are parents. A previous study by the authors assessed the data collected on 2,504 such individuals undergoing gender reassignment. In that study, it was confirmed that gender transition in a parent is not a neutral event in the life of the child. Furthermore, specific age-related variables were identified that served as risk or protective factors in the adjustment of these children. With the exception of Green (1978, 1998), and a case study of one child (Sales, 1995), there is no literature systematically addressing the progressive and regressive components of adaptation in these children. The present study, therefore, is an attempt to focus on the children themselves, and as such, is a retrospective analysis. Fifty-five children were identified who had a transsexual parent. The transitioned parent was interviewed, and data was attained on multiple parameters. Additionally, the authors saw 25% of the children. Both the immediate and long-term relationship between both parents and the child was explored. In addition, variables such as gender of the child, presence of a pre-existing psychiatric disturbance, shame affect arousal in peer relations, variables of temperament, and support from extended family, among other variables, were analyzed. It was hypothesized that cooperation between parents, or at least a lack of conflict, would improve adjustment in the child. It was also hypothesized that children who had extended family support, who were extroverted in temperament, and those who disclosed to peers, would have a better overall adjustment. Each child was assigned an adjustment score based on measures across several domains, including decrement in school performance, social stigmatization, current relationship with the parent, and fear of embarrassment. The results identify certain variables that predict overall adjustment, but underscore the extreme variability in the way children ultimately adapt to this highly anomalous life situation. Previously reported resiliency factors, which seem applicable to other trauma or unusual life events, fail to adequately predict adaptation in this cohort. Indeed, the best predictor of long-term adjustment in the child is the nature of the relationship with the transsexual parent at the time of the gender transition.

## Parallel Sessions

Thursday, September 6, 2007

### Surgery Sessions - FTM

Moderators: Dr. Piet Hoebeke, ND, PhD &  
Dr. Michael Brownstein, MD

#### **Combined Buccal Mucosa Graft and Local Flaps for Urethral Reconstruction in Female Transsexuals**

Djordjevic - MD, M; Perovic, S; Korac, G; Bizic, M; Majstorovic, M

School of Medicine, University of Belgrade, Serbia

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Purpose: Metoidioplasty is a variant of phalloplasty in female transsexuals allowing voiding while standing. Urethroplasty presents the most difficult part in this reconstruction. We evaluated using of buccal mucosa graft combined with the local skin flap for urethral reconstruction.

Material and methods: Between July 2003 and October 2006, metoidioplasty was performed in 47 patients (aged 18 to 55 years). The buccal mucosa was grafted on the tunica albuginea of the clitoris. The distal part of mucosa was sutured to the glans, and the proximal end was sutured to the native urethral meatus. Well vascularized fasciocutaneous flap was harvested from labia minora or dorsal clitoral skin and sutured to the buccal mucosa to form the neourethra. Proximal part was anastomosed to the native urethral meatus. Distally, new urethral meatus was created using double faced technique. New urethra was covered with well vascularized subcutaneous flaps harvested from remaining labia minora and both labia maiora. Reconstruction of the lengthened and straightened clitoris was performed using available clitoral skin. Labia maiora with testicle implants were joined to create normal scrotal appearance.

Results: Urinary stream and penile shape were satisfactory in 41 cases. Urethral fistula occurred in 9 cases, closing spontaneously in 3 cases. The other six cases required secondary repair 6 months later. One case with distal urethral stenosis was cured by periodic urethral dilation during a three months period.

Conclusion: Combined buccal mucosa graft and local flaps represent good choice for urethral reconstruction, especially due to complication rate less than previously reported results.

#### **Musculocutaneous Latissimus Dorsi Free Transfer Flap for Total Phalloplasty in Female Transsexuals**

Perovic, S; Djordjevic - MD, M; Stanojevic, D

Belgrade Gender Dysphoria Team, Belgrade, Serbia

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Introduction: Phalloplasty is a surgical project posing considerable challenges. There are many alternatives to this procedure (groin flap, forearm flap, rectus flap, etc). Our preference is latissimus dorsi flap because of good size of the neophallus.

Methods: From April 2001 till October 2006 total phalloplasty was performed on 33 female transsexuals aged between 19 - 54 years. A musculocutaneous latissimus dorsi free flap was harvested with thoracodorsal artery, vein and nerve. The flap was transferred to the pubic region and anastomosed to the femoral artery, saphenous vein and ilioinguinal nerve. Urethroplasty was performed in 14 patients in two stages: using buccal mucosa in 8 and buccal mucosa combined with split thickness skin graft in 6 patients. In all patients clitoral remnants were incorporated into the neophallus in order to preserve orgasmic sensitivity. Inflatable (5) or semirigid (6) penile prosthesis were implanted in 11 patients in order to reestablish sexual intercourse.

Results: Mean follow-up was 29 months. Penile size varied from 13 to 17 cm in length and from 10 to 12 cm in circumference. No flap necrosis, neither partial nor total, was noted. Urethral fistula was occurred in 4 patients and repaired six months later. The donor site healed acceptably in 26 cases while in the remaining 7 moderate scar occurred. Penile prostheses function is satisfactory.

Conclusion: Latissimus dorsi musculocutaneous flap presents a good choice for phalloplasty in female transsexuals. This technique enables creation of neophallus with size according to the patient wish.

### **The Pedicled Anterolateral Thigh Flap in Phalloplasty Procedures**

Ceulemans - MD, P; Hoebeke – ND, PhD, P; Buncamper, M; Hamdi, M; Van Landuyt, K; Blondeel, Ph; Monstrey – MD, S

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Introduction: The radial forearm free flap (RFFF) is universally considered as the “the gold standard” in penile reconstruction. However, the major drawback of this operation remains the wide circumferential scar on the forearm which for transsexual patients can be pathognomic for their condition. The pedicled anterolateral thigh (ALT) flap has been proven to be a possible alternative for the RFFF.

Material/Methods: The ALT flap has been used as a pedicled flap in 11 penile reconstructions. The lateral femoral cutaneous (LFC) nerve is anastomosed to the clitoral nerve to provide sensory innervation. The inner tube, for urethral conduit, has been reconstructed in different ways: with the material of a previous attempt of penile reconstruction (n=3), with a short invagination flap in case of penile aplasia in extrophia vesicae (n=3), with a pedicled peritoneo-fascial flap (n=1) and with a prelamination using split thickness grafts (n=3) or full thickness grafts (n=1). In one patient a pre-operative expansion was performed allowing primary closure of the donor area.

Results: All pedicled ALT flaps survived completely. The different possibilities of reconstructing the urethral conduit will be evaluated and discussed, as well as the various functional (urological) and aesthetic outcomes.

Conclusion: The ALT flap phalloplasty is a promising alternative for the RFFF phalloplasty. Refinements however are needed to provide the same aesthetic and functional result as the RFFF phalloplasty. In thin patients all essential goals are obtained and the ALT flap phalloplasty has proven to be a very useful alternative. In other patients the results depend upon the quality of the inner tube and the technique that is been used.

### **One Stage Metaidoplasty**

Kanhai – MD, PhD, RCJ

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#### **Abstract:**

To create a male appearance of the hypertrophic clitoris in a female-to-male transsexuals, due to hormones, there are basically two procedures available. This in order to be able of micturition while standing. The patient can choose for the complex, multistaged microsurgical mutilating phalloplasty or the one-stage metaidoplasty.

In latest method the proximal and distal part of the neo-urethra are created from the labia minora. The clitoris is straightened and lengthened by releasing the chordee.

The scrotum is created from the labia majora and the skin and fat tissue from the mons pubis.

With this technique there is more tissue and layers to protect the urethral anastomosis which could prevent fistels. Due to this technique it's possible to create a functional penis in one stage but a fistel can be the problem in 25% of the cases.

A metaidoplasty should be the first operation and probably followed by a phalloplasty if the patient require such an operation.

### **Metaidoplasty Using Labial Ring Flap**

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The first official Sex Reassignment Surgery in Japan was performed in 1998. Sixty-seven Female-to-Male Transsexuals have received metaidoplasty during 1998 and 2006 at Saitama Medical Center. Oophorohysterectomy and metaidoplasty were performed in one-stage procedure. On the first 22 cases of our series Hage's technique had been used. In 2004 we have developed a new method called “Labia Ring Flap Technique”. This method utilizes all the labia minora skin



incorporated with anterior vaginal flap for urethral lengthening. With this method we could have obtained good diameter of the neo-urethra and decline in complication rate of stenosis or fistula formation. Twenty-five of 42 (66 %) can void in standing position. Forty-six patients after this operation could have obtained documents as men under a new Transgender Law after 2004 and 5 have got married with female partners as males. In 19 patients who desired a larger phallus, various techniques of phalloplasty were performed subsequently.

Technical details of our metoidioplasty and the influence of legal/ social background on Sex Reassignment Surgery in Japan will be presented.

### **Total Laparoscopic Hysterectomy as the Method of Choice for Hysterectomy In Female-To-Male Gender Dysphoric Individuals.**

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Study Objective: To report on a large single-handed series of total laparoscopic hysterectomy (TLH) in female-to-male (FTM) transsexual patients.

Design: A retrospective study

Setting: the gender team of a large university hospital.

Patients: Patient files of 64 consecutive cases of total laparoscopic hysterectomy between April 2003 and April 2006 were reviewed and analyzed.

Intervention: Total Laparoscopic Hysterectomy with or without mastectomy

Measurements and Main Results: The average operating time for the TLH was 66 (30-150) minutes. The estimated blood loss for the TLH averaged 93 (50-600) ml. We encountered two bladder perforations, which were immediately repaired, and one hematoma of the vaginal dome, which necessitated a second intervention. The serious complication rate of our series is 1.6%.

Conclusions: Sex reassignment surgery (SRS) has proven to be the most effective treatment for patients with gender dysphoria. In female-to-male (FTM) transsexual individuals, hysterectomy is an essential part of SRS. Since 2003 we perform total laparoscopic hysterectomy (TLH) in conjunction with a subcutaneous mastectomy as a first step in SRS in FTM-transsexual patients, thus facilitating the transition for the patient and improving the operative planning for the different surgical teams. Total laparoscopic hysterectomy has undoubtedly proven to be superior to abdominal hysterectomy regarding the esthetical aspects, postoperative pain and recuperation, while it is as safe as the vaginal or abdominal route. We think that TLH is the most appropriate method for hysterectomy in FTM-transsexual patients.

### **Vaginectomy as a Complimentary Procedure in the Course of Sex-Reassignment Surgery of Female-To-Male Transseksuele**

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Introduction: Total vaginectomy (colpectomy) is a rare procedure. Only early stages of primary vaginal cancer, and by way of exception VAIN III lesions occupying the entire vagina, give the indication for total vaginectomy. Only few comprehensive descriptions of vaginectomy have been published. Beyond gynaecologic oncology sex reassignment surgery (SRS) may be another indication for total vaginectomy. Female-to-Male transsexuals (FtM's) increasingly ask for vaginectomy, either to get rid of an organ with an indisputable female connotation or due to complaints derived from vaginal discharge. In 2006 the Amsterdam genderteam started to offer vaginectomy as part of its SRS procedure. This presentation describes our experiences with primary and secondary total vaginectomies for transsexuals. It focuses on possible complications and pitfalls. Additionally patients' subjective ideas about this procedure are collected and evaluated.

Methods: 40 FtM's being indicated for SRS by the Amsterdam genderteam in 2006, and 8 patients undergone vaginectomy in 2006 received a questionnaire with special attention to both their ideas, expectations and fears about vaginectomy, and (dis-)satisfaction after surgery. Patient files were checked and intra- and postoperative data collected and evaluated.

Results: Transsexuals belong to those patients being best informed about treatment options. However, referring to vaginectomy ideas and objective facts differ considerably. The vagina seems to be repressed both for and after sex reassignment. In general FtM's cope with high morbidity rates of plastic surgical construction of a male imposing external genital. In contrast, vaginectomy is often not asked for because of serious concerns about bladder and rectal lesions. This



attitude towards vaginectomy can neither be legitimated by literature nor by own data. Above all vaginectomy often causes considerable blood loss (n=8, median 450ml, range 150 – 1600ml). No patient required blood transfusion perioperatively. One patient underwent surgical revision 7 days after primary surgery due to severe haemorrhage caused by inadequate switching from heparins to oral anticoagulants. Bladder or rectal lesions did not occur, but one single urethra lesion was registered in a patient not suitable for positioning a catheter intraoperatively due to pre-existent narrowing of the neo-urethra. This lesion was covered intraoperatively. Postoperative recovery was uneventful.

Conclusion: Vaginectomy is not as harmful as supposed. However, the indication should be made carefully. Only if the vagina interacts negatively with the male self-esteem and/or discharge feels to be unbearable, vaginectomy should be indicated.

### **Post-Operative Orgasm in The Female-To-Male Transsexual**

Sidelinker – *PhD*

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This study examined human sexual orgasm from a physiological perspective. A pilot test was conducted to determine the effectiveness of the equipment's ability to measure orgasmic responses using an invasive model. The invasive probe, developed specifically for this test, was designed in two configurations: one to measure vaginally, the other utilizes an anal application. The variance in design allowed measurement of a female, a male or couple. This particular study targeted "Female to Male" transsexuals who have opted for the complete phalloplasty. All target subjects have undergone significant alteration of all external genitalia. A control group of unaltered females and males provided orgasmic measurements from which to establish similarities between controls and the test group. The researcher predicted results that would provide evidence that "Female to Male" transsexuals need not expect the loss of orgasm if they decide to seek surgically created male genitalia via a full phalloplasty. Indirectly, the results also showed a significant commonality between the orgasmic measures of female and male controls.

### **The Hidden Scar of a New Subcutaneous Mastectomy Technique**

Kanhai – *MD, PhD, RCJ*

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Masculinisation of a female-to-male transsexual includes a subcutaneous mastectomy. The goals of a subcutaneous mastectomy are to remove mammary gland and fat tissue, reduce the areolar-complex and in some cases even the nipple. Last but not least to solve the problem of excessive skin. To achieve this goal in a female-to-male transsexual there are different techniques depending on the breast size/volume which to use.

We know the donut procedure, partial periareolar, transareolar incision, inframammary scar, liposuction and free nipple graft.

In this new technique which is for large volume and excess of skin breasts, the scar will be hidden in the anterior axillary's line and circumareolar. The nipple-areolar complex has a thin medio-cranial pedicle which provide the sensation and viability.

Complications which may occur are: haematoma, nipple-areolar complex necrosis (partial or complete), loss or hyper-sensated nipple-areolar complex, wound, scar problems, asymmetry.

These complications can occur in each of the different type of techniques for subcutaneous mastectomy.

*Member of NVPC (dutch organisation of plastic surgeons), Member of WPATH*

*As a plastic surgeon I perform SRS. I perform vaginoplasty, metaidoioplasty and also subcutaneous mastectomy.*

**Policy & Epidemiology – Rock River Room**  
**Moderators: Jude F. Patton, LMFT & Alyson Meiselman, Esq**

### **Birth Order and Sibling Sex Ratio in Homosexual Transsexual South Korean Males: Effects of the Male-Preferring Stopping Rule**

Zucker – *PhD*, KJ; Blanchard, R; Kim, TS; Pae, Cu; Lee, C

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Two biodemographic variables--birth order and sibling sex ratio--have been examined in several Western samples of homosexual transsexual males (e.g., Blanchard & Sheridan, 1992; Blanchard et al., 1996; Green, 2000). The results have consistently shown that homosexual transsexuals have a later birth order and come from sibships with an excess of brothers to sisters; the excess of brothers has been largely driven by the number of older brothers and hence has been termed the *fraternal birth order effect*. In the present study, we examined birth order and sibling sex ratio in an Asian sample of 43 homosexual transsexual men and 49 heterosexual control men from South Korea. Although the transsexual men had a significantly late birth order, so did the control men. Unlike Western samples, the Korean transsexuals had a significant excess of sisters, not brothers, as did the control men, and this was largely accounted for by older sisters. In Korea, it has long been shown that parents have a marked preference for sons (Bae, 1991; Cho, Hong, & Hayashi, 1996; Larsen, Chung, & Das Gupta, 1998; H. T. Lee, 1984; S. H. Lee, 1988; S. Y. Lee, 1996; Park, 1983; Park & Cho, 1995; Park & Kim, 1976; WuDunn, 1997). When there is a strong bias in favor of one sex over the other, there is considerable epidemiological evidence that parents continue to have children until the birth of a baby of the preferred sex. At that point, they "stop" having children (Altmann, 1990; Osman & Yamashita, 1987). We conclude, therefore, that a male-preferring stopping rule governing parental reproductive behavior (McClelland, 1999; Yamaguchi, 1989) had a strong impact on these two biodemographic variables. Future studies that examine birth order and sibling sex ratio in non-Western samples of transsexuals need to be vigilant for the influential role of stopping rules, including the one identified in the current study.

*Dr. Zucker is the Head of the Gender Identity Service (for children and adolescents) at CAMH in Toronto. Dr. Blanchard is a psychologist at the Adult Gender Identity Service at CAMH. Our Korean colleagues collected the raw data, which they provided to the first 2 authors for analysis.*

## **On the Calculation of the Prevalence of Transsexualism**

Olyslager, F; Conway, L

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Professor Lynn Conway, 3640 CSE Building, University of Michigan, Ann Arbor, MI 48109-2121 USA

In past years, the most-cited estimates of the prevalence of transsexualism have been based on counts of people who have undergone gender reassignment (usually involving SRS) under the care of certain clinics in e. g. Sweden, The Netherlands and a few other European countries. Lower bounds for prevalence are then determined by dividing the reassignment counts by the relevant population numbers. In this paper, we discuss these past reports and the methods they used. We then develop mathematical methods for further analyzing the data in those reports. Noting that the incidence of gender reassignment in many countries has been in a "start-up transient" of gradual increases over the years, we refine earlier estimates using mathematical analyses to determine prevalence from accumulating incidence data - taking into account birth, reassignment and death rates. We also provide a mathematical method for estimating the latent and inherent numbers of people who will at some point during their lives undergo SRS, based on the ongoing incidence of SRS and the age-distribution of the occurrences of SRS. These analytical methods are then applied to refinements and extensions of results of past reports on the prevalence of SRS. Finally, we describe several alternative methods for estimating the prevalence of SRS. These methods are used to triangulate on and confirm the validity of the estimates determined by SRS counting methods.

*Femke Olyslager PhD, is Professor of Electrical Engineering and Applied Physics in the Department of Information Technology at Ghent University in Belgium. Femke is author of more than 250 publications in international journals and conference proceedings, has authored two monographs and has received many national and international scientific distinctions. Femke is a Supporting Member of WPATH and a patient of the Genderteam at Ghent University Hospital in Belgium.*

*Lynn Conway is Professor of Electrical Engineering and Computer Science, Emerita, at the University of Michigan in Ann Arbor, Michigan, U.S.A. Lynn is internationally known for her pioneering research in microelectronic chip design, and has received many national awards for her work, including election to the U. S. National Academy of Engineering. Lynn transitioned in 1968 under the care of Harry Benjamin, M.D. Coming out in 2000 after decades of stealth, Lynn maintains a trans-information site at [www.lynnconway.com](http://www.lynnconway.com)*

## **New Identities, New Care: Addressing the Needs of the GenderQueer Community**

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Substantial strides have been made in healthcare targeting the transgender community. This is not to suggest that trans-identified people are not marginalized or disenfranchised by many medical and mental health providers, but the critical issue is that the transgender identity is more visible. One population that is still seemingly invisible is those who identify as genderqueer.

In this client-centered approach to health, we will explore the various ways in which people self-identify as genderqueer. We will address the ways that many patients are influenced by well-intentioned providers to assume a more traditional gender identity and persuaded that the genderqueer identity is not "valid-enough". Though this identity is often considered solely a political and/or youth movement, we will discuss the existence of genderqueer individuals spanning socioeconomic classes, ages, and levels of medical transition. We will also discuss the variety of options available to people who identify as genderqueer with regard to medical and hormonal intervention as well as the benefits and shortcomings of the traditional medical protocols currently available.

### **The Impacts of Gender Policy in Athletics**

Green – MFA, J; Worley, K

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Canadian National Waterski Team, 2007, Candidate for the Canadian National Olympic Cycling Team, 2008  
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This paper reviews the concept of gender testing that has been imposed upon world-class athletes which effectively singles out transgender and intersex competitors and subjects them at best to ridicule, undue scrutiny (invasion of privacy), embarrassment, and at worst to exclusion, shame, and even death threats. The Stockholm Consensus of 2004 led to the current state of such policies, and while at the time it was considered a positive step in the direction of transgender inclusion in sport, it has since proven to have a more detrimental effect. The authors will provide an overview of problematic policies, discuss the impacts of the current policies on world-class, professional, amateur, and youth competitors, and offer some policy alternatives. The authors will also report on an event organized in 2006 by Ms. Worley that introduced inner-city transgender youth in Toronto to the sport of waterskiing and demonstrated how access to sport can increase self-esteem, an important quality that helps ensure a successful life trajectory for transgender people. Finally, the authors will consider how WPATH might be effective in working toward policy improvements that will promote ethical competition while eliminating unnecessary barriers for transgender and intersex participants in sport.

*Mr. Green is a Ph.D. candidate in Law whose research is focused upon the use of medical expert witness testimony (often predicated upon GID) in validating or invalidating gender. He is also an author, educator, and policy advocate specializing in transgender and transsexual issues, consulting with corporations, social service agencies, legislative bodies, professional specialty groups, and schools and universities with the goal of improving the health, safety, and civil rights of all transgender people.*

*Ms. Worley is a design engineer for a leading boat manufacturer and an elite athlete in Canadian and International sport, competing for over 25 years in cycling and waterskiing. For the past two years she has been engaged in dialog with sports leaders in medicine, anti-doping, and event administration concerning what it means to be gender-variant, the effects of transsexual transition on human physiology, and the impacts of barriers to sport upon transgender people.*

### **Shifting Paradigms: Making the Case for Moving Gender Identity Disorder Out of the Diagnostic and Statistical Manual (DSM)**

Stone – MS, MR

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Drawing upon the author's original thinking and reviewing current discontent within health and human services care for transgender persons, the paper will discuss 1) the rationale for removal of Gender Identity Disorder from the DSM via the creation of a new paradigm of transgender health care; 2) address the concerns regarding continuity of care during such a process; 3) posit suggestions for an alternative diagnosis within other categories of the ICD 9 and ICD 10 codes.

I have a 20 years experience working with transgender clients in my private psychotherapy practice. I have worked extensively as an educator and consultant on all things trans for over 15 years. That education has been both for other professionals and for consumers. I have sat on trans related health care committees at the Gay and Lesbian Medical Association, National Coalition for LGBT Health combined with a very vigorous participation as a transgender human/civil rights activist.

I am former Board Chair of the International Foundation for Gender Education, Inc. former Board Co-Chair of the New York Association for Gender Rights Advocacy, Inc. and am currently on the Board of Directors of the National Gay and Lesbian Task Force, Inc.

### **Transphobia: A Price Worth Paying for Gender Identity Disorder?**

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Those who live transgendered lives are regarded by Western psychiatry as mentally disordered. People who transphobic, on the other hand, are not. Expressed in daily acts of prejudice and discrimination, transphobia impairs the quality of life and health of transpeople worldwide. Results are now available from a recent international study of transphobia. Led by the author and conducted in seven countries worldwide (Malaysia and the USA (both identified in this study as comparatively transphobic societies), UK and Philippines (both comparatively transaccepting) and China, Singapore and Thailand (all intermediate)), the findings suggest five important components of transphobia. One of these components is the belief that transgenderism is a mental disorder. This belief is associated with other components of transphobia. This association, observed across a range of societies and cultures examined in this study, suggests that the pathologisation of gender variance may serve to exacerbate the prejudice and discrimination with which transpeople are faced. These findings strengthen the case made in recent years for the removal of terms such as 'Transsexualism' and 'Gender Identity Disorder' from the medical and psychiatric manuals. It is argued that, while a few transpeople in the developed world may be able to avail themselves of free or subsidized health services on the bases of such diagnoses ('Transsexualism' in ICD-10 and 'Gender Identity Disorder' in DSM-IV), the majority of transpeople worldwide pay a heavy price.

*Eight years research into transgendered communities in East and South East Asia. Teaching in the area of sexual and gender diversity. Involvement in trans rights movement in Hong Kong.*

### **Report on the Results from UK Government Research Project - Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination**

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This research project was undertaken for the UK Government's Equalities Review between the period of July 14<sup>th</sup> and September 1<sup>st</sup> 2006. During this 6 week period, the researchers undertook a mixed quantitative / qualitative approach to collecting and analysing information on transgender and transsexual people's experiences of inequality and discrimination in the UK.

This paper is a summary of the results obtained, with some analysis where appropriate and it outlines the life experience and levels of inequality and discrimination that trans people face.

The work undertaken is certainly the largest data collection ever analysed and the largest survey response ever received when doing research on trans people's lives. One can never claim that research data is entirely representative of a community, even less so when the community being studied consists of many small sub-communities as is the case with trans people. However, the estimated number of transsexual people in the UK means that this piece of work reflects the experiences of a substantial section of the trans community. As such, this research is as near a reflection of the reality of trans people's lives as is possible through data collection.

The main areas covered are: The Workplace; Safety in Public Spaces; Confidence in accessing Health care; Access to Goods and Services; the School Experience; The home and the neighbourhood

*Stephen Whittle is Professor of Equalities Law at Manchester Metropolitan University; Vice-President of Press for Change; Coordinator of the FTM Network and President-elect of HBI/GDA. His research has been used by many NGO's; he has sat on numerous government consultations, and provided court briefs throughout the world. His publications include (with S Stryker) The Transgender Studies Reader (2006) and Respect and Equality: Transsexual and Transgender Rights (2002). Dr Lewis Turner is an independent researcher, trainer and stakeholder consultant. His PhD work researched the lives of an informal transgender support network, and he has also worked on issues of educational exclusion.*

### **Mental Health - Ohio River Room Moderators: Dr. John C. Capozuca, PhD & Dr. Oliver R. Robinow, MDCM, FRCP**

### **Gender Identity Disorder and Attachment Theory: The Influence of the Patient's Internal Working Models on Psychotherapeutic Engagement**

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Up till now studies related to Gender Identity Disorder (GID) in adult patients, carried out within the framework of Attachment Theory, have been scarce. The current research project was aimed to explore in adult patients suffering from GID the theme related to the specific nature of the States of Mind with regard to Attachment, simultaneously evaluating the level of psychopathology associated with conditions of GID and the influence of the Dismissing Attachment Internal Working Model on the relative resistance to the psychological investigation of the patients' clinical and existential experiences. The first 18 patients suffering from GID, who came to the Functional Area of Psychology of the Department of Neuroscience of "Federico II" University Hospital Department requesting treatment to provide psychological assistance for problems connected to Gender Dysphoria, among 2004 and 2005, were registered in sequential order. The following tests were administered to all patients: 1) Investigation of case histories and motivation; 2) Minnesota Multiphasic Personality Inventory (MMPI-2); 3) Adult Attachment Interview. The statistical analysis was carried out using a specific software package (SPSS 12.0). The results confirm the increase, among people with this disorder, of Insecure Conditions of the Mind, especially of the Dismissing type, and of Unresolved/Disorganised conditions of the Mind with respect to Traumas or Losses. Moreover, dismissing subjects tend to reflect a general difficulty in establishing relations characterised by real object investment and by a relative resistance to psychotherapeutic treatment. Results obtained by MMPI-2 confirm the absence of other psychopathological conditions previously reported in scientific literature.

*Since 1997 up until now he plans and activates a Counselling Service for Adults Patients suffering from GID at the Functional Area of Psychology of the Department of Neuroscience and Behaviour of "Federico II" University Hospital Department. In this Service he works as a psychotherapist and as a psychiatrist. One of his main research interests is the psychoanalytic point of view on the Gender Dysphoria. He wrote many scientific papers and is co-editor of two books on psychoanalysis and Gender Dysphoria.*

## **Interaction and Communication Patterns In the Psychiatrist-Patient Consultation in the Gender Identity Clinic**

Speer – PhD, MSc, S; Green – MD, JD, R

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In this paper we summarize initial findings from a large scale, in depth, qualitative study of the construction of gender identities within Charing Cross Hospital Gender Identity Clinic - the largest GIC in the world. Funded by the UK's Economic and Social Research Council, one of the primary aims of this study is to provide a detailed empirical examination of interaction and communication processes within the psychiatric assessment process, and to offer practical suggestions that will improve the current treatment of transsexuality and gender dysphoria.

Unlike much existing literature on the assessment of transsexual patients, which tends to be based on second-hand reports on treatment, in this study our analyses are based on a corpus of 150 hours of real life audio-recordings of actual psychiatric consultations. We analyse this data with a view to examining:

- the conversational practices that are used by transsexual patients as they discuss and formulate their identities;
- the interactional skills and techniques that psychiatrists use to establish the precise nature of the 'gender problem';
- how both patients and psychiatrists legitimate or challenge specific understandings of gender;
- how tensions and misunderstandings are played out and managed within the treatment context.

Drawing on several exemplar excerpts from the corpus, in this paper we report some of the key themes that we have identified on the basis of our preliminary mapping of the data, and reflect on what these findings might tell us about the psychiatric assessment process and how it may be improved.

*Dr Susan Speer is Principal Investigator (with Prof. Richard Green) on a three year project 'Transsexual Identities: Constructions of Gender in an NHS Gender Identity Clinic', which is funded by the UK Economic and Social Research Council as part of the Identities and Social Action Research Programme (award number RES-148-0029).*

*Richard Green co-edited the first multi-disciplinary text on transsexualism in 1969, "Transsexualism and Sex Reassignment". He has been Professor of Psychiatry at the University of California and the State University of New York (US) and Imperial College (UK). He has been on the law faculty of the University of California and Cambridge University. He was Research Director or Head of the Gender Identity Clinic, Charing Cross Hospital, 1994-2006.*

## **Transactivism as Therapy: A Client Self-Empowerment Model Linking Personal and Social Agency**

Raj – MA, R

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Based on paper of same name in press – scheduled for publication in special activist issue of Journal of Gay & Lesbian Psychotherapy in late 2007.

Drawing upon his combined clinical and community activist experience, this writer (a transactivist and therapist working out of an LGBTT program in a Toronto, community-based health centre) will present a practical therapeutic model, which will outline how an activist-cum-clinician can facilitate the self-empowerment of transsexual and transgendered clients in the therapeutic process by “encouraging,” and then linking, the transperson’s personal *and* social agency. This agency, in turn, is manifested in the dual form of self-advocacy and community activism (transactivism) through a process of skills building.

Specifically, these interventions include: 1) appropriate therapist self-disclosure (as a transactivist) and modelling of particular transactivist activities, 2) assisting clients, in the counselling session, to build self-advocacy skills (in a way that *maximizes* “healthy” narcissism), particularly with respect to health care and social service providers, with a view towards transferring these skills to community advocacy (e.g., trans activism) (in a way that *minimizes* “unhealthy” narcissism), 3) delivering workshops on how to develop/enhance activist skills for both seasoned and novice transactivists (including client and non-client populations), and 4) facilitating opportunities for transactivism to interested transsexual and transgendered clients (including points of entry to neophyte activists).

These interventions are psychoeducational *and* psychotherapeutic in that they provide creative opportunities to facilitate the self-empowerment and the interconnectedness of trans clients, who are typically marginalized individually and as a group. In Adlerian psychology, this sense of connection translates as “social interest” or “community conscience” (i.e., a connection to the human community, in particular, and to the cosmos, as a whole) and is highly correlated with positive mental health.

### **Vancouver Hospital Transgender Health Program: Further Developments in Service Delivery**

Knudson – MD, MPE, FRCPC, G; Walther, L; Preece – PhD, D, M

<sup>1</sup> Clinical Assistant Professor, Department of Sexual Medicine, University of British Columbia Vancouver, BC

<sup>2</sup> Sessional Instructor, Department of Psychology, University of British Columbia, Vancouver, BC

Department of Sexual Medicine, University of British Columbia, Echelon 5, 855 West 12<sup>th</sup> Ave, Vancouver, BC, Canada

The Transgender Health Program (THP) of Vancouver Coastal Health has now been in existence since June 2003. The closure the Vancouver Hospital Gender Dysphoria program and the creation of the THP were presented at the HBIQDA meeting in 2005.

This paper will focus on the developments in the program since then, which continue to establish this program as not only efficacious but unique.

With respect to service delivery, pathways to assessment and access to care were developed in the child, youth and adult populations.

In terms of hormone readiness and eligibility assessment, a number of training workshops were delivered, along with ongoing monthly supervision meetings. A program for surgery readiness and eligibility assessment was also developed and implemented.

The role of the Program Coordinator was also expanded, as were peer support options and mentoring opportunities.

This paper will also set the stage for the remainder of the presentations in the symposium namely the Youth Program, the Sex Reassignment Surgery Program and the Transgender Care Project.

*Dr. Knudson is the Medical Director of the Vancouver Coastal Health Transgender Health Program.*

*Mr. Walther is the Program Coordinator for the Vancouver Coastal Health Transgender Health Program.*

*Dr. Preece is in charge of the Youth Programs for the Vancouver Coastal Health Transgender Health Program.*

### **Personality Development after Sex Reassignment Surgery**

Preece – PhD, D, M; Gehring – MSW, RSW, M; Knudson – MD, MPE, FRCPC, G

University of British Columbia

UBC Clinical Instructor Psychiatry/ Faculty of Medicine e-mail: [Darlynne.gehring@vch.ca](mailto:Darlynne.gehring@vch.ca)

The purpose of this study was to examine the personality characteristics of individuals presenting for treatment at the Gender Dysphoria Clinic at the BC Centre for Sexual Medicine, Vancouver Hospital, Canada. Eighty-seven transsexuals completed self-report questionnaires at their first assessment visit (1995). In 2002, 39 individuals agreed to participate in a follow-up study. Personality traits were measured with the Revised NEO Personality Inventory (NEO-PI-R; Costa & McCrae, 1992), which includes 30 facet scales that define the broad domains of the Five Factor Model of personality. There were substantial differences in the five-factor traits from Time 1 to Time 2. Specifically, scores were significantly lower for Neuroticism at Time 2, and significantly higher for Openness, Agreeableness, and Conscientiousness. An examination of the 30 facets revealed a number of factors that indicated more positive adjustment at T2, such as significantly lower levels of Angry Hostility, Depression, and Vulnerability, and significantly higher scores on Warmth, Positive Emotions, Fantasy,



Aesthetics, Feelings, Ideas, Values, Straightforwardness, Altruism, Compliance, Modesty, Competence, Dutifulness, and Self-Discipline. The pattern of changes observed is consistent with other literature looking at personality maturation (Robins et al., 2001), and suggests that personality development is an added benefit of treatment for gender dysphoria.

*Darlynn Gebring, MSW, RSW; Clinical, VA Professional Practice Leader -Social Work, GFS-MP, UBCH, VGH, UBC  
Clinical Instructor Psychiatry/ Faculty of Medicine*

*Melady Preece, Ph.D. Registered Psychologist, Instructor, Department of Psychology*

*Gail Knudson, MD MPE, FRCPC, Clinical Assistant Professor, Department of Sexual Medicine, UBC, Medical Director,  
Vancouver Coastal Health Transgender Health Program*

### **“Should I Check Male or Female?”: The use of standardized personality assessment measures with transgendered clients**

Bradley-Rönne - *PhD*, KL

Chicago School of Professional Psychology

Chicago School of Professional Psychology, 325 N. Wells, Chicago IL 60610

Objective personality tests are often used to evaluate gender-variant individuals although test norms for this population are nonexistent. Many personality tests use gender-specific norms for scoring and interpretation. Gender-specific norms present a problem when evaluating individuals transitioning from one gender to the other, and for transgendered, bigendered, or intersex clients who may move fluidly between male and female identities. In this study, 50 male-to-female gender-variant individuals attending either a support group or a conference for gender-variant people took the 16 Personality Factor Test (16PF), a test of normal personality. 16PFs were scored as both male and female, thus, two profiles were created for each participant. Means and standard deviation ns were calculated for 16PF Primary and Global scale scores. 23 of 27 mean Primary and Global Scale scores were within one SE of the mean when compared to published test norms; the remaining 4 were <2 SE from the mean. Paired t-tests were used to compare protocols scored as male to those scored as female and significant ( $\alpha=.01$ ) differences were found between all 6 scales having gender-specific scoring. Despite the significant change in scores when gender-specific scoring was used, all mean scale scores remained within the normal range. These results suggest that gender variant individuals score similarly to population norms on the 16PF. However, identifying test-takers as male versus female produced significantly different 16PF profiles. Some guidelines for using gender-normed personality measures with gender-variant populations will be presented.

### **The Discrepancy Between Time Spent in the Preferred Gender Role and Time Participants Wished to Spend in the Preferred Gender Role Does Not Predict 16PF Emotional Adjustment, Social Adjustment, Mood or Self-Esteem? How Can That Be?**

Blount, C; Bradley-Rönne - *PhD*, KL

Chicago School of Professional Psychology

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Therapists tend to assume that inability to spend as much time as desired in the preferred gender role is a major cause of distress and dissatisfaction for gender variant clients. In this study, 50 male-to-female gender-variant individuals took the 16 Personality Factor Test (16PF) and filled out a Gender Identity Questionnaire that asked how much time she spent in the preferred gender role, and how much time she would spend in the preferred gender role “if you could.” All participants who were not living full-time as the preferred gender indicated they would spend more time as the preferred gender if they were able. The difference between days/month spent in the preferred gender role and days/month wished to spend in the preferred gender role (the “Difference” score) was calculated for each subject, and correlations were computed between this Difference score and Emotional Adjustment, Social Adjustment, Anxiety and Self-esteem scales of the 16PF. We assumed that participants with lower Difference scores would fare better on measures of emotional adjustment. Much to our surprise, the Difference score was completely unrelated to any of the emotional adjustment measures. Correlations tended to be <.3 and did not even approach significance. Efforts to produce the expected result through data manipulations such as median splits and t-tests between the low-Difference and high-Difference groups also failed to produce any relationship between the Difference score and emotional adjustment. This negative finding is highly surprising, and has significant implications for some of our assumptions about quality of life for gender-variant populations.

*Kerri Bradley Ronne is an associate professor in the Clinical program at the Chicago School of Professional Psychology. She teaches a course on working with transgendered clients, does some community education and outreach regarding GID, is involved in ongoing research with the gender variant population in Chicago. She has a small private practice seeing mainly transgendered clients, and is a member of WPATH.*

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**A Qualitative Study Of The Psychosocial Aspects Of Female Transsexualism**

Valerio, P; Orlando, E

**SYMPOSIUM**  
**FRIDAY, SEPTEMBER 7, 2007**  
**SALONS A - D**

**Invited Speaker: Etiology: Nature versus Nurture: (Dr. Richard Green, MD, JD)**

Professor, Psychological Medicine

Imperial College, London

In 1969, with John Money, I wrote: "Research into the etiology of transsexualism will proceed on many fronts. No one now, be he psychoanalyst or neuroendocrinologist, or expert in any other science, can claim to have the complete explanation of transsexualism." (Transsexualism and Sex Reassignment, p. 468)

This remains true. However, there are clues.

Most research progress has been "nature". As more physiologically innate sex differences are identified, they provide markers of innate male or female characteristics in the transgendered. They include otoacoustic emissions, finger length, brain nuclei, hand use preference, dichotic listening. Emerging human genetics research offers considerable promise.

But, strong "nurture" factors are also apparent in some gender dysphoric persons. The paths along which they travel to the conviction that they need to change sex are varied.

Among gender dysphoric persons there is great diversity. Variations include cross- vs iso-gender childhood characteristics, presence/absence of eroticism to cross-gender dressing, erotic arousal to persons of the same/other birth sex.

This spectrum in the gender dysphoric/transsexual population mandates consideration that no single etiology will be revealed.

**Invited Speaker: Dichotomy or Diversity? (Dr. Walter O. Bockting, PhD)**

Coordinator of Transgender Health Services, Program in Human Sexuality  
Associate Professor, Department of Family Medicine and Community Health  
University of Minnesota Medical School  
[bockt001@umn.edu](mailto:bockt001@umn.edu)

Working with transgender persons continues to challenge our understanding of sex, gender, identity, and sexuality. Gender identity conflict has been described as "women trapped in men's bodies" and "men trapped in women's bodies," with sex reassignment as a resolution. However, increasingly, transgender persons have challenged this binary understanding of sex and gender, and have come out to express their gender variance. Moreover, in an attempt to resolve gender identity conflict, many pursued their desire to change sex, only to discover an integrated identity transcends the dichotomy. Using data from an online study, the diversity among the U.S. transgender population will be illustrated. Important differences in discourse associated with viewing sex/gender as binary versus along a spectrum will be reviewed. Clinical implications beg the question: Is it really possible to change your sex?

**Parallel Sessions**

**Friday, September 7, 2007**

**Standards of Care – Ohio River Room**  
**Moderators: Dr. Stephen Whittle, PhD, MA, LLB, BA &**  
**Dr. Eli Coleman, PhD**



## Trans Women: Options about the Real Life Experience (RLE)

Barker, H; Wylie – MD, K

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A search of MEDLINE and PsychInfo with the terms 'living in role', 'real life experience'(RLE) and 'real life test' as search terms for papers published from 1998 - 2005 revealed no results. Three of the five elements of clinical work with patients traditionally necessitates input from mental health professionals. The gatekeeper role of mental health professionals often puts them at odds with the supportive role which most caring professionals adopt. Progression to surgery is usually supported after a successful RLE. We reviewed the opinion of the HBGDA guidance with a cohort of patients who were currently undergoing gender role transition.

Patients gave informed verbal consent. All 19 patients were male to female trans women. Thirteen of the 19 were on hormones and 4 were post-operative. Eighteen of the 19 lived in role all of the time and 14 were totally aware of the criteria for living in role. Eighteen of the 19 found it useful to live in role full-time and 13 found it very useful for clinicians to know that they were living in role. Ten found it very easy to live in role. Six reported no problems due to living in role, 8 not many, 3 some and 2 many. Despite this 17 said they would live in role all of the time even if their behaviour was not being assessed for progression to surgery. Eighteen (100% of all responders) thought that living in role was an important part of the assessment process for gender dysphoria.

Despite this statement of importance a number of suggestions were given for clinicians. These include incorporating any time spent on the waiting list with documented real life experience, being able to commence hormone therapy as soon as the RLE is started and clinicians having a more realistic expectation of how gender roles may be presented. They found image consultancy beneficial and a regular peer group beneficial.

In summary, the vast majority of patients found the real life experience both valuable for themselves as well as perceiving it to be valuable for clinicians progressing them through to hormone therapy or recommendations for surgery. Whilst there may be some difference of opinion on the exact specification of the RLE, clinicians and patients should negotiate a transition period which both acknowledge as vital.

## Supporting FTMs Throughout the Transition Process

dickey – MA, Im

University of North Dakota  
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In the spring of 2006 over 500 female-to-male (FTM) transgender people responded to an internet survey that examined the effectiveness of support groups for this burgeoning community. The study looked at the on-going need for support post-transition. While there was not a significant difference in reported need for support between those early in transition and those post-transition; the on-going need for support was significant ( $M=3.56, SD=1.35, p<.01$ ). The study also examined the effectiveness of group leaders through the administration of the Group Environment Scale (GES; Moos, 2002). When compared to test sample norms, FTMs reported less satisfaction with meeting leaders ( $M=5.58, SD=2.30, p<.01$ ). Over half of the participants (57.1 percent) agreed that support groups are not meeting their on-going needs ( $M=3.38, SD=1.45, p<.01$ ). This does not necessarily mean that their needs are actually unmet; just that support groups are not accomplishing this. Some limitations of the study include that it was conducted over the internet, it used participant self-report, and that nearly three quarters of the participants were of Caucasian background. This research points to the need for the FTM community to develop a support group model that can effectively meet the needs of participants at differing stages of transition. This presentation will be used to discuss the implications of this research and the need for additional research with the FTM community.

I am a doctoral student at the University of North Dakota in Counseling Psychology. My primary line of research is examining the FTM experience

## The Trans Care Project: Developing Evidence-Based Guidelines for Transgender Care

Bockting – PhD, WO; Goldberg, JM

Walter O. Bockting, PhD<sup>1</sup>, Joshua M. Goldberg<sup>2</sup>

<sup>1</sup>Transgender Health Services, Program in Human Sexuality, Department of Family Medicine and Community Health, University of Minnesota, Minneapolis, MN, USA, <sup>2</sup>Transgender Health Program, Vancouver Coastal Health, Vancouver, BC, Canada

Dr. Walter O. Bockting, PHS, 1300 South Second Street, Suite 180, Minneapolis, MN 55454, phone 612 624 7869, email [bockt001@umn.edu](mailto:bockt001@umn.edu)

In 2002, the Gender Dysphoria Program at Vancouver Hospital closed. In 2003, the Transgender Health Program was created and tasked with developing a decentralized network of community-based family physicians, nurses, social workers, counselors, and other clinicians with an interest in transgender care. Clinical training was paramount as most community-based clinicians had minimal experience.

With funding from the Canadian Rainbow Health Coalition and Vancouver Coastal Health, the *Trans Care Project* was created to develop advanced practice and training protocols. Local and international clinicians were contracted to partner with transgender community members to create best practice guidelines, frameworks for clinical training, and consumer education materials relating to primary medical care, mental health, care of transgender adolescents, hormone therapy, speech/voice change, sex reassignment surgery, and social and medical advocacy. The *Trans Care Project* guidelines go beyond the *WPATH Standards of Care* to address not only the transition needs of transsexuals, but also the broader physical, socioeconomic, mental, and spiritual health concerns of the diverse transgender community. The project is also significant as a collaborative endeavor between clinicians and transgender community members.

This paper will describe the clinical guidelines developed in the *Trans Care Project*. Clinical and process lessons from the project will be discussed, along with suggested next steps to build clinical competence among health and social service professionals working in the community setting

*Dr. Walter Bockting directs the Transgender Health Services at the Program in Human Sexuality, Department of Family Medicine and Community Health, University of Minnesota Medical School. He served as a consultant for the Transgender Health Program of Vancouver Coastal Health to assist in the development of guidelines for transgender care and train community-based health providers. Dr. Bockting's current research focuses on the HIV risk behaviours of transgender individuals and their partners, and the development of effective HIV prevention interventions. He is editor of several books, including Transgender and HIV: Risks, Prevention and Care (Haworth Press, 2001) and Transgender Health and HIV Prevention: Needs Assessment Studies from Transgender Communities across the United States (Haworth Press, 2005). He is a member of the Board of Directors of the World Professional Association for Transgender Health and co-editor of its official journal: The International Journal of Transgenderism.*

*Joshua Goldberg has been involved in the transgender community since 1996, co-founding three transgender organizations and working on numerous policy, education, research, and legislative initiatives. He coordinated the community consultation that led to the creation of the Transgender Health Program, coordinated the program's startup for the Vancouver Coastal Health Authority from 2003-2004, and as the Education Consultant for the program from 2005-2007 guided the development of an international initiative to create advanced clinical training for health and social service professionals. Joshua is the author of numerous publications relating to transgender issues and has been an invited presenter at universities, colleges, and conferences speaking about transgender health and community development.*

## **Female-to-Male Transsexuals (FTM's): Re-socialization in a post-passing phase of development**

Ippolito – LCSW, J

Chestnut Hill College

Joe Ippolito, email address: [joeippolito@comcast.net](mailto:joeippolito@comcast.net), phone: 267-974-4259, address: 305 East Upsal Street, Philadelphia, PA 19119.6909 E. Greenway Parkway. Suite 240 Scottsdale, AZ 85254 602.451.5533 [Lewbert@aol.com](mailto:Lewbert@aol.com)

This study explored re-socialization issues in post-passing--3 years or longer on testosterone-- Female-to-Male (FTMs) Transsexuals. A phenomenological approach was used to conduct this research, which allowed for an in-depth exploration of the FTM experience following a "post-passing" phase of development. Phenomenology is a study of experience from the perspective of the individual (Lester, 1999) and is the description of how one experiences phenomena (Hammond, et al. 1991). The phenomena being explored in this study was the re-socialization experience. A purposive sampling of twenty adult FTM's were used. This sample provided an in-depth understanding of the FTM's re-socialization experience, once he started "passing" as a man. Results of this study expands on the psychological, cultural and social literacy of the post-passing, FTM experience by exploring such developmental issues as: emotionality, achievement and success, masculinity/femininity, sexual and affectionate behavior, relationships with others and grief and loss.

*Joe Ippolito, is a 36-year-old, Female to Male transsexual (FTM), living in Philadelphia. Joe is a 6<sup>th</sup> year doctoral candidate in Psychology at Chestnut Hill College and a licensed clinical social worker (L.C.S.W) in Pennsylvania. In July 2006, he started his final internship at Northwestern Human Services (NHS). In addition to doctoral studies, Joe works part-time as a therapist for the Mazzoni Center, Philadelphia's only LGBT Health and Wellness Center, and has a small private therapy practice. Joe is Treasurer and Provider Day Co-chair for the Philadelphia Trans-Health Conference (THC) and Co-Chair for the American Psychological Association (APA) Division 44's Committee on Transgender and Intersex Issues. Joe works as a consultant and trainer, conducting professional trainings, workshops and discussions on transgender issues at a local, state and national level.*

## **Gender Change as a Transformative Process Towards Social-Self-Realization: An Experiential Roadmap**

Etscovitz – EdD, LAP

Transgender Specialists, L.L.C.

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Gender Identity Dysphoria (GID) is a complex phenomenon usually involving some measure of suffering. The sufferer is challenged to undertake a journey or process of moving from a life of such suffering to a life of living the true gender identity. It is the therapist's task to facilitate that process in terms of both inner and outer work.

The paper being proposed here is a theoretical formulation based on clinical data, hopefully generating research along these lines. It posits four major developmentally connected dimensions of gender change, namely, suffering, owning, presenting, and living one's truth. The basic aspects of each of these four dimensions of the transgender experience are then described.

In terms of suffering one's truth, GID is traumatic, involving a life of danger, secrecy, and isolation, fed by shame and guilt and resulting in social-self-nullification. The individual who chooses to put an end to the suffering constructively faces a wall of fear of the unknown which must be surmounted in order to begin the transition from one gender to the other, a process involving owning and presenting the truth.

To own the truth, the individual faces the inner emotional and spiritual challenges of self-recognition and self-acceptance which are met with the overcoming of shame.

To present the truth (to people), the individual faces the physical and social challenges of achieving social recognition and social acceptance through the resolution of guilt in making the change of gender.

The individual may finally commit to live his or her truth, that is, to embrace fully the true gender identity. Such a commitment is possible upon achieving a greater measure of dignity and entitlement, as opposed to shame and guilt, and thereby achieving social-self-realization. At last the individual is able to live in safety, openness, and connection.

This paper thus presents a paradigm of the transgender journey, an experiential roadmap, if you will, in terms of which both clients and therapists can grasp in a developmentally useful way the complexity of the transgender experience as a whole. This gender change process must also address any other psychological issues in the life of the transgendered individual which might negatively affect the overall transition.

*The author is a private therapist for individuals and couples in general with a subspecialty in transgender issues, and a corporate consultant on transgender issues who writes and speaks on transgender issues.*

### **Self-Concept during Transsexual Transitions**

Pittman, C

University of Calgary, Calgary, Alberta, Canada

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Phone (home): 1 (403) 247-3457

This paper presentation will be reporting on new trans research and results. My Doctoral research, which began in 2004, was initially presented at the XVIII Biennial Symposium, in Gent, Belgium, in September, 2003. It was carried out on an international level, with research participants from Ireland, the United States, and Canada. The purpose of the study was to identify possible changes in self-concept and body image during transsexual transition. Research participants were assessed both before and after starting any of the various medical treatments or interventions typically offered to transsexual persons. The multimodal assessment battery included the Tennessee Self-Concept Scale, the Draw-a-Person series, an objective measure of participant's sense of gendered self, as well as a subjective section, which allowed participants to share their experiences using their own words. Data collection has just been completed. Although a satisfactory number of participants entered the study (28), only eight individuals were able to complete both the pre-test and post-test phases of the research. The results of this research will be presented along with implications for individuals hoping to transition, for professionals working with trans persons, and for society at large.

*Currently, I am a Registered Psychologist, and Ph.D. Candidate, working with trans people.*

## **Family – Salons A - D**

**Moderators: Dr. Randi Ettner, PhD & Dr. Lee Emory, MD**

### **What About My Children?**

Angello – *PhD, M*; Canfield-Lenfest, M

Visiting Assistant Professor Widener University

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In this amazing age of positive media coverage and more awareness on the part of healthcare professionals, one group that is still lacking support are the children of transitioning adults. In the past, they were assumed to be traumatized by their parents' transition and often either abandoned by the transgender-identified parent, or forbidden to continue a relationship after their parent transitioned. This is changing and more families are choosing to stay together and continue to co-parent. With this paradigm-shift, children, pre-teens and adolescents need a different kind of support.

This paper will discuss the ways in which several families have chosen to support their children when a parent transitions. Considerations will be made with regard to developmental appropriateness of information (ie. keeping the child's age in

mind) and will briefly discuss therapeutic methods that have allowed the children to develop resiliency and a better understanding of their parent's experience.

### **Supporting Resilient Marriages During Gender Transition**

Sargent – MSN, APRN-BC, KJ  
3410 Hillsborough St, Raleigh NC, 27607

More male to female transsexuals and their wives are remaining married after transition. Why do some couples end their marriages at the thought of transition, others remain married with great anxiety, and others thrive through transition? Some research indicates that resilience or hardiness factors such as an optimistic attitude, individual courage and high self esteem predict more positive outcomes for families in crisis. Marital psychotherapy can build on these strengths and assist couples in maintaining marriages through very difficult stresses. Unfortunately psychotherapy for transwomen and their spouses often focuses on fear, betrayal, loss, and anger. This paper examines ways of strengthening family resilience during gender transition to improve the couple's chances of maintaining their marriage after transition. The impact of the psychotherapist's belief system on whether the couple remains married is also examined. Family centered, holistic interventions that support family resilience on the levels of belief systems, organizational patterns, and communication processes are provided. Case studies of transwomen and their spouses who are successfully maintaining their marriages while dealing with gender transition are presented.

*Kimball Sargent is an advanced private practice psychiatric nurse in Raleigh North Carolina. She has worked primarily with the transgender community for the past 10 years. She has an informal network of medical professionals who provide care for her clients consisting of a psychiatric, psychologist, endocrinologist, dentist, and several family practice physicians. She currently has about 60 open cases of clients dealing with gender issues.*

### **Family Matters**

Reed, T

Gender Identity Research and Education Society (GIRES)  
GIRES, Melverley, The Warren, Ashted, Surrey KT21 2SP, UK; [admin@gires.org.uk](mailto:admin@gires.org.uk)

Poor support from the family is a recognised prognostic factor for a trans person's experience of regret, following gender confirmation surgery (Landén, 1999). Family acceptance is an important, sometimes vital, ingredient in the successful rehabilitation of the individual in the new gender role.

GIRES has been able to ensure that the new standards of care currently in preparation in the UK, include a section on the responsibility of clinicians working in the field of transsexualism, to recognise that trans people do not live in a vacuum. Engagement with the family should form a part of the care package offered to trans individuals.

GIRES has run a series of workshops, involving a total of nearly 200 people. The GIRES' team includes parents and partners of trans people, and also a trans man and a trans woman.

The aims of the workshops are to encourage optimism about the future, to promote open discussion of the many difficulties faced by trans people, to lessen the tension between them and their families, and to enable families to support the trans person.

Feedback questionnaires have been provided to participants, routinely. These indicate that support and education for families, in the early stages of transition, can often prevent deterioration of, or lead to significant improvements in, relationships by mitigating the experience of pain and loss.

*Trustee of GIRES, which provides information and education, based on research, about gender dysphoria and transsexualism; see "Atypical Gender Development – A Review" in International Journal of Transgenderism (2006) 9:1 <http://www.gires.org.uk>.*

### **Therapeutic Considerations in Working with the Family, Friends, and Partners of Transgendered Individuals**

Zamboni – PhD, BD

Program in Human Sexuality, University of Minnesota Medical School  
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This presentation reviews the therapeutic considerations in working with the family, friends, and partners of transgendered individuals—the issues they face and suggestions for helping them. Family, friends, romantic partners, and other loved ones of transgendered relatives may experience denial, anger, and depression during the coming out process. Cognitively, families and friends likely need to ask questions and understand the implications of having a transgender loved one in their family. Families need to mourn any perceived losses and reconcile changes to the family identity and the transgender relative's personal identity. Children and romantic partners face unique challenges in their adjustment. Models of family adjustment in response to a transgendered loved one are presented. Therapists can help families by giving them space, alone and later with the transgender loved one, to express themselves. Validating emotions, increasing social support, and providing accurate information on transgenderism are important components of therapy. With appropriate professional guidance, family, friends, and partners can learn to appreciate a transgendered loved one and strengthen family bonds.

*I work at the Program in Human Sexuality and work with transgender clients in various ways.*

## Transgenderism and Psychoanalysis: Connecting Separated Identities into a Usable Integration

Juran – *PhD, S*

Professor of Psychology at Pratt Institute, Brooklyn, NY  
163 Clinton Street, Brooklyn NY 11201 ([Sjuran@aol.com](mailto:Sjuran@aol.com); 718-625-6526)

The interface of psychoanalysis and gender identity disorders has always interested me. As a psychoanalyst, I am interested in understanding the dynamic and relational aspects of disorders and as a sexologist and psychologist I have been seeing clients with gender identity issues for more than 25 years, since I operated NYU Medical Center's Clinic for the Study of Sexual Development. Now I see people privately.

I am one of the few psychoanalysts who works with transgendered clients. They come in to explore a resolution of their gender dysphoria. It may end with surgery or it may end short of surgery, with some combination of therapy and hormonal intervention. I am attempting to help people feel more integrated and whole with or without a sex-change operation. I work in a humanistic, interpersonal/relational style, which involves engaging the client in a mutual interaction in which both real relationships and internal experiences are analyzed.

Internal self-representations are related to early object ties and attachments. These are explored as the client experiences them in the therapy and with current relationships. Less rigid ways of experiencing oneself and others are encouraged. The concept of "androgyny" may be used, however loosely, to help clients maintain a more integrated sense of themselves than before. I in no way assume that gender dysphoria is "cured," but for some people it can be experienced in a less distressing manner such that radical life-style changes (divorce, job relocation and surgery) may be avoided. Two clinical cases will be presented.

*I am a member of WPATH, a psychoanalytic graduate of NYU's Postdoctoral program in Psychoanalysis, a psychologist in private practice who works with transgendered clients. I am also a Professor of Psychology at Pratt Institute where I teach their Sex & Gender courses.*

## Advanced Practice in Mental Health and Hormone Therapy by Family Physicians: An approach to comprehensive care for transgender persons

Corneil – *BA, MD, MHSc, CCRP, FFRC, T*

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In Canada, the UK, Australia, and Northern Europe, family physicians provide first access, continuous, and comprehensive health care to patients with or without referral to specialists. Qualification involves significant training in both psychiatry and internal medicine. Once certified, they provide a full range of services in clinical behavioural sciences that meet the basic requirements of a Mental Health Professional as per the HBIQDA Standards (6th Version). With additional training and experience in transgender health, family physicians offer individuals with gender dysphoria a broad set of skills that may include assessment, DSMV diagnosis, psychotherapy, hormone therapy, surgical referral, and post-operative care.

In Vancouver, through a coordinated effort by university educators and the local health authority, we have developed an approach to comprehensive transgender care that includes each of these elements in the context of a multidisciplinary team. In addition to general services, family physicians play a central role in providing both assessment and transition therapy. This has significantly increased the accessibility, quality, and continuity of care for a systemically marginalized population in the public setting.

## Mental Health Differences Between Female-to-Male Transgender People Receiving Testosterone Treatment Compared with Untreated

Davis – *MSW, SA*; Melendez – *PhD, R*

San Francisco State University  
1530 McAllister Street, Apt. #4, San Francisco, CA 94115

Objectives: This research study compared FTM transgender/gender-variant participants receiving testosterone treatment versus those not receiving testosterone, in terms of depression, anxiety, anger, body image, and sex drive.

Method: A 98-question written survey was completed by 208 transmen and gender-variant people, all of whom were assigned female at birth but no longer fully identified as female; 118 respondents were receiving testosterone and 90 were not.

Results: Participants receiving testosterone treatment were found to be significantly less depressed ( $p \leq .001$ ), less anxious ( $p \leq .001$ ), less angry ( $p \leq .001$ ), more comfortable with their body ( $p = .005$ ), and to have a higher sex drive ( $p \leq .001$ ) than those not receiving testosterone. In an unstructured question regarding perceived changes in mood, respondents taking testosterone reported feeling happier (43%), more assertive (31%), and calmer (30%). Weekly testosterone administration

was correlated with less depression ( $p = .04$ ) and less anger ( $p = .05$ ) than biweekly administration. Among participants taking testosterone, those who had also undergone chest surgery had significantly improved body image ( $p \leq .001$ ) and were less anxious ( $p = .01$ ) than those who had not had surgery.

Conclusions: This study found testosterone treatment to be significantly correlated with improved mood and body image in FTM transgender/gender-variant people. FTM transgender people as well as their medical providers may benefit from this research in making an informed decision regarding testosterone treatment.

*I am an FTM transgender graduate researcher, a social worker, and a community organizer. I am very closely connected with the FTM transgender/gender-variant community in the San Francisco Bay Area, and direct several large nonprofit projects including 2 transgender/genderqueer support groups, a Gender Education Speakers Bureau advocacy project, and the San Francisco Trans March.*

## **Endocrinology/Disorders of Sexual Development**

### **Rock River Room**

**Moderators: Dr. Tom Mazur, PsyD & Dr. Hertha Richter-Appelt**

### **Consensus Statement on Management of Intersex Disorders: An Overview**

Mazur - *PsyD, T*

Clinical Associate Professor of Psychiatry and Pediatrics, State University of New York  
School of Medicine, State University of New York at Buffalo tel: 716-878-7093  
[tamazur@buffalo.edu](mailto:tamazur@buffalo.edu)

The consensus statement on the management of intersex disorders is the result of 50 international experts meeting in Chicago in October of 2005. Prior to this meeting, small working groups were formed, each with the task of reviewing such issues as management of intersex disorders, long-term outcome, surgery, hormone replacement, cultural and social factors and future studies. These groups submitted responses to a defined set of questions resulting from an evidence-based review of the literature. This presentation presents the highlights of this consensus statement and some unresolved issues after which questions will be addressed by members of the WPATH Intersex Committee, who participated in the formulation of this document.

*WPATH Disorders of Sexual Development Committee Chairperson*

### **“When I Am Grown Up, I Will Remember That I Am A Girl.” – Gender Dysphoria In A Male Assigned 46, Xx Individual With Congenital Adrenal Hyperplasia (CAH)**

Schweizer, K; Brinkmann,L; Richter-Appelt, H  
University-Hospital Hamburg Eppendorf

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Tel.: 0049 40 42803 7765, [k.schweizer@uke.uni-hamburg.de](mailto:k.schweizer@uke.uni-hamburg.de)

#### **Abstract:**

A 48-year old male assigned 46,XX individual with Congenital Adrenal Hyperplasia (CAH) brought up in a little village in Germany will be presented. The person is a participant of the Hamburg Intersex research project investigating treatment experiences and quality of life of individuals with different forms of Disorders of Sex Development (DSD). CAH is one of the most frequent intersex conditions and refers to a group of syndromes where an enzyme deficiency in the adrenal gland leads to an overproduction of androgens. At birth, children with CAH and 46,XX show more or less virilized ambiguous genitalia and are usually assigned female.

Due to a severe clitoris hypertrophy at birth, the subject presented was assigned male and raised as a boy. The CAH condition was only diagnosed in adolescence at the age of 17 and repeated surgical interventions followed. The patient was not informed about the diagnosis and the background of the interventions until adulthood.

Today, the patient reports a strong female gender identity from childhood on suppressed by the parents and therefore kept secret.

In retrospect, the subject considers the male gender assignment and following interventions as wrong. Meanwhile he has started to seek (re-)transition to female. The applicability of the models "gender identity disorder" and "gender change" in persons with CAH will be discussed. Implications for psychological and medical practice in intersex and transgender care will be drawn.



*The authors work at the research team for DSD (head: Richter-Appelt) of the Institute of Sex Research at the University Hospital Hamburg and are specialized on the treatment, counselling and psychotherapy of adult and adolescent patients with gender dysphoria, gender identity disorders and individuals with different forms of intersexuality (disorders/variants of sex development).*

### **Cross-Sex Hormone Administration Changes Pain Incidence and Characteristics in Transsexual Women and Men**

Meriggiala – MD, PhD MC; Bachiocco, MV; Costantino, A; Armillotta, AF; Cerpolini, S; Berra, M; Ceccarelli, I; Pelusi, G; Aloisi, AM

Obst Gynecol Unit<sup>1</sup> and Anaest Int Care<sup>2</sup>, Univ of Bologna, S. Orsola Hospital and Dept of Physiol, Neuroscience and Applied Physiol Section<sup>3</sup>, Univ of Siena  
Dept Obst and Gynecol, S. Orsola Hospital, University of Bologna, Via Massarenti 13, 40138 Bologna, Italy

It has been suggested that incidence of chronic pain is higher in females than in males. Whether sex hormones play a role in this difference is unclear. Transsexuals who undergo hormonal treatment represent a unique model in the study of the relationship between sex hormones and pain.

**Design:** 47 MtF and 26 FtM transsexuals taking hormones for at least one year, completed questionnaires about social demographic status and pain (Mc Gill Pain Questionnaires [MPQ] and VAS scales [0-10]). Serum hormone levels at baseline and at the time of the completion of the questionnaires were recorded.

**Results:** During hormone intake, 11 MtF subjects developed pain, while only 1 FtM developed pain, while in 6 FtM frequency and intensity of pain improved. In all subjects, the most frequent types of pain were headache, breast and musculoskeletal pain.

#### **SUBJECTS WITH PAIN**

	<b>Baseline</b>	<b>Treatment</b>
MtF	3/47 (6.4%)	14/47* (29.8%)
FtM	15/26 (57.7%)	16/26 (61.5%)

\*=p<0.05

Twenty FtMs and 13 MtFs had undergone some type of surgery.

All MtF subjects reported to be more sensitive and less tolerant towards thermal stimuli (both warm and cold).

**Conclusions:** E treatment increased the incidence of pain in MtF transsexuals while T treatment did not change the incidence of pain in FtM subjects but changed its characteristics. Whether these effects are due to central or peripheral actions of steroid hormones remains unknown.

### **Advanced Practice in Mental Health and Hormone Therapy by Family Physicians: An approach to comprehensive care for transgender persons**

Corneil – BA, MD, MHSc, CCRP, FFRC, T

Vancouver Coastal Health, British Columbia, Canada, University of British Columbia, British Columbia, Canada  
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In Canada, the UK, Australia, and Northern Europe, family physicians provide first access, continuous, and comprehensive health care to patients with or without referral to specialists. Qualification involves significant training in both psychiatry and internal medicine. Once certified, they provide a full range of services in clinical behavioural sciences that meet the basic requirements of a Mental Health Professional as per the HBIQDA Standards (6th Version). With additional training and experience in transgender health, family physicians offer individuals with gender dysphoria a broad set of skills that may include assessment, DSMV diagnosis, psychotherapy, hormone therapy, surgical referral, and post-operative care.

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**Afternoon Symposium - Salons A – D**  
**Chair: Dr. Walter Meyer, MD**

**Invited Speaker: Telepsychiatry - The Practice of Telemedicine**  
**(Dr. Lee Emory, MD)**

Telemedicine is the use of electronic communication and information technology to provide clinical care at a distance. This field has been developed rapidly over the last ten years and is now perfected in such institutions as the University of Texas Medical Branch which services per month over 4,000 telemedicine consultations involving 24 medical specialties. Telemedicine provides personalized comprehensive care resources way beyond the mental health provider's office. It reduces travel time both for the provider and for the patient. It is particularly useful for providing care to remote locations such as rural areas and in countries where travel is very difficult from one area to another. Equipment for telemedicine is relatively simple. It requires computer with high speed communication and cameras in both the provider's area and in the patient's area. Since the cost of equipment continues to fall and its availability increases, new cheaper ways of providing telemedicine are being developed. The major clinical issues continue to involve consent, confidentiality and credentialing of the provider both in the country/state and in the country/state of the patient. For relatively uncommon conditions such as gender identity disorder, telemedicine offers a chance to do assessments and care over long distances. It can provide a mechanism to actually increase frequency of visits at patient lower cost. The individual can be interviewed in their home/community environment. This should reduce the degree of stress and increase understanding their goals, and to support them better during their real life tests. Telemedicine will allow regular contact with ongoing support and treatment regardless of how geographically far they are maybe for the provider. It is expected that telemedicine will become more and more available throughout the world as the technology costs fall and the providers and clients become more familiar with it.

**Web-Based Transgender Care**

Dr. Lin Fraser, EdD

2538 California St, San Francisco, CA 94115 linfraser@aol.com

As the Internet proliferates, people are exploring ways to access information and care online. Whether termed online counseling/therapy, etherapy, distance counseling/therapy, or web-based care, providers need to become educated about this burgeoning modality to make informed decisions about whether they want to participate.

WPATH is in the forefront of healthcare and most members are comfortable with ethically based cutting-edged practice. This paper will address general information about web-based practice as well as specific transgender concerns focusing on advantages, limitations, ethics, and the process of online psychotherapy.

A brief overview of research findings, myths and realities will be described. Issues of credentialing, licensing, standards, informed consent, delivery methods (synchronous and asynchronous email, text chat, video chat, VOIP) and the location of therapy will be addressed.

Next, strengths and limitations specific to online transgender care will be discussed. Our population is particularly appropriate for web-based care in terms of geography (difficulty in accessing enlightened care) computer expertise, intelligence and motivation. A worldwide information network is already in place. Psychotherapy has great potential for creative delivery methods, including avatars and immersive worlds for people already comfortable with fluidity. Practice RLT is a possibility. Cautions specific to our population include the aforementioned strengths, transpeople need to be out and about as well. Ethics of hormone and surgical referrals will be addressed.

An online psychotherapy case involving a Saudi-based American MTF and a San Francisco therapist will be discussed, including process, transference considerations, ethics and outcomes. Time permitting, video chat will be demonstrated.

*I am a San Francisco-based licensed psychotherapist with a 30+ year subspecialty in gender identity concerns. I am a charter member of WPATH. I have recently become a DCC (Distance Credentialed Counselor).*

**A Professional Web-Based Gender Dysphoria Counseling Service**  
**Web-based Evaluation of Gender Identity Development in Gender Space**

Dr. Wal Torres, M.Sc., Ph.D

Gendercare Gender Clinic, OII- Organisation Intersex International

Estrada do Itanhanga 2021, Rio de Janeiro-Brazil, CEP 22753-00, Phone number: 005521 2494288, Email:

[torrwad@gendercare.com](mailto:torrwad@gendercare.com)

Gender variance and gender dysphoria are conditions that affect far more people than previously thought—approximately one of every 50 individuals assigned male everywhere in the world as well as a significant number of those assigned female. Wide agreement exists about the benefits of gender therapy and medical treatment for people with gender dysphoria, but



adequate treatment so far has mainly been available only in some urban areas of the most developed countries. The author describes the development and implementation of a Web-based service (now in operation for five years) for the diagnosis and treatment of underserved populations of gender dysphoria patients, with special reference to Brazil (the author's home country). Included are practical details of diagnosis and treatment methodology, statistics on patient demographics and outcomes, and payment arrangements. Consideration is given to ways in which the cultural environment in many countries and the unique characteristics of a Web-based gender therapy service require a modification in the standard methods used for gender dysphoria treatment in developed regions. The author also indicates directions for the expansion and improvement of Web-based gender dysphoria treatment.

## Parallel Sessions

### Surgery MTF - Ohio River Room

**Moderators: Dr. Mick van Trotsenburg, & Dr. Loren Schechter, MD**

#### **Prototype One-Stage Vaginoplasty: A Collaborative Description**

Bowers - MD, M

Trinidad Reproductive Healthcare, Seattle Reproductive Healthcare  
328 Bonaventure, Suite #2, Trinidad, CO 81082, (719) 846-6300

Dr. Bowers will share results, outcomes and technical advances achieved in over 400 primary male-to-female vaginoplasties. In addition, a verbal description and short video demonstrating her current technical advances will also be shown. Dr. Bowers' willingness to openly discuss her outcomes will be offered in hopes of achieving greater inter-surgeon cooperation in managing complications and improving results for all surgeons worldwide.

*Dr. Bowers is a Gynecologic surgeon who specializes in Gender Reassignment. Dr. Bowers assumed the Reassignment Surgery duties from Dr. Stanley Biber in 2003, practicing primarily in Trinidad, Colorado. She is also the only postoperative transsexual currently performing Reassignment Surgery in the US.*

#### **Characteristics Of Neovaginal Tissue After Vaginal Reconstruction With A Penile Skin Graft In Male-To-Female Transsexuals: Follow-Up On 13 Patients**

von Lipinski, OVM; Gehring – MSW, RSW, D; Thompson, S; Stevenson, RW; Knudson – MD, MPE, FRCPC, G

<sup>1</sup>Department of Obstetrics and Gynecology, University of British Columbia, Vancouver, BC, Canada

<sup>2</sup>Department of Sexual Medicine, University of British Columbia, Vancouver, BC, Canada

Department of Sexual Medicine, University of British Columbia, Echelon 5, 855 West 12<sup>th</sup> Ave, Vancouver, BC, Canada

Background: this is a follow-up study on 13 male-to-female transsexuals (MTF) after vaginoplasty using penile skin. There is very little research on the long-term effect on the neovaginal tissues in MTF. Two observers have noted the tendency of vaginal graft tissues to assume the histological features of normal vaginal mucosa, regardless of their origin. Six cases of vaginal neoplasia in MTFs were described in recent publications. There is no data to support that heterotopic penile skin is at an increased risk of developing neoplasia and there is no convincing evidence that vaginoplasty techniques affect the subsequent risk of neovaginal carcinoma. The glans of penis is retained as the neocervix. Should these patients receive cytological screening as natal women do? Our main interest was to study neovaginal tissues in patients who had vaginoplasty and at the same time were castrated estrogen-treated former males. Methods: gynecological examination and tissue biopsies. Literature review was included. Results: our study was limited to a very small number of patients. All biopsy results were normal. Conclusion: The standards of Care for Gender Identity Disorder state that "gender patients should be screened for pelvic malignancies as are other persons". There is currently no consensus for screening for pelvic malignancy in MTFs. New women should follow the same gynecologic care of their genitalia as is available to genetic women. More data and laboratory based research is needed. We hope future studies will develop guidelines recommending regular pelvic examination and cytological screening for cancer of the vagina in new women.

#### **Complications of Male-To-Female SRS in 8 Years Of GID Service - Brazil**

Silveira, MT; Soares, M; Silva, NA; Neiva, GF; Costa, MR

Universidade Federal de Goiás – Brazil

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The Brazilian Council of Medicine had approved the sex reassignment surgery (SRS) just in 1997. Due to the demand of transsexual persons, looking for treatment in Clinical Hospital of Federal University of Goiás, the director had created a

team that could give attendance to this population, in 1999. The first surgery was made in 2000, using penile skin flaps and placing the glans inside the vagina, but the team went on operating using penile skin flaps (without scrotal flaps) and the glans to build up the clitoris. Since then 13 operations were performed. The aim of this paper is to describe the difficulties and the complications that our team has encountered till now.

PATIENTS	NUMBER OF SURGERIES	DIFFICULTIES AND COMPLICATIONS
MG	2	Stenosis, IVL, prolapsed neovagina
JUL	4	IVL, rectum perforation without fistula
LR	3	Neoclitoris hypertrophy
SH	3	Urethral stenosis, neoclitoris necrosis(keeping orgasm)
RB	2	IVL
JULL	6	Pos-operative neovaginal infection, IVL
MC	2	Big labia majora(BLM)
LZ	1	IVL, BLM
JO	3 (till now)	IVL, neoclitoris necrosis (keeping orgasm), rectum perforation with fistula
RA	1	none
GA	2	Narrow neovaginal introitus
ML	3	BLM, IVL
VL	4	Urethral stenosis
MN	2	Urethral stenosis, penile flap necrosis, IVL

IVL – Inadequate Vaginal Length

*Since de beginning of the Transsexual Project at the university, I have been the coordinator of the gender team. I have worked with transsexual people since 1999, as a coordinator of the gender team. I have been graduated in Medicine and Psychology. My interest in Psychology was mainly to study Human Sexuality. Because of that, when the transsexuals knew that the SRS was allowed in Brazil in 1997, they put pressure on the director of the University Hospital and he invited me to build up the team and to coordinate it. Since then, it has been my most rewarding work, because I realize that there are few health professionals available to help them with respect and kindness.*

## **Do Histological Changes in The Skin-Lined Neovagina of Male-To-Female Transsexuals Really Occur?**

Dekker, JJML; Joris Hage, J; Karim,, RB; Kanhai – MD, PhD, RCJ; Bloemena, E

From the Departments of (1) Gynecology and Obstetrics and (4) Pathology at the VU University Medical Center and the Departments of Plastic and Reconstructive Surgery at the (2) Antoni van Leeuwenhoek Hospital and (3) OLVG Hospital, Amsterdam, The Netherlands

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Controversy exists on whether, or not, the epidermal keratinizing squamous epithelium of skin grafts and flaps applied to line a neovagina changes histologically to a non-keratinizing mucosal type squamous epithelium after vaginoplasty in male-to-female transsexuals. To end this discussion, the aim of this study was to objectify the short-term and long-term histological aspect of this neovaginal epithelial lining.

Biopsies were taken from the epithelium lining of the neovagina of 9 male-to-female transsexuals, from the moment of vaginoplasty up to 14 years after. These were stained with hematoxylin-eosin and periodic-acid-Schiff's stain for histological comparison to normal vaginal biopsies. Because no changes that might have been induced by local influences or hormonal therapy were found, we concluded that short-term and long-term changes in the histological aspect of inverted skin flaps do not occur after penile and scrotal skin vaginoplasty in male-to-female transsexuals.

*Both the senior authors J.J. Hage & R.B. Karim are dedicated to transsexuals surgery, dr Kanhai is working in the field of gender surgery from his residency.*

*J.J.M.L. Dekker is working in the VUMC at Amsterdam an is interested in gender surgery and has been a co author in more the one article on gender surgery.*

## **Revision Vaginoplasty with Sigmoid Interposition: A Reliable Solution for a Difficult Problem**

Schechter – MD, LS; Boffa, J; Ettner – PhD, R; Ettner – MD, F

Chicago Gender Center  
9000 Waukegan Rd. Suite 210 Morton Grove, IL 60053

The most common method of vaginal construction involves the use of penile inversion flaps, often in conjunction with scrotal skin grafts. However, depending upon the length of the penis and the success of the skin grafts, patients may suffer from inadequate vaginal depth. This can preclude intercourse and lead to disappointment with surgical results. What options remain after failed penile inversion vaginoplasty?

We report on two patients who underwent previous penile inversion vaginoplasty with inadequate vaginal depth. Both patients underwent unsuccessful courses of vaginal dilation, in addition to attempted surgical revision with local flaps and/or revision skin grafts. Both patients were unable to have vaginal intercourse. Successful revision vaginoplasty was performed with sigmoid interposition.

Revision vaginoplasty was performed by a combined abdominal and perineal approach. The sigmoid colon was harvested by the general surgical team, and the perineal dissection was performed concurrently by the plastic surgical team. A 12-15 cm segment of sigmoid colon was used for vaginal construction. Hand sewn, end-end anastomoses of the colon were performed to restore intestinal continuity. The distal bowel was sutured to the introitus of the neovagina with a single layer of 3-0 vicryl. The neovagina was packed for 3-4 days with a soft stent. Patients remained hospitalized until tolerating a regular diet and return of bowel function was achieved.

Both patients achieved vaginal depth in excess of fifteen centimeters, adequate vaginal lubrication, and successful, pain-free vaginal intercourse. Revision sigmoid vaginoplasty should be considered early in the treatment of failed penile inversion vaginoplasty.

*I am a board-certified plastic and reconstructive surgeon practicing in a multi-disciplinary environment with the Chicago Gender Center. As director of plastic surgery for the Chicago Gender Center, I work with primary care physicians, psychologists, and other health care providers for surgical care of both male-to-female and female-to-male transgendered individuals. I perform both primary and revision SRS surgery in addition to facial, breast, and body surgery.*

## **Articulation and The Perception of Gender in Male-To-Female Transsexuals**

Free, N; Dacakis, G

La Trobe University, Melbourne, Australia  
School of Human Communication Sciences, La Trobe University, Melbourne, Australia 3086, Telephone: +61 3 94791793,  
Email: G.Dacakis@latrobe.edu.au

The aim of this study was to investigate whether the preciseness with which a male-to-female transsexual articulates her speech affects a listener's perception of her as female.

Twenty male-to-female transsexual participants provided two reading samples. The first represented 'precise' articulation. The second sample followed a brief training session to facilitate 'imprecise' articulation. A number of articulation errors known to be more familiar in the speech of males were included in the second sample.

Eleven first-year speech pathology students rated the samples for perceived sex of the speaker and, using a 10cm visual analogue scale, the extent to which the speech sample represented the perceived sex of the speaker. Mean Fo (voice pitch) was acoustically analysed for each sample using the Computerised Speech Laboratory (Kay Elemetrics Corporation, 1999).

A Wilcoxon signed-ranks test yielded a statistically significant result for gender representativeness ( $Z = -2.156$ ,  $p = 0.031$ ), i.e., the samples using precise articulation scored higher on female gender representativeness than those using imprecise articulation.

Analysis of the mean Fo data provided the unexpected finding that the precise articulation speech samples were produced with a statistically significant higher mean Fo than the imprecise articulation speech samples.

The present study provides preliminary evidence to suggest that therapy to improve articulation precision in male-to-female transsexuals who present with imprecise articulation may increase perceptions of the speaker as female.

Georgia Dacakis is a speech pathologist and university lecturer who has worked in the area of transsexualism since 1980, providing speech pathology intervention, publishing and conducting research into male-to-female transsexual communication. She has been member of the Queen Victoria Hospital and later the Monash Gender Dysphoria Clinics (Melbourne, Australia) since 1981.

## **Voice Changes: The Role of the Speech and Language Therapist (SLT) and Voice Surgery**

Antoni, C; Richards, C

Speech and Language Therapy Department, Charing Cross Hospital  
Fulham Palace Road, London, W6. [cantoni@hnt.nhs.uk](mailto:cantoni@hnt.nhs.uk) 0044 208 8461761

This presentation addresses voice services for trans clients including Speech and Language Therapy intervention and Ear Nose and Throat (ENT) voice surgery.

For many trans people voice is a crucially important element of presentation and social integration. Voice is a complex phenomenon. Trans voice has additional therapeutic requirements which require highly specialist SLT clinical intervention. The role of the SLT may encompass many indirect interventions such as; non-verbal communication, social skills and psychological adjustment to their modified voice. It also includes direct interventions such as; pitch, resonance and intonation exercises.

The role of the SLT trans voice service at Charing Cross, currently the largest service provider in this growing field, also includes teaching and the development of service delivery models.

Increasingly, many trans individuals are seeking ENT surgical intervention to assist them in achieving voice change. Kanagalingham et al (2005), Matai et al (2003) and our own data indicate that better surgical outcomes are achieved when combined with SLT intervention pre and post surgery.

Current HBGDA standards of care do not include guidelines regarding Speech and Language Therapy intervention. They do, however, caution against vocal surgery occurring prior to the completion of all other surgeries. At Charing Cross, pitch surgery may be offered following SLT intervention and when a client is well advanced into the Real Life Experience (RLE), but not necessarily after all other surgery has occurred. All clients are offered Speech and Language Therapy post surgery to maximise the possible benefits of surgery and as part of their holistic treatment within the gender identity clinic.

*C. Antoni is a Consultant Speech and Language Therapist (Voice) both within the NHS and in independent practice.*

*C. Richards is a trans woman with experience of receiving services from Charing Cross, a psychology student and a trans peer counsellor.*

## **Feminization Laryngoplasty**

Thomas, JP

Private Practice

909 NW 18<sup>th</sup> Avenue, Portland, Oregon, 97209-2324, USA

Feminization Laryngoplasty (FemLar) is a type of laryngeal framework surgery designed to obtain a more feminine sounding voice in the male to female transgender patient. Several types of procedures target the frequency or pitch of the resting speaking voice to some degree. Thyrohyoid suspension may be performed alone or along with a Feminization Laryngoplasty to change some resonance characteristics of the speaking voice by changing the configuration of the vocal tract and not just the vocal cords themselves.

Video and audio recordings of normal larynxes as well as recordings of patient voices undergoing the various procedures should offer the audience a better understanding of the voice as well as a better comparison of the results of these procedures than numbers alone do.

Feminization Laryngoplasty will also be compared with CricoThyroid Approximation (CTA), which is designed to place the voice into a permanent falsetto.

*My current involvement with Gender Identity Disorder is as a surgical specialist of the voice. I have been developing the above procedure (FemLar) over the past four years and have presented some preliminary results at previous meetings.*

## **Mental Health - Special Populations - Rock River Room**

**Moderators: Dr. C. Christine Wheeler & Dr. Eric Avery**

## **Analysis of the Legal Status of Transsexuals and Transgender in Latin America**

Adrian, T

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The legal status of transsexuals and transgender in Latin America largely vary from country to country. This legal status goes from a total lack of legal recognition of their condition – ordinarily accompanied by a deprivation of their more elemental human and political rights, and even the lack of action of public forces in the case of torture and hate crimes- as it is the case in certain countries in Central America; to a more or less limited judicial recognition of the right to change the name and the sex in the identity documents –often after a long and difficult process, and only after a GRS- accompanied with a certain protection of their human rights under the grounds of unlawful discrimination. In the very recent past, certain legislators have proposed laws concerning transgender and transsexual people, and some of them are over the point to

become law, but this movement remains quite exceptional. The purpose of this paper is to analyze the similarities and differences of the legal status of transsexual and transgender people in Latin America, and to propose an uniform law for the region allowing transsexual and transgender people not only to be legally recognized according to their identity, but also to be entitled to receive public health treatments and full recognition and protection of their human rights, specially with regard to studies, work and lodgement.

### **Autocastration and Autopenectomy as Surgical Self-treatment in Incarcerated Persons with Gender Identity Disorder**

Brown – MD, GR

Professor of Psychiatry, East Tennessee State University and Chief of Psychiatry, James H. Quillen VAMC  
549 Miller Hollow Road, Bluff City, TN 37618

The author presents a case series of five inmates in the United States with severe gender identity disorder (GID) who engaged in surgical self treatment of their gender dysphoria via autocastration, autopenectomy, or both in the absence of concomitant psychosis or substance use disorder. All cases were encountered during litigation by the inmates to obtain access to transgender health services. Two inmates completed both autocastration and autopenectomy in maximum security settings. In all instances of autocastration, the inmates suffered life-threatening blood loss and incurred substantial expense to the prison system in acute medical and surgical treatment. No inmate regretted having conducted self-surgery. The relatively sparse literature on genital self harm is also reviewed. Incarcerated persons with severe GID may resort to life-threatening surgical self treatments when persistently denied access to psychiatric evaluation and possible treatment by health care practitioners experienced in transgender health care. In all cases of surgical self-treatment, the intensity of gender dysphoria decreased compared to reported baseline levels, although symptoms of GID were still present. Three cases led to significant changes in policy regarding the management of GID in three separate states but only through successful litigation.

*Board of Directors, WPATH; Standards of Care Revision Committee (version 7); practicing psychiatrist and forensic psychiatry, evaluating and treating persons with GID*

### **Women on the Inside: A Model Program for Transgender Women in Prison**

Kohler – MD, L

Correctional Medicine Consultation Network  
1940 Bryant Street, San Francisco, CA 94110

Transgender women have long been ignored by the correctional medicine community. Departments of Corrections continue to debate the necessity of medical treatments for this population, and for the most part have chosen not to recognize the transgender identities of their inmates. The California Department of Corrections and Rehabilitation currently houses approximately 300 transgender women in the men's prisons. The majority of these women are eventually transferred to the Correctional Medical Facility (CMF) in Vacaville. Most of the transgender inmates in Vacaville are poor women of color who have been convicted of nonviolent crimes, have some degree of feminization, and many are HIV infected. Despite having lived full-time as women for many years, few transgender inmates have had consistent medical care or physician-prescribed hormones prior to their incarceration. Before 1999 there was inconsistent provision of feminizing hormones to transgender inmates in California. In 1999, after a successful lawsuit brought by a transgender prisoner, I developed the first clinic for transgender inmates in a California prison. Over the past eight years, I have treated close to 400 transgender women and maintain a panel of approximately 70 patients. The success of this program has led to a statewide policy that ensures access to cross gender hormones for all transgender inmates. This presentation will review the California policy regarding access to care and treatment of transgender inmates, and present a model of care for the prison setting. The high risk of incarceration faced by transgender women will also be examined.

*Transgender people have been part of my medical practice since 1994. Over the past 13 years, I have cared for more than 700 transgender people. Currently, I see transgender people in my family medicine clinic, run a clinic for transgender women in one of the State prisons, and provide telemedicine consultation for transgender inmates throughout the California prison system. I have given lectures and trainings on various topics related to transgender health care in a variety of forums, including international and national conferences, government and state funding agencies, and departments of health.*

### **Gender Identity and the Military**

Belkin, A; Witten – PhD, MSW, TM; Brown – MD, GR

Dr. Belkin, Director - Michael D. Palm Center, a think tank studying sexual minorities in the military, Dr. Tarynn M. Witten, PhD, MSW, Fellow of the Gerontological Society of America, and Senior Fellow/Executive Director of the TranScience Research Institute; Dr. George R. Brown, MD, military psychiatrist, psychiatrist for the VA, and author on transsexuals in the military; Monica Helms - founder and president of the Transgender American Veterans Association, Advisory Board member of the National Center for Transgender Equality.  
Palm Center, 3218 Vallejo Street, Denver CO 80211

The question of military service of transgender individuals is an important topic. The military is one of the largest employers in the nation. Transgender-identified persons have served and continue to serve in the military. Other international allied forces serving alongside United States service members allow transgender people to serve openly. That said, there has been little research on this topic. In this panel, leading experts will discuss their research and experiences: What are the regulations governing the service of transgender people in the military? Does the service of transgender individuals in the U.S. military impact readiness and the military's ability to fulfill its mission? To what extent does the military attract MTF and FTM individuals as a result of the gendering experience of military service? How does the fact that the military medicalizes and pathologizes the transgender experience impact transgender service members and others?

### End of Life Care of the Transsexual Elder

Witten T.M.† – *PhD, MSW, TM*; Eyley A.E.§ – *MD, MPH, AE*; Whittle, S.T.◊ – *PHD, MA, LLB, BA, ST*

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Social gender transition frequently takes place during early to mid-adulthood, although there are increasing numbers of younger individuals undergoing gender transition. After navigating the challenges of the transition and post-transition periods, many people are able to live for decades without experiencing further crises related to gender identity.

The final stage of life is a time of crisis, characterized by both the need to bring meaning out of one's life experience and intended legacy, and by a host of practical needs. Maintaining mental clarity while receiving analgesia and sedation, personal dignity in the context of physical debility, and autonomy as abilities fade, become substantial challenges for the elderly person who is nearing the end of life.

End of life difficulties can be more complicated for transsexual elders, as waning cognitive and physical capabilities interfere with "identity management" and bodily privacy. Unresolved family tensions often re-emerge, and lack of legal protections can interfere with chosen relationships, inheritance, and funeral wishes.

This panel presentation will discuss the care of elderly transsexual persons during the final phase of life, from the perspectives of medicine, social work and the law. Case examples will be provided.

*All three members are active researchers in the field and who have been writing about transgender aging for quite some time and are expert in their field (Medicine, Social Work or the Law) as they apply to the needs and care of transgender-identified persons.*

## Children – Salons A - D Moderator: Dr. Walter J Meyer

### Gender Identity Development Treatment of Adolescents – International Comparisons Reed, B

Gender Identity Research and Education Society (GIRES)  
GIRES, Melverley, The Warren, Ashted, Surrey KT21 2SP, UK; admin@gires.org.u33

#### Abstract:

At the 2005 HBIGDA Symposium, in Bologna, Dr Walter Meyer announced the formation of a team, comprising an international multidisciplinary group of clinicians as well as user representatives, including 8 members of WPATH, who have experience that is relevant to the medical treatment of gender variant adolescents. Puberty causes intense stress for adolescents who experience profound and persistent gender dysphoria as their bodies develop in conflict with their innate gender identities. Young trans men develop breasts and start to menstruate. Young trans women experience erections, deepening of the voice and growth of facial and body hair. The team's tasks were to (a) compare the different approaches to treatment and (b) prepare consensus guidelines. GIRES procured funding for the team to attend a small Symposium in London. The majority of the team's members favoured intervention, in carefully screened cases, to suspend puberty at an early stage as permitted in the UK's Royal College of Psychiatrist's Guidance (1998) and the HBIGDA Standards of Care (2001). This fully reversible intervention relieves stress and allows more time for diagnosis. Subsequent intervention regulates final height and promotes cross-sex development in accordance with the confirmed gender identity. However, the British team members insisted that these adolescents must experience full pubertal development before any physical intervention and had written Guidelines, embodying this practice, that the British Society of Paediatric Endocrinology and Diabetes (BSPED) had endorsed in 2004. Following the Symposium, five other members of the team published papers in professional journals that support early suspension of puberty. Also, BSPED withdrew its Guidelines, although the British approach has not yet changed. Currently, early suspension of puberty is offered in 9 centres, in Australia, Belgium, Canada, The Netherlands and the USA.



*Trustee of GIRES, which provides information and education, based on research, about atypical gender identity development and transsexualism; see <http://www.gires.org.uk>. GIRES has presented papers at the HBGDA Symposia in London, Galveston, Ghent and Bologna. Two of its trustees are members of WPATH.*

### **Cross-National Replication of the Gender Identity Interview for Children**

Wallien, M.,<sup>1</sup> Cohen-Kettenis, P. T.,<sup>1</sup> – PhD, Owen-Anderson, A.,<sup>2</sup> Bradley, S. J.,<sup>2</sup> Zucker, K. J.<sup>2</sup> – PhD

<sup>1</sup>Gender Clinic, VU medical centre, Amsterdam, The Netherlands, <sup>2</sup>Gender Identity Service, Canada Centre for Addiction and Mental Health, 250 College St., Toronto, Ontario M5T 1R8, Canada; e-mail: [Ken\\_Zucker@camh.net](mailto:Ken_Zucker@camh.net)

Over the past three decades, a variety of diagnostic-specific measures have been developed for use for children who meet the DSM diagnostic criteria for gender identity disorder (Zucker, 2005). Unfortunately, most of these measures have been developed on North American samples of children, so their application in other countries and cultures remains uncertain. As part of a cross-national, cross-clinic collaborative study, the present study examined the psychometric properties of the Gender Identity Interview for Children (Zucker et al., 1993), a child-informant measure, in a sample of clinic-referred children with gender problems from Toronto, Canada and Amsterdam, The Netherlands. The GIIC is a 12-item interview schedule that consists of questions pertaining to both cognitive and affective gender identity confusion. Each item is scored on a 3-point scale. The GIIC was administered to 371 gender-referred children from Toronto, 217 gender-referred children from Amsterdam, and 178 control children (siblings, clinical controls, and community controls) from Toronto. The children ranged in age from 3-12 years, with a mean age of 7.65 years. Factor analysis identified a one-factor solution, containing all 12 items from the GIIC, accounting for 37.6% of the variance. Cronbach's alpha was .84 and corrected item-total correlations ranged from .42-.67. For each child, we calculated a total GIIC scale score by summing the 12 (unit-weighted) items. A 3 (Group) x 2 (Sex) analysis of variance (ANOVA) revealed a significant main effect for Group,  $F(2, 760) = 63.52$ ,  $p < .001$ . Duncan's post-hoc tests showed that both the Toronto and Dutch probands had a significantly higher deviant score than the controls and that the Dutch probands had a significantly higher deviant score than the Toronto probands (all  $ps < .01$ ). Using Cohen's  $d$ , the Toronto proband-control effect size was 1.72 and the Dutch proband-control effect size was 2.92. In Zucker et al. (1993), cutoff scores of 3+ or 4+ deviant responses were used to calculate specificity and sensitivity rates. For the controls in the present study, a cutoff score of 3+ deviant responses yielded a specificity rate of 86.0% and specificity rates of 57.4% and 83.4% for the Toronto and Dutch probands, respectively. For the controls, a cutoff score of 4+ deviant responses yielded a specificity rate of 92.7% and specificity rates of 46.9% and 70.5% for the Toronto and Dutch probands, respectively. The results of the present study showed that the GIIC had excellent psychometric properties. Although both the Toronto and Dutch gender-referred children had significantly higher deviant scores than the controls, the Dutch clinic children had more deviant scores than the Toronto clinic children. This finding was similar to two previous studies in which parents also reported more cross-gender behavior in the Dutch children than in the Toronto children (Cohen-Kettenis et al., 2003; Wallien et al., 2006). The discussion will consider the factors that account both for similarities and differences in clinical presentation of children with gender identity disorder across these two clinics.

*All authors work with patients with gender identity disorder (children, adolescents, and adults). Dr. Cohen-Kettenis is the Head of the Gender Clinic at the VU in Amsterdam and Dr. Zucker is the Head of the Gender Identity Service (for children and adolescents at CAMH in Toronto.)*

### **The Recalled Childhood Gender Identity/Gender Role Questionnaire: A Comparative Study of Adolescents with Gender Identity Disorder and Transvestic Fetishism**

Zucker – PhD, KJ, Owen-Anderson, A, Bradley, SJ

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The Recalled Childhood Gender Identity/Gender Role Questionnaire (RCGIQ) consists of 23 items designed to assess an individual's recollection of his or her gender-related behavior during childhood. All items are rated on either a 4-point or a 5-point scale. Factor-analysis identified a two-factor solution: Factor 1 consisted of 18 items that pertained to gender role and gender identity, which accounted for 37.4% of the variance, and Factor 2 consisted of three items that pertained to parent-child relations (closeness to mother and father), which accounted for 7.8% of the variance (Zucker et al., 2006). In the present study, we administered the RCGIQ to 134 adolescents (age range, 13-19) referred to a gender identity service for children and adolescents: 94 had a diagnosis of gender identity disorder (GID; 54 males, 40 females) and 40 had a diagnosis of transvestic fetishism (TF; all males). Demographic data included age at assessment, IQ, and parent's social class and marital status. The patients' sexual orientation (in fantasy) was assessed with the Erotic Response and Orientation Scale (EROS; Storms, 1980), which consists of 16 items, each rated on a 5-point scale. Half of the items pertain to heteroerotic attractions and the other half pertain to homoerotic attractions (vis-a-vis the patient's birth sex). Both the male and female adolescents with GID recalled significantly more cross-gender behavior in childhood on Factor 1 of the RCGIQ than did the male patients with TF. The female adolescents with GID also recalled significantly more cross-gender behavior in childhood on Factor 1 than did the male adolescents with GID. The sexual orientation of the female adolescents with GID was almost uniformly homoerotic, i.e., sexual attraction to biological females, whereas there was considerably more

variability among the male adolescents with GID. Regarding the latter finding, this was entirely consistent with the literature on adults with GID. To explore the relation between recalled gender identity/gender role and the sexual orientation of the adolescents with GID, we performed correlations between the RCGIQ Factor 1 score and the EROS ratings. This was done by computing a difference score between the mean homoerotic and mean heteroerotic scores. In both the female and male adolescents with GID, a relatively higher homoerotic score on the EROS was significantly correlated with more cross-gender behavior on Factor 1 of the RCGIQ. The results of the present study showed that the RCGIQ had discriminant validity in that the adolescent patients with GID had significantly more recalled cross-gender behavior in childhood than did the patients with TF. Indeed, the mean score of the adolescent patients with TF was remarkably similar to that of a reference group of heterosexual male controls without TF. The finding that a higher homoerotic score on the EROS was significantly related to the extent of cross-gender behavior in childhood is consistent with previously established empirical relations on these two parameters on adult males with GID; interestingly, the same pattern was evident among the female patients with GID, even though our adolescent girls were, overall, predominantly homoerotic in their sexual orientation. The RCGIQ appears to be a promising measure for use with adolescent patients referred for gender identity issues.

*All authors work with child and adolescent patients with gender identity disorder. Dr. Zucker is the Head of the Gender Identity Service (for children and adolescents) at CAMH in Toronto.*

## **What Can We Learn from Adult Transsexual Patients for the Treatment of Children and Adolescents with Gender Identity Disorders Asking for Early Sex Reassignment Hormonal Treatment?**

Preuss, WF

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According to guidelines of the German Association of Child- and Adolescent Psychiatry, 2003, and The Royal College of Psychiatrists, 1998, children and adolescents with gender identity disorders should not receive hormonal sex reassignment treatment. In the Netherlands since the nineties (Cohen-Kettenis, P. T. & van Goozen, S.H.M., 1997) after careful evaluation adolescents with the diagnosis "primary transsexualism" are treated successfully with puberty delaying substances and hormones as follow-up-studies so far could show. As in mass-media recently reported, in Germany a few „transsexual“ children aged 13 have been treated with puberty delaying substances and with hormones. Adequate treatment guidelines and settings with interdisciplinary cooperation of gender-specialists, child- and youth psychiatrists and psychotherapists, and pediatric endocrinologists (gender-teams) are yet to be established in Germany.

The case of a thirty-nine woman (diagnosed with primary male-to-female transsexualism) is presented. Her psycho-sexual development was severely impaired by the non-acceptance of her girl-identity by her family. The case is reflected and discussed under the aspect, what can we learn from adult patients with primary transsexualism for the diagnosis and therapy of children and adolescents with gender identity disorders asking for early hormonal sex reassignment therapy?

*Psychiatrist, psychotherapist, gender-specialist, sex-therapist. Member of the scientific and clinical staff at the Institute of Sex Research and Forensic Psychiatry, University Clinic of Hamburg, since 1992. "Informal" clinical specialist for children and adolescents with gender identity disorders, trying hard together with Prof. Dr. Hertha Richter-Appelt and colleagues of Child-and-Adolescent-Psychiatry to improve services for gender disordered children and adolescents. Clinical specialisation in psychotherapy of patients with gender identity disorders, and in group-psychotherapy with pedosexual patients. Sex-therapist, working with the Hamburg Model of Sex Therapy (a modified concept of sex therapy according to Masters and Johnson). Research activities in studying (AAI) types of adult attachment in patients with gender identity disorders, sexual dysfunctions and sexual delinquency. Member of a National Committee for "Standards of Care of Transsexuals" (adapted to specific legal and medical conditions in Germany) initiated by the German Association of Sex Research, published 1997. Member of the World Professional Association for Transgender Health (WPATH). Member of the German Association of Sex Research (DGFS).*

## **Departures from the Standards of Care II: Two Cases of Gender Transition in Adolescence**

Capozuca – PhD, JC, Wheeler – PhD, CC

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The Standards of Care (SOC) for the hormonal and surgical sex reassignment of gender dysphoric persons has evolved considerably in its six revisions from 1979 through 2001.

One of the most significant expansions occurred in the 5<sup>th</sup> edition in 1998, where among other comprehensive changes, the treatment of children and adolescents were first addressed.

While providing great latitude in the development of endorsements for triadic therapies, the SOC require that departures be thoroughly documented as a means of ensuring excellence in patient care and ongoing evolution of the field. The current presentation is undertaken in an effort to fulfill of these requirements.

Two case histories of adolescent MTF individuals seen jointly by these workers are presented. Specific factors leading to the clinical decision to depart from the guidelines, as well as the nature of those departures are discussed. Finally, implications for ongoing clinical work relative to immediate outcomes in these cases are considered.



## Healthy TransTeens 2007: Ethical & Practical Psychiatric Recommendations for Working with Transgender Adolescents in the U.S.

Pleak, RR

Long Island Jewish Medical Center

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There has been an increase in the number of young people openly identifying themselves as transgender over the past several years; however, the number of mental health clinicians with experience working with these youths is very small. Those who present as transgender during adolescence pose unique opportunities and challenges for mental health clinicians, due to the particular developmental issues they face and the legal issues involved in treating minors. Clinicians who work with transgender adults, but who are not adept at dealing with children and adolescents, are often stymied by these issues, the uncertainties that arise, and the incumbent work needed with families and social agencies such as schools and foster care services. A host of decisions and possibilities are encountered, including when to use or not use the diagnosis of gender identity disorder (GID), finding appropriate resources and support for the adolescent and the family, helping social agencies overcome resistance to supporting transgender teenagers, when and how to refer minors for hormone treatment, and educating mental health students and peers in how to best serve transgender youth. Discussion will focus on the history and current variability of treatment and the in the U.S. and Canada, the ethical implications of using the GID diagnosis and the efforts to change this diagnosis, the controversy about use of hormones in minors, and recent initiatives to promote greater awareness by mental health clinicians about the needs of transgender teenagers. Recommendations in these various areas will be given for promoting mentally healthy transgender teenagers.

*I am Chair of the Sexual Orientation & Gender Identity Issues Committee of the American Academy of Child & Adolescent Psychiatry, and direct the Sexual Identity Service at Long Island Jewish Medical Center for gender variant children and adolescents.*

## Diagnosing the Debates Over Gender Identity Disorder in Children

Bryant, K

University of California, Santa Barbara [note: new affiliation as of August 2007 will be Assistant Professor of Sociology and Women's Studies, State University of New York, New Paltz]

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This paper analyzes current debates over Gender Identity Disorder in children in light of the historical construction of the diagnosis. Drawing on archival materials, interviews, and professional literatures on gender-variant children, the paper weaves together historical analysis with the author's own autobiographical experiences as a research subject for fifteen years in one of the most widely known studies of feminine boys. This paper traces the initial construction of the medicopsychological 'problem' of gender-variant children, the formalization of the diagnosis, and the continuing debates over its legitimacy up to the present. It outlines the changing political terrain, professional cultures, and clinical practices that have impinged on the diagnosis and related debates. Instead of viewing the debates over the legitimacy and meanings of GID in children as solely adversarial, I look at the ways that critics and defenders may unknowingly work together to create knowledge and practice concerning gender variant children; gender and sexuality more generally; and ideas about health and illness. I argue that while critics and defenders adopt generally opposing positions, they both work within a common framework based on the discursive, material and historical conditions from which childhood GID was produced. These include the early framings of gender variance as a problem, the enduring interest in psychosexual outcomes, and the formalizing of GID in children as a psychiatric diagnosis. By staying within this established framework, I argue that critics have sometimes unintentionally participated with GID-defenders in such things as shoring up existing categories of gender identity and sexual orientation.

*I am a sociologist who has been actively researching the construction of and debates over Gender Identity Disorder in children for the past 5 years.*

## Benefits of an Active and Constructive Attitude from Schools Towards Children and Adolescents with Gender- Variant Behavior

Franse, BC

Landelijk Bureau Humanitas

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Humanitas Netherlands aims to support children and adolescents with gender- variant behaviour through providing information, counselling and advice to them, to their family members and to other important persons in their lives/ network such as school staff and peers. We try to adjust the care to the individual needs of 'the client'. Besides offering (individual) counseling to teenagers and/ or their caretakers we organize a teenager support group and facilitate a parent

support group. Often we are contacted by teachers, counselors, youth workers etc. to provide them with information on gender variant- behaviour.

More and more, school staff members, teachers, school counselors etc. contact us in their search for advice and guidance in organizing accurate (practical and mental) support for a child or teenager with (persistent) gender- variant behaviour in their school. We usually advise parents to choose a school that is not ignorant or hesitant towards the (possible) 'extra needs' of their child. Therefore the parents need to be assertive and open in their communication with (high) schools, also in the early stadium of pre- enrollement.

Many times, as a result, the school staff actively informs itself further (e.g. contacts professionals with relevant knowledge and experience), makes adjustments to their (f)(m) based administration, invests time in getting to know the child and the parents better and therefore their wishes and needs. As a result, more and more, parents maintain functional contact with school, teenagers feel safer and wish to 'out' themselves with e.g. a (prepared) presentation in front of their classroom (with support from parents and school staff), school works actively to prevent bullying of the child or teenagers with gender-variant behaviour and therefore shows responsibility in creating a safe(r) school environment, supporting visibility and stimulating tolerance towards diversity.

As a result it (often) becomes easier for the child or adolescent with gender- variant behaviour to express her/himself, experience less (feeling of) invisibility, grow more self-esteem, achieve better school results, connect (more) with peers, ask for assistance in case of bullying, be seen as and respected for 'who s/he is.

In this presentation I would like to tell you more about the results and insights of our practice- based, direct interaction with schools.

*Co- operator and social worker for project 'children and adolescents' at 'Werkgroep Transseksualiteit en Genderdysforie' Humanitas, The Netherlands*

## POSTERS

### Surgery:

#### **Voice Parameters That Result in Identification or Misidentification of Biological Gender in Male-to-Female Transgendered Veterans**

King, RS; Quillen, JH; Brown – MD, GR; McCrea, CR

Robert S. King, M.A., CCC-SLP; Staff Speech-Language Pathologist, James H. Quillen VA Medical Center, Mountain Home, TN

George R. Brown, M.D., DFAPA; Chief, Psychiatry Service, James H. Quillen VA Medical Center, Mountain Home, TN and Professor of Psychiatry, James H. Quillen School of Medicine, East Tennessee State University

Christopher R. McCrea, Ph.D., CCC-SLP; Assistant Professor, Department of Communicative Disorders, East Tennessee State University.

James H. Quillen VA Medical Center, Audiology and Speech Pathology Service (621/126), Mountain Home, TN 37684, [ROBERT.KING2@MED.VA.GOV](mailto:ROBERT.KING2@MED.VA.GOV); 423-926-1171, x 2747

The objective of this study was to examine the voices of male-to-female transgendered veterans and biological females that can result in identification or misidentification of biological gender. All transgendered veterans who participated were interviewed for transgender status by a Board Certified psychiatrist recognized as an expert in the diagnosis of GID and related conditions. The interaction of speaking fundamental frequency (SFF) and formant (resonatory) frequencies in gender discrimination was investigated. Nine biological females and 21 biological males were selected. A minimum reading fundamental frequency of 152Hz for biological males with no minimum for biological females was required in subject selection. This study found that an average SFF above 180Hz in conjunction with a speaking pitch range of 140 to 300Hz appears to be the most powerful acoustic feature or marker in the perception of a female voice in a biological male. An SFF of approximately 170Hz appears to be the lower limit that would result in a biological male being perceived as having a female voice by most listeners. A slight elevation in F2 and F3 formants does not appear to have a significant influence in the perception of a female voice in biological males. Female voices appear to be perceived as male by most listeners if average SFF is at or below 165Hz, the low SFF is below 130Hz, and a low F3 is exhibited. No statistical evidence was found that a wide pitch range in connected speech is a salient feature resulting in the perception of a female voice in biological males. The acoustic impact of intonational patterns in gender identification is unclear. The results support the hypothesis that elevated pitch is the strongest acoustic marker in the perception of a female voice in biological males.

## Cytologic Findings After Construction of a Neovagina in Male Transsexuals

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In order to know about how much time it takes or what factors could influence the transformation from de penile skin into a normal vaginal epithelium, we collected pap smears in the patients who underwent the SRS, independent on the time of the surgery. All the patients use estrogens continuously.

PATIENTS	DATE - SURGERY/PAP	RESULTS
L	Aug 2002 – March 2006	Keratinization without nucleated cells. Cocobacils.
S	Sept 2002-April 2006	Inconclusive. Cocobacils.
M	Nov 2004 – March 2006	Superficial inflammatory cells. Rare neutrofiles. Gardnerella
Jl	Nov 2004 – March 2006	Keratinization mainly. Rare nucleated cells with features of superficial cells. Cocobacils.
Jo	Dec 2004 – March 2006	Superficial and parabasal cells. Cariomegaly and one multinuclear cell. Cocobacils. Many neutrofiles. ASCUS
G	March 2005 – March 2006	Keratinization
ML	April 2005 – March 2006	Keratinization; rare nucleated cells with features of superficial cells. Cocobacils
R*	Dec 2005- March 2006	Few nucleated cells with the features of intermediate and superficial cells. Cocobacils.

\* technique using the glans inside de vagina

*Since de beginning of the Transsexual Project at the university, I have been the coordinator of the gender team. I have worked with transsexual people since 1999, as a coordinator of the gender team. I have been graduated in Medicine and Psychology. My interest in Psychology was mainly to study Human Sexuality. Because of that, when the transsexuals knew that the SRS was allowed in Brazil in 1997, they put pressure on the director of the University Hospital and he invited me to build up the team and to coordinate it. Since then, it has been my most rewarding work, because I realize that there are few health professionals available to help them with respect and kindness.*

## The Pedicled Anterolateral Thigh Flap in Phalloplasty Procedures

P. Ceulemans, P. Hoebeke\*, M. Buncamper, M. Hamdi, K. Van Landuyt, Ph.Blondeel, S. Monstrey

Department of Plastic, Reconstructive and Aesthetic Surgery, \*Department of Urology, University Hospital Ghent, Belgium

**Introduction:** The radial forearm free flap (RFFF) is universally considered as the “the gold standard” in penile reconstruction. However, the major drawback of this operation remains the wide circumferential scar on the forearm which for transsexual patients can be pathognomic for their condition. The pedicled anterolateral thigh (ALT) flap has been proven to be a possible alternative for the RFFF.

**Material/Methods:** The ALT flap has been used as a pedicled flap in 11 penile reconstructions. The lateral femoral cutaneous (LFC) nerve is anastomosed to the clitoral nerve to provide sensory innervation. The inner tube, for urethral conduit, has been reconstructed in different ways: with the material of a previous attempt of penile reconstruction (n=3),

<sup>1</sup> Department of Obstetrics and Gynecology

<sup>2</sup> Department of Pathology

with a short invagination flap in case of penile aplasia in extrophia vesicae (n=3), with a pedicled peritoneo-fascial flap (n=1) and with a prelamination using split thickness grafts (n=3) or full thickness grafts (n=1). In one patient a pre-operative expansion was performed allowing primary closure of the donor area.

Results: All pedicled ALT flaps survived completely. The different possibilities of reconstructing the urethral conduit will be evaluated and discussed, as well as the various functional (urological) and aesthetic outcomes.

Conclusion: The ALT flap phalloplasty is a promising alternative for the RFFF phalloplasty. Refinements however are needed to provide the same aesthetic and functional result as the RFFF phalloplasty. In thin patients all essential goals are obtained and the ALT flap phalloplasty has proven to be a very useful alternative. In other patients the results depend upon the quality of the inner tube and the technique that is been used.

## Cosmesis of the Neovagina and Psychophysiologic Outcome of Sexual Reassignment Surgery in Male-To-Female Transsexuals

O.V.M. von Lipinski<sup>1</sup>; D. Gehring<sup>2</sup>; S. Thompson<sup>1</sup>; R.W. Stevenson<sup>2</sup>; G. Knudson<sup>2</sup>.

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Background: this study investigated 13 male-to-female transsexuals with a mean follow-up of 2,7 years following sex reassignment surgery. The purpose of this study was objective and subjective evaluation of the cosmetic and functional outcomes of the neovagina. Methods: the participants were interviewed and then completed a self-report questionnaire. In addition gynecological exam were performed evaluating the quality of cosmetic (normal appearing genitalia) and functional (ability to perceive orgasm) adequacy of the neovagina. Results: Demographic and questionnaire data were summarized. None of the patients reported regret with sex reassignment surgery. Mean length of the neovagina was 8,9 cm (range 5,5 – 11,6 cm). The global satisfaction with neovagina was 84,7%. Two patients complained of shortening of the neovagina since surgery. These two patients did not have permanent sexual partners and were also the oldest in the group. The sexual experience was improved even in patients with a short neovagina. Conclusion: overall the results in this group of patients were positive. The majority of patients have adequate neovaginal length. Assuming that a short vagina could be a problem for some of the patients, it's unclear if this correlates with significant sexual dysfunction. This data also needs to be discussed in the context of differences in phenotype and genotype as an important factor in the successful vaginal construction. Future research is needed to measure implications on postoperative mental health in male-to-female transsexuals to meet adequate expectations of these patients.

## Other:

### The Changing FTM Voice

Constansis, AN

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Having being a professional singer for many years before official transition in 2003 made it imperative for me to research the particulars affecting the changing FTM voice and discover if, unlike the established views, it was possible for the new vocal persona to retain a good singing ability. I started by anticipating my own changes and initially focused on academic works dealing with the closest possible equivalent – the vocal as well as general transition from child to adolescent and consequently to adult biomale. However, I soon realised that there were far more significant factors to be taken into consideration. This work deals with original theories and experiments as well as explains the methods used and results obtained from 15 individuals (including myself) from 2003 to date.

[The first version of this paper has been presented at the 6<sup>th</sup> International Congress on Sex and Gender Diversity (Reflecting Genders), 12<sup>th</sup> September 2004, MMU, Manchester, U.K.]

*The doctorate researcher and writer of this paper / poster is himself an FTM and has been working in the field of the changing singing / speaking voice for FTM / MTF individuals since beginning of 2002 (one year before his 'official' transition). Alex. N. Constansis has retained his singing ability after transition and has acquired - and currently possesses - a vocal range of more than 4 octaves.*

## Gender and Sexual Fluidity Among Gender Queer Adults: Implications for Health and Mental Health Care

Jennifer Lewis, MSW, PhD (ABD)

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Traditional Western culture defines men and women as mutually exclusive, whose gender roles, sexual activities and anatomy are perfectly co-aligned, and ideally have no overlaps between types. Yet, even transgender individuals who have rejected static notions of gender and sexuality often have difficulty negotiating a society which reinforces binaries. This qualitative study describes and analyzes the experiences of transgender individuals who choose fluid gender and sexual expression. Self-identified often as gender queer, the research highlights the experiences of these individuals' with significant others including health and mental health providers. The theoretical frameworks undergirding this study are symbolic interactionism and social constructivism rather than one grounded in positivist science. The research design involves in-depth interviews and observations. It involves a primary sample composed of 10 gender queer individuals over 21 years of age. The research has implications for mental health providers who are making assessments, diagnoses and providing psychotherapy, for medical providers and for society at large. Quite possibly the results might serve to normalize gender variance and increase tolerance.

*Jennifer Lewis, LCSW is currently a psychotherapist in private practice working with transgender identified people. She is in the process of completing her Doctoral Dissertation in Social Work at New York University and previously was the Director of Mental Health at Callen-Lorde Community Health Center in NYC. She was integral to developing a health and mental health treatment protocol.*

### **Harry Benjamin's Syndrome – Standards of Care**

Diane Lynn Kearny, Penny, Ellen, MaryPearl, Kelly, Kelli, Jennifer Usher

Mrs. Diane L. Kearny, P.O. Box 172, Mexico, Pa. 17056

Group site: <http://groups.yahoo.com/group/HarryBenjaminSyndrome/?yguid=155548887>

Web site: <http://www.harrybenjaminsyndrome-info.org/>

The 'Harry Benjamin's Syndrome – Standards of Care' (HBS-SOC) is regarded as the new model for transsexual treatment and healthcare. Advancements in scientific research have yielded new findings that place transsexualism into a new category – that of Congenital Neurological Intersex. The HBS-SOC were formulated to consolidate the current knowledge regarding transsexualism and to provide a new paradigm to the global community at-large as well as practitioners specializing in HBS fields of service.

As the global population increases, so do cases of Harry Benjamin's Syndrome. However, it remains, per capita, a rare occurrence. Nonetheless HBS continues to be misunderstood, miscategorized, and inconsistently treated. Thus it is imperative to revise the current understanding of the fundamental nature of HBS and to redefine protocols for its effective treatment.

The acceptance of 'transgender' as an accepted social group has entrapped HBS (formerly 'transsexualism') under its umbrella, an action that is both unwarranted and unwanted. To help remove HBS from the transgender stigma and clarify it as a unique medical condition with a biological cause, we offer the HBS-SOC.

*We, the above named individuals, constitute the owners, web development team, and sole authority for the website <http://harrybenjaminsyndrome-info.org/>. With over two centuries of cumulative personal experience living with HBS, we are privileged to serve as educational providers for the advancement of its cause and cure*

### **Is Genital Nullification a Form of Transgender?**

Gerald Porter, Ph.D.

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This paper is a preliminary investigation of the rationales, motivations, and self-constructs of persons engaged in genital nullification, the surgical alteration or removal of some or all of their genitalia. Through a series of in-depth interviews with practitioners of genital nullification, sometimes referred to as "nullos," this paper attempts to answer the question, "Is genital nullification a form of transgender?" Is the deliberate surgical elimination of all outward signs of biological sex best conceptualized as a legitimate form of gender expression, a manifestation of Gender Identity Disorder, or body dysmorphia? What light does the self-report of these individuals on their motivation and the perceived benefits of their genital modification shed on this question?

*Gerald Porter is completing a book manuscript on the many diagnostic controversies that surround transgender. He also teaches a graduate course on transgender and intersex for educators, human service workers, and mental health practitioners.*

### **Uric Acid Metabolism in Transsexual People with Cross-Sex Hormone Treatment**

Esteva I<sup>a</sup>, Yahyaoui R<sup>c</sup>, Haro JJ<sup>a</sup>, Almaraz MC<sup>a</sup>, Hernando V<sup>d</sup>, Bergero T<sup>b</sup>, Giraldo F<sup>b</sup>, Lara J<sup>b</sup>, Martínez J<sup>b</sup>, Gómez M<sup>b</sup>, C-Soriguer L<sup>a</sup>, Sánchez I<sup>a</sup>, Alvarez M<sup>a</sup>, C-Soriguer F<sup>a</sup>.

<sup>a</sup>Endocrinology, <sup>b</sup>Psychology/Psychiatry, <sup>c</sup>Laboratory, <sup>d</sup>Family MD, (Andalusian-Gender-Team (AGT), Carlos-Haya-Hospital, Málaga, Spain. (mesteva@wanadoo.es) (S.A.S 60/06, RCMYNC03-08)

A poster session

Introduction: the lower levels of seric uric acid(UA) in biological women with regard to men are due to an increase in the renal clearance and urinary fractional excretion(FE), probably mediated by the estrogenic effects. The literature hardly describes the effects on the UA metabolism although it seems to be an independent marker of cardiovascular risk.

Objective: To study the influence of the standard cross-sex hormone treatment for a long-term in UA serum levels and FE in a cohort of transsexuals.

Methodology: From the total group of 616 subjects a sample of 110 transsexuals: 42 Male-to-Female (MtF) and 68 Female-to-Male (FtM), with treatment and followed up at least 2 years. In basal time and after 2 years of treatment, the following variables were studied: age, body mass index(BMI), estrogen and androgen dose, serum levels of UA, creatinine, 17 $\beta$ -oestradiol(pg/ml), total testosterone(ng/ml) and UA plus creatinine in 24-hour urine.

Results:

	MtF Mean $\pm$ SD	FtM Mean $\pm$ SD	P
Age(years)	24,5 $\pm$ 8,03	26,4 $\pm$ 6,64	0,15
Basal-UA	4,98 $\pm$ 0,90	3,87 $\pm$ 0,77	<0,0001
2-years-UA	3,67 $\pm$ 0,98*	5,05 $\pm$ 0,91*	<0,0001
Basal-FE	8,22 $\pm$ 10,98	10,33 $\pm$ 11,59	0,40
2-years-FE	12,03 $\pm$ 5,50*	7,95 $\pm$ 2,80*	0,02
Basal-17B-oestradiol	34,13 $\pm$ 15,60	103,21 $\pm$ 63,76	<0,0001
2-years-17B-oestradiol	68,70 $\pm$ 29,14*	81,21 $\pm$ 59,31*	0,59
Basal-Testosterone	6,18 $\pm$ 2,29	0,65 $\pm$ 0,90	<0,0001
2-years-Testosterone	1,03 $\pm$ 1,77*	6,68 $\pm$ 3,95*	<0,0001

Before starting the treatment(basal time) a positive correlation between 17 $\beta$ -oestradiol and UA levels and a negative correlation between 17 $\beta$ -oestradiol and FE were found, being reversed both the correlations after 2 years. The independent variables that have contribute significantly to the FE changes were the 17 $\beta$ -oestradiol levels and oestrogen dose in MtF. In the FtM this results weren't reproduced.

Conclusions: Transsexual people in long-term treatment show changes in UA metabolism with an opposite profile of the biological sex.

*The authors are working in the first and only public Unit in Health System in Spain and (Carlos Haya Hospital in Málaga, Andalucía : Andalusian Gender Team (AGT) ), since 1999 and in this period we have attended more than 600 people with GID in a multidisciplinary unit with Psychologist, Psychiatrist, Endocrinologist and Plastic surgeons. We works in the unit according to the Hbfgda standards of care. Our attention include the whole phases in SRP , we have made more than 100 genitoplasties and we follow up their clinical evolution.*

## Relevance of the Sexual Behavior In Transsexual People Visited In Andalusian Gender Team (AGT), Málaga, Spain

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Objective: To study the sexual behavior at the presurgical phase of the SRP with a standardized questionnaire in 200 patients ( 142 MtF and 58 FtM) from the total group of 616 transsexual people visited in the first and only public Unit in Spanish Health System.

Method: Questionary that explores the familial attitude toward sexual behavior, autoerotism, sexual fantasies, sexual orientation, traumatic experiences and estressor situations related to the sexuality, difficulty in sexual relationships , libido, sexual arousal, orgasm and expectatives of sexual behavior post cross-sex hormone treatment and/or genitoplasty.

Results: The outcomes alerts about the sexual difficulties in these people linked to the body scheme, erotic areas, lost or decrease of libido, sexual refuse, anorgasmia or orgasm disfunction.

Conclusion: It is important to consider the sexual expectatives and attitudes during the SRP not only in presurgical phase but also in long-term postoperative period. This approachment improve the self-esteem and the couple relationships.

*The authors are working in the first and only public Unit in Health System in Spain and ( Carlos Haya Hospital in Málaga, Andalucía : Andalusian Gender Team = AGT ), since 1999 and in this period we have attended more than 600 people with GID in a multidisciplinary unit with Psychologist, Psychiatrist, Endocrinologist and Plastic surgeons. We works in the unit according to the Hbigna standards of care. Our attention include the whole phases in SRP , we have made more than 100 genitoplasties and we follow up their clinical evolution.*

## Resolving Trauma In Transgender Clients

Graham, J

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### Abstract:

Resolving trauma is a critical consideration for working with transgender clients in mental health settings. This presentation will discuss a specialized group treatment strategy for transgender survivors of trauma. Many transgendered people report experiencing continual abuse related to gender non-conformity beginning in childhood and may not have ever lived without being the object of subtle or overt hostility. Transgendered people are keenly aware of the extreme violence directed at their community further exacerbating anxiety and depression. Discrimination compromises opportunities to develop and maintain self-esteem. In turn economic and social discrimination further complicates recovery from complex PTSD.

Transgender people may be uncomfortable discussing the full extent of their trauma in groups with cisgendered people. For example, discussing what occurred when “she was a boy” or addressing self-blame related to internalized transphobia in a group where members may be unsupportive is very difficult. Some transgendered people may feel the need to positively represent all transgender individuals among cisgendered people and thus minimize their experiences.

The specialized group treatment strategy we will present focuses on skill building for both post traumatic and current traumatic events. One goal of the group is for members to develop the coping skills and the social skills required to survive in a transphobic society. Another goal is for group members to build self-esteem and resilience through group work with peers. Finally, group members will experience the freedom to discuss sexual violations without fear that group members will make the assumption that the abuse caused the experience of transgenderism.

**Bio:** The presenter is the Gender Program Coordinator for the Center for Special Problems in San Francisco, overseeing all the mental health components for transgender and gender non conforming clients. She is a member of WPATH. She has worked with many clients who identify as gender dysphoric, transgender or gender questioning. She has been in practice since 1990 but has exclusively focused on gender clients for the past 2 years.

## Testosterone Increases the Atherogenic Lipid Profile, and Reduces Serum Leptin Levels in Female To Male (FTM) Transsexuals

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### Abstract:

Testosterone therapy in men results in decreased high density lipoprotein cholesterol (HDL-C) and low density lipoprotein cholesterol (LDL-C) which has been documented in a few studies in female to male (FTM) transsexuals<sup>3,4,5</sup>. We sought to determine whether testosterone therapy has this same effect on lipid parameters and whether there was a change in adipocyte hormones. Our study was approved by the Boston University IRB and conducted at the Boston University GCRC. We enrolled 12 FTM transsexuals (mean age 29±9 years) prior to initiating on testosterone injections (50-125 mg

<sup>3</sup> Berra M, Armillotta F, D'Emidio L, Costantino A, Martorana G, Pelusi G, Meriggiola MC. Testosterone decreases adiponectin levels in female to male transsexuals. *Asian J Androl.* 2006 Nov;8(6):725-9.

<sup>4</sup> Elbers JM, Giltay EJ, Teerlink T, Scheffer PG, Asscheman H, Seidell JC, Gooren LJ. Effects of sex steroids on components of the insulin resistance syndrome in transsexual subjects. *Clin Endocrinol (Oxf).* 2003 May;58(5):562-71

<sup>5</sup> Goh HH, Loke DF, Ratnam SS. The impact of long-term testosterone replacement therapy on lipid and lipoprotein profiles in women. *Maturitas.* 1995 Jan;21(1):65-70.



IM every two weeks). Each subject provided a fasting lipid profile including serum total cholesterol (TC), HDL-C, LDL-C, and triglycerides (TG) at the start and after 1 year of initiating testosterone therapy. In a subset of subjects, we measured resistin and leptin levels. The mean serum HDL-C decreased significantly from  $52 \pm 11$  to  $40 \pm 7$  mg/dL ( $p < 0.001$ ). The mean LDL-C increased from  $113 \pm 22$  to  $1210 \pm 29$  mg/dL ( $p > 0.05$ ), while mean TG, and TC levels remained unchanged ( $p > 0.05$ ). The serum resistin ( $n=5$ ) remained unchanged from  $10.3 \pm 2.1$  to  $9.6 \pm 2.2$  ng/dL and serum leptin ( $n=5$ ) decreased from  $31.2 \pm 29.5$  to  $19.1 \pm 17.5$  ng/dL after at least 6 weeks of therapy. Testosterone therapy in FTM transsexuals results in a more atherogenic lipid profile with lowered HDL-C and a trend towards higher LDL-C. Although limited by the population size, our study found that testosterone therapy lead to about 25% decrease in serum leptin levels with no effect on serum resistin levels. The decrease in leptin confirms previous studies in FTM. The clinical significance of lowered leptin levels after testosterone therapy is still unknown and warrants further investigation in regards to redistribution of fat stores.

**Bio:** Dr. Vin Tangpricha, who is the senior author on this paper has been a member of WPATH since 1999. He is a board certified endocrinologist practicing in Atlanta, GA at Emory University School of Medicine. He has cared for over 200 transsexual patients in Boston and Atlanta. He has been an active investigator in transsexual health and has published on topics related to transgender health in International Journal of Transgenderism, Clinical Endocrinology and Endocrine Practice.

## Moving Beyond Gatekeeping and the Medical Model

Lev – MSW, AI

New York University, Arizona State University

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### Abstract:

This workshop will introduce a developmental model for the process of transgender emergence that guides psychotherapists in an honest evaluation of identity development and allows for unique gender expressions, outside of a pathologizing framework. When therapists are placed in a "gatekeeping" role, it limits the potentiality of the client-therapist relationship, since clients desiring medical treatments try to "fit" into the parameters of diagnostic categories. Gender-variant clients who are struggling with gender dysphoria, those requesting referral for medical services, or who are willing to risk being honest with the therapist about their phenomenological experience of gender difference, present with diverse experiences and identity configurations. These narratives are often outside the medical paradigm, and have a developmental trajectory, as the client emerges into an authentic description of self. We will examine newer models that are emerging that empower transgender and transsexual people in their identity development, and we will also look at ethical dilemmas, Standards of Care, and issues of "readiness" and "eligibility" from a clinical standpoint.

## Transsex/Intersex? Political and legal implications of biological research into transsex aetiology

Lane, R

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### Abstract:

Biological research into transsex has important political and legal ramifications. Using the influential 2001 *Re Kevin* decision of the Family Court of Australia as a case study, this paper examines the politics of the production and dissemination of scientific knowledge about the aetiology of transsex. *Re Kevin*, which allowed a transsex man to marry, represents a progressive shift from prior judgements in transgender jurisprudence where legal sex was based on genital and/or chromosomal sex at birth. Two important aspects of the decision were: a shift in the definition of sex reassignment surgery (SRS) for legal purposes away from genitals; and a finding that transsex probably has a biological basis in the brain. The decision highlighted some problematic questions, which have been debated by Australian transsex and intersex advocates. Is transsex actually "brain intersex"? Are transsex and transgender dimorphic or on a continuum? Should SRS be the essential marker for legal sex change? If medical technology improves to allow determination of "brain sex", should an "intersex brain" be required to receive SRS? This paper employs a detailed critical analysis of the written discourses about brain sex, transsex and *Re Kevin*, focussing on those produced by advocacy organisations, and supplemented by interviews with selected participants in the debate. Examination of these debates can assist development of effective strategies for transgender law reform in the light of changing scientific research.

**Bio:** I am currently a PhD candidate investigating how the production, dissemination and reception of biological research which proposes a neurological cause for transsex intersects with: political organisation by transgendered people; legislative and judicial reform of the status of transgender people; transgender clinical practice; and broader social changes around gender inequality. This investigation utilises an interdisciplinary approach that incorporates insights from biological science, sociology and gender studies.

## Old-Timer Transsexuals: Their Dreams and Their Worries: Self-Help for Old-Timer Transsexual Males in the Netherlands

Wormgoor - Mr.dr.s.,TW; Bakker, A

Humanitas werkgroep transsexualiteit en genderdysforie, t.a.v. Mr. drs. Th. W. Wormgoor, Postbus 71, 1000 AB Amsterdam

Most participants of Humanitas' transsexual men's group in the Netherlands are in the process of transitioning: either shortly before or after, or in the middle of the process. A lot of transmen don't attend anymore, once they have advanced more in the process. The counselors see this as a logical and natural development. These 'senior' males do not need any further counseling, they are finished!

We began to question this assumption two years ago. We noticed that these men did want to talk, but there was no room for their stories in the regular men's group. Besides, we realized that the thought "they are finished", is rather naive. Once the transition is finished, these men are confronted with the heritage of their past. Also, a new life phase begins with new issues: social contacts, relationships, intimacy, sexuality.

The men's group counselors from Humanitas decided to invite transmen who had transitioned at least eight years ago. There were four open meetings, with a total of 40 different men. Themes for discussion were: dealing with your history, new surgical options, relationships and family. Furthermore, we started a more intensive group on request, with eight participants and two counselors.

This group has produced insight in dilemmas, coping strategies and their impact. If you have a good job, but you don't dare to chat freely with your co-workers during your break, does that mean you have succeeded? What does it mean if you are in a relationship and you keep thinking you fall short? What if nobody will ever think that you once were a woman, but frenetically you keep trying to prove to yourself you're a man? In this presentation we would like to tell you about the results and insights of this support group.

*My name is Thomas Wormgoor, I am a full member of WHP.ATH since a year or so. I am the coordinator of the 'werkgroep transsexualiteit en genderdysforie' of Humanitas in the Netherlands. The previous coordinator was Petra Klene, as I believe well known to many of you.*

*Professionally I am both a lawyer and a psychologist. Part of my work is counseling of male transsexuals who went through their transformation at least 8 years before entering our self-help group. As we tried to make clear in the abstract, the work with 'old-timers' has given us profound insights into the needs and particularities of this group, that we think might be of relevance for more professionals working with transgendered people. My co-author is Alex Bakker. He is an historian and a writer and familiar with the subject in many ways.*

## Provider-level Customization of the Standards of Care

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While some attention has been given to the ways in which the Standards of Care (SOC) can be customized for the treatment of different clients, much less attention has been given to the ways in which these standards are customized across different providers. This has given rise to a common misunderstanding of the SOC as a monolithic entity, both among members of the trans community as well as among professionals themselves.

Several factors influence provider level customization, including provider values. Is it fairer to make decisions on a case by case basis, or to have a clearly defined policy for all? Is the provider more comfortable with working with clients to formulate a careful transition plan or are you willing to allow for some experimentation? How much experimentation? To what extent is the provider's professional identity tied to doing therapy or providing health care and to what extent to helping clients navigate various systems? How holistic an approach does a provider take? Does the provider have a view of trans people as inherently healthy or unhealthy? How therapy oriented is the mental health provider? In what cases might therapy not be necessary? Is the provider comfortable working with clients who are not traditionally transsexual, such as gender-queer clients or clients who do not wish to fully medically transition?

Additionally, contextual factors affect provider level customization. What kind of a population does the provider generally serve? To whom is the provider likely to need to advocate? Being able to show how a client's treatment is consistent with the SOC can be a powerful advocacy tool. Resources can also play a role—how financially accessible is the provider to the client? To what degree do the mental health provider and the medical provider work as a team?

The SOC do specifically allow for providers to use a harm reduction approach for clients accessing hormones. This calls upon providers to decide whether and how they will do so. Some providers use a harm reduction approach (or informed consent approach) with all clients, some only with some clients. Some providers who use a harm reduction approach for access to hormones specifically do not engage in writing letters for access to surgery. For providers who choose to use a harm reduction approach, does this apply only to clients who are currently accessing hormones through black or grey market sources, or to clients at risk for doing so? On the other hand, not all providers will choose to use a harm reduction

approach, and the SOC also specifically allow providers to refuse to work with clients who are not following medical recommendations. If a client is involved in treatment for substance abuse which uses a harm reduction approach, at what point is the client considered to have the substance abuse problem under control?

Many providers have an implicit understanding of how they interpret the SOC, but explicitly thinking through these issues can help facilitate better communication with clients and avoid a simplistic interpretation of the SOC.

*Dr. Randall Ebrbar is a psychologist currently working at New Leaf Services for Our Community, a community mental health agency which serves the LGBT communities in San Francisco. He previously completed a post-doctoral fellowship at the University of Minnesota Program in Human Sexuality. He has several years experience working as a provider for trans clients. He is also a member of the American Psychological Association's Taskforce on Gender Identity, Gender Variance and Intersex Conditions as well as the American Psychological Association's Committee on Lesbian Gay and Bisexual Concerns.*

## Transforming Couples & Families: A Psychoeducational Workshop for Providers Who Support Partners and Families of Transpeople

Raj – MA, R

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Based on paper of same name in press – scheduled for publication in [Journal of GLBT Family Studies](#) in early 2008). The recent emergence of gender-divergent youth and trans-identified adults presenting in therapy, in tandem with the scant clinical work with their partners and families, indicates a serious gap in the research literature, as well as a critical need for an increase of clinically-sensitive and culturally-competent therapists who can provide support for these “trans forming” couples and families. To be effective, such treatment interventions must be grounded in a sound body of gender-diverse and transgender knowledge.

Drawing upon this writer’s clinical experience (and from the literature), this paper will identify a number of clinical issues experienced by gender-normative partners and family members (often an integral part of the transformative process), who are working towards acceptance of their gender-anormative loved one. Effective psychotherapeutic and psychoeducational interventions to help meet the challenges facing these trans forming families and couples will be outlined by means of the author’s Transformative Therapeutic Model (TfTM). The model will demonstrate ways to support the partner or family member(s) in conjunction with the trans-identified or gender-divergent loved one as a cohesive and dynamic systemic unit. Specific clinical application of the TfTM will be illustrated through a case study of a young gender-divergent child and “hir” family.

*I have been working as a clinician (psychotherapist and gender specialist) since April of 2000 (school internship till July 2001 and in private practice till January 2003) and as a Counsellor/Psychotherapist of the LGBTT Program at Sherbourne Health Centre in Toronto, Ontario, Canada since November 2002. I provide individual, couple, family and group therapy for transpeople (adults and youth), gender-divergent youth, those questioning and their loved ones, and have also provided collaborative family therapy with a transpositive psychiatrist for “trans forming” families.*

*To date, I've published two clinical research papers and a book review with two more papers in press:*

Raj, R. (In press). *Trans forming couples, trans forming families: Therapeutic support for transpeople and their loved ones.* [Journal of GLBT Family Studies](#). (Vol. 4(1)). Haworth Clinical Practice Press. (scheduled for publication early 2008).

Raj, R. (2007). *Review: Transgender emergence: Therapeutic guidelines for working with gender-variant people and their loved ones.* [Journal of GLBT Family Studies](#). (Vol. 2(3/4)). Haworth Clinical Practice Press.

Raj, R. (In press). *Transactivism as therapy: A client-self-empowerment model linking personal and social agency.* [Journal of Gay & Lesbian Psychotherapy](#). (Issue 3/4): *Activism in LGBT Psychology Practice*. Haworth Clinical Practice Press. (scheduled for publication end of 2007).

Gapka, S., & Raj, R. (2003). [The trans health project report](#). Ontario Public Health Association. ([http://www.opha.on.ca/ppres/2003-06\\_pp.pdf](http://www.opha.on.ca/ppres/2003-06_pp.pdf)).

Raj, R. (2002). *Towards a transpositive therapeutic model: Developing clinical sensitivity and cultural competence in the effective support of transsexual and transgendered clients.* [International Journal of Transgenderism](#). ([http://www.symposium.com/ijt/ijtvo06no02\\_04.htm](http://www.symposium.com/ijt/ijtvo06no02_04.htm)).

*I also provide professional training workshops on trans-related issues and transpositive care at conferences, universities, colleges, hospitals, health centres, social service & community agencies, etc. for health care and social service providers, educators, researchers, students, policy makers, politicians, journalists, etc. and have presented at: Centre for Addiction and Mental Health (Toronto, Canada), Canadian Rainbow Health Coalition Conference (Ottawa & Halifax), EGALÉ Canada Conference (Montreal),*

*Annual Sexuality Conference (Guelph, Canada), Gay & Lesbian Medical Association Conference (Toronto & San Francisco),  
International Sex & Gender Diversity Conference (Manchester, UK), etc., etc.*

## **Nowhere Near Enough: A Needs Assessment of Health and Safety Services for Transgender and Two-Spirit People in Manitoba and NorthWestern Ontario**

Jennifer Davis\*, Written by Catherine Taylor, PhD, Co-Principle Investigator, University of Winnipeg

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The struggle for an end to discrimination against transgender and Two Spirit people can be thought of as one of the key human rights issue for the 21<sup>st</sup> century.

With this and years of anecdotal evidence stemming from the transgender and two-spirit communities and the service providers who support them in mind, we secured funding for a comprehensive Needs Assessment of the health and safety needs of the trans and two-spirit communities.

An advisory committee, comprised predominantly of the transgender/two-spirit population and entirely of members of the greater LGBTT community, facilitated the process. Further to this, all communication was held directly with members of the transgender/two-spirit communities through surveys, focus groups and interviews. A comprehensive set of results has been created that we are currently using as fuel for our fight to gain access to equal rights for trans folks.

The results of the needs assessment clearly outline where there are gaps in the system and where we should focus our energy to create more acceptance for this population. A report has been created based on the results, and presentations and workshops have been developed based on the results of the survey, years of research and work in the greater LGBTT community.

## **Cultural Differences in Individualism Predict Relative Prevalence of Nonhomosexual Male-to-Female Transsexualism**

Lawrence – MD, PhD, AA

Private practice

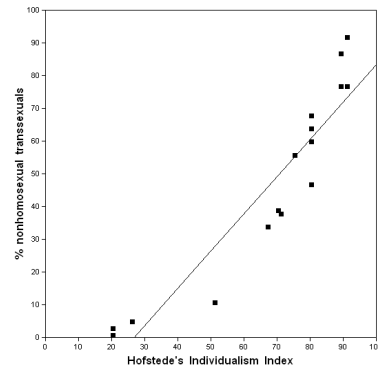
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Several studies have demonstrated that there are two distinct subtypes of male-to-female (MtF) transsexuals, homosexual and nonhomosexual. The relative prevalence of these subtypes varies dramatically across cultures, but no explanation has been forthcoming.

Dion and Dion (1993) observed that the expression of romantic love also varies dramatically across cultures, with extensive expression in individualistic cultures (e.g., the US) and limited expression in collectivistic cultures (e.g., China). I have proposed (Lawrence, in press) that nonhomosexual MtF transsexualism can be conceptualized as an expression of romantic love. This suggests the hypothesis that nonhomosexual MtF transsexualism will be higher in relative prevalence in individualistic cultures than in collectivistic cultures. To test this hypotheses, I examined data from 16 studies of MtF transsexuals, representing 13 countries. For each, percentage of nonhomosexual participants was plotted against Hofstede's (2001) Individualism Index for that country. Results are displayed in the figure below. A linear model explained 86% of the observed variance.

The 16 studies varied greatly in their definitions of MtF transsexualism and sexual orientation. Moreover, percentage of nonhomosexual transsexuals is a crude metric for the underlying construct. Despite these limitations, the observed relationship was strong, suggesting that the hypothesis has merit.

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Lawrence, A. A. (in press). Becoming what we love: Autogynephilic transsexualism conceptualized as an expression of romantic love. *Perspectives in Biology and Medicine*.

*My medical practice primarily involves patients with gender identity disorders. I have published extensively on gender identity issues. I serve on the American Psychological Association's Task Force on Gender Identity, Gender Variance, and Intersex Conditions.*

## Photographs: Passing, Climbing, Reading and Slumming: Jake/Angelique "Live" in Los Angeles

Jones, J; Pathy Allen, M C; Hale, JC

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In a diptych portrait by Mariette Pathy Allen, FTM philosopher C. Jacob Hale queers trans conventions. In one half of the portrait he appears in casual academic male attire with a panoramic skyline of Los Angeles in the background. In the other, he appears in an infamous LA alley attired in garish MTF "tranny hooker" drag as his mean-street killer-queen alter ego Angelique. The double reversal of gender presentation in these photographs jars expectations. Hale (born female) easily "passes" as male but Angelique (also born female but easily read as born male) does not pass as female. Hale, as a transsexual, seems "natural." Angelique, as a citation of "woman," or an FTM in "drag" as an MTF, seems artificial. As Angelique, Hale also confounds simple class and race categorization. Hale appears middle-class and of northern European extraction, but Angelique appears underclass and possibly Latina. He is pictured overlooking the City; she is pictured embedded into its street. Allen and Hale's collaboration in producing these images sits securely within the realm of cultural production. But it also points towards complex issues of differences in ability to pass between FTMs and MTFs, and of differences in privilege and access to education, employment, health care and other social and economic perks between different categories of transpeople. Photographer Mariette Pathy Allen will join cultural critic Jordy Jones in discussing the implications of the work and her collaboration with Jacob Hale - who will join the conversation by proxy via his written commentary.

• **Jordy Jones** is a Chancellor's Fellow at the University of California at Irvine, where is completing his dissertation project: *The Ambiguous I: Photography, Gender, Self*. As male chair of the San Francisco Transgender Civil Rights Implementation Task Force, he was key in implementing trans inclusion in the health benefits package for City employees and for furthering trainings for the police and sheriff's departments.

• **Mariette Pathy Allen** is a New York based photographer who by next year will have been documenting transgender communities and individuals for thirty years. Her first book was *Transformations: Crossdressers and Those Who Love Them* and her latest is *The Gender Frontier*, which won the 2004 Lambda Literary Award in the Transgender/Genderqueer category.

• **C. Jacob Hale** received his Ph.D. in Philosophy from The University of North Carolina at Chapel Hill. His current research includes biomedical ethics and medical regulation of gender variance in the United States from 1979 to the present, transsexual autobiography, and Los Angeles/Southern California transgender history.

## Social Network Analysis of Individuals in Gender Transition

Hoffman, B; Milburn, J

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Gender transition can be tremendously disruptive to an individual's social network. It can be argued that almost every social bond in an individual's social network is strained, broken or renegotiated in the process of changing gender. Marriage and parental bonds are frequently broken and become the subject of legal difficulties and employment problems are frequently encountered resulting in profound financial distress. The success or failure of an individual's transition can often depend upon their ability to form new social bonds, or successfully renegotiate existing bonds, that support the new gender identity. Establishing a fully functional social network that recognizes the individual's new gender is the defining characteristic of a successful transition.

A pilot study is now underway to develop analytical methods for understanding the dynamics of social networks of individuals undergoing gender transition. Individuals that attend a monthly informal group focused on transition issues in Los Angeles, California form the study sample. The study group includes people that range from just beginning the process to fully post-operative and functioning as the transitioned gender and all points in between. The mathematical tools of social network analysis will be used to develop metrics that may be helpful in understanding the relationships that exist at various points in the transition process, perceptions underlying these relationships, and the quality of these relationships. This knowledge will lead to a better understanding of social dynamics during the transition process and may help in guiding individuals through the social difficulties inherent in transitioning.

## Transgender Resources in Second Life

Preece – PhD, D, M; Lynch, A

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This paper analyzes current debates over Gender Identity Disorder in children in light of the historical construction of the diagnosis. Drawing on archival materials, interviews, and professional literatures on gender-variant children, the paper weaves together historical analysis with the author's own autobiographical experiences as a research subject for fifteen years in one of the most widely known studies of feminine boys. This paper traces the initial construction of the medicopsychological 'problem' of gender-variant children, the formalization of the diagnosis, and the continuing debates over its legitimacy up to the present. It outlines the changing political terrain, professional cultures, and clinical practices that have impinged on the diagnosis and related debates. Instead of viewing the debates over the legitimacy and meanings of GID in children as solely adversarial, I look at the ways that critics and defenders may unknowingly work together to create knowledge and practice concerning gender variant children; gender and sexuality more generally; and ideas about health and illness. I argue that while critics and defenders adopt generally opposing positions, they both work within a common framework based on the discursive, material and historical conditions from which childhood GID was produced. These include the early framings of gender variance as a problem, the enduring interest in psychosexual outcomes, and the formalizing of GID in children as a psychiatric diagnosis. By staying within this established framework, I argue that critics have sometimes unintentionally participated with GID-defenders in such things as shoring up existing categories of gender identity and sexual orientation.

*Melody Preece, Ph.D., Instructor, Dept. of Psychology, member of the Hormone Assessors Group of the Transgender Health Program in Vancouver, BC. She also works with a number of transgendered individuals, and runs a group for transgendered teens.*

*Ashley Lynch, Officer, Transgender Resource Center, Second Life*

## Drawing the Curtain: An Overview of Medical Privacy Protections and Risks for Transgender Patients and Providers

Gorton – MD, N, Thaler – Esq, C, Keisling, M

NG – Lyon-Martin Women's Health Services; CT – Lambda Legal; MK – National Center for Transgender Equality

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Privacy of medical information is an ethical obligation spanning the entire health care system. Every person or organization with access to individual health care data maintains an ethical responsibility to protect confidential information. However historically, transgender people have been required de facto to reveal their medical history in order to access many crucial aspects of gender transition such as changes in identity documents and access to gender segregated services.

As more medical information is stored electronically the potential for such confidential information to be inappropriately transferred increases. This heightened risk has prompted actions to protect privacy such as the HIPPA law. However despite increased concern, transgender people face paradoxically greater threats to patient privacy due to policy and legislation designed to allow greater surveillance and security. For example under the RealID act, records of gender change



may be encoded within magnetic strips on state drivers licenses, making such medical history available to anyone with access to this identification.

Providers face a paradox: while ethically mandated to protect patients' privacy, in order to help patients secure identity documentation and access to appropriate facilities and services they must also actively engage in the very systems that undermine patient privacy. Therefore it is critical for providers to advocate for stronger protections of their patients' medical information and to work to ensure that safety and access is not dependent on public revelation of transgender status.

*Nick Gorton is a physician at Lyon-Martin Women's Health Services, a non-profit clinic in San Francisco treating a large population of transgender patients. He is an active member of the Gay and Lesbian Medical Association. He volunteers as a medical-legal consultant for Lambda Legal and the Sylvia Rivera Law Project, and is a member of the Steering Committee of the National Center for Transgender Equality's Advisory Board.*

*Mara Keisling is the founding Executive Director of the National Center for Transgender Equality. A Pennsylvania native, Keisling came to Washington after co-chairing the Pennsylvania Gender Rights Coalition. She has been an integral part of drafting transgender-inclusive legislative language for the federal Employment Non-Discrimination Act and Hate Crimes legislation. Keisling's policy work has won support for transgender equality from Republicans and Democrats alike, and her work within the larger LGBT social justice movement has given transgender people a voice in the national agenda. Keisling has served on the board of Directors of Common Roads, an LGBTQ Youth Group, and on the steering committee of the Statewide Pennsylvania Rights Coalition. Prior to her work on transgender issues, Keisling worked for over two decades in social marketing and opinion research. She is a graduate of Penn State University and did her graduate work at Harvard University in American Government*

*Cole Thaler is Lambda Legal's National Transgender Rights Attorney. He is based in Lambda Legal's Southern Regional Office in Atlanta, and conducts litigation, education and policy work on behalf of the transgender community across the country. Among other cases, Thaler is co-counsel on Sundstrom v. Frank, a federal lawsuit challenging a Wisconsin law that prohibits transgender-related health care for state prison inmates. Thaler is a member of the Steering Committee of the National Center for Transgender Equality's Advisory Board.*

## **Identity Challenges: Evolving Policies Regarding Identity Documents and Recommendations on How WPATH, Individual Health Care Providers, and Community Advocates Can Work Together to Meet the Challenges**

Thaler – Esq, C; Ehrbar – PsyD, R; Mottet – Esq, L; Chung, C; Keisling, M; Spade – Esq, D  
CT – Lambda Legal; RE – New Leaf Services for Our Community; LM - Transgender Civil Rights Project, National Gay and Lesbian Task Force; CC - Transgender Law Center; MK – National Center for Transgender Equality; DS – Williams Institute, UCLA School of Law and Harvard School of Law

**Address first author:** Cole Thaler, Staff Attorney - Transgender Rights' Lambda Legal 730 Peachtree St. NE, Suite 1070, Atlanta, GA 30308, (404) 897-1880 ext. 232, CThaler@lambdalegal.org

As criteria for issuance and amendment of identity documentation become increasingly stringent in the United States, transgender people experience heightened difficulty obtaining documents that reflect gender identity and presentation. Transgender people seeking to amend such documents report that state and federal agencies are growing more restrictive and may require more medical documentation before granting document changes. Making matters worse, shifts in federal policy have led some agencies to cross-check records. Transgender people find themselves stuck with inaccurate documents and vulnerable to Social Security "gender no-match letters" revealing their transgender status to employers.

This increasing scrutiny has a ripple effect on transgender people's lives. "Gender no-match letters" indicating employees' medical history jeopardize employment opportunities for transgender people. Lack of a driver's license or passport that matches their identity and presentation complicates basic actions including boarding a plane, using a credit card, leaving the country, or even walking in public unharassed. Moreover, inability to secure changes in identity documents before undergoing extensive medical treatment compromises the Real Life Experience for many.

Transgender people are increasingly vulnerable to a catch-22: they need identity documents to facilitate RLE and need extensive medical treatment to change identity documents. Providers can facilitate solutions to this problem by being mindful of the interplay between government policies and medical documentation; by advocating for patients and for broader policy changes that promote transgender health; and by collaborating with advocates and patients regarding challenges posed by a world where remaining "stealth" is no longer possible.

*Cecilia Chung is the Deputy Director of the Transgender Law Center where she works with hundreds of community members to make California a state in which every person can fully and freely express their gender identity.*

*Dr. Randall Ehrbar is a psychologist who works at New Leaf Services, a community based mental health center for LGBT communities. Prior to this he completed a post-doctoral fellowship at the Minnesota Program in Human Sexuality. He has served as a provider for transgender clients for several years. He is also a member of the American Psychological Association's Taskforce on Gender Identity, Gender Variance, and Intersex Conditions as well as the American Psychological Association's Committee on Lesbian Gay and Bisexual Concerns.*

*Mara Keisling is the founding Executive Director of the National Center for Transgender Equality. A Pennsylvania native, Keisling came to Washington after co-chairing the Pennsylvania Gender Rights Coalition. She has been an integral part of drafting*



*transgender-inclusive legislative language for the federal Employment Non-Discrimination Act and Hate Crimes legislation. Keisling's policy work has won support for transgender equality from Republicans and Democrats alike, and her work within the larger LGBT social justice movement has given transgender people a voice in the national agenda. Keisling has served on the board of Directors of Common Roads, an LGBTQ Youth Group, and on the steering committee of the Statewide Pennsylvania Rights Coalition. Prior to her work on transgender issues, Keisling worked for over two decades in social marketing and opinion research. She is a graduate of Penn State University and did her graduate work at Harvard University in American Government*

*Lisa Mottet has served as the Legislative Lawyer for the Transgender Civil Rights Project at the National Gay and Lesbian Task Force since 2001. In her role, Mottet assists transgender activists and allies with transgender-related legislation and policy. Mottet is also a member of the Steering Committee of the National Center for Transgender Equality's Board of Advisors.*

*Dean Spade is a Law Teaching Fellow of the Williams Institute UCLA School of Law and Harvard School of Law. He was the founder of and a staff attorney for the Sylvia Rivera Law Project in New York. His academic research, litigation, and advocacy work are all focused on transgender rights issues.*

*Cole Thaler is Lambda Legal's National Transgender Rights Attorney. He is based in Lambda Legal's Southern Regional Office in Atlanta, and conducts litigation, education and policy work on behalf of the transgender community across the country. Among other cases, Thaler is co-counsel on *Sundstrom v. Franks*, a federal lawsuit challenging a Wisconsin law that prohibits transgender-related health care for state prison inmates. Thaler is a member of the Steering Committee of the National Center for Transgender Equality's Advisory*

## **Identity Theory and its Application to Adjustment in Transitioning in Transgender Identity**

van Houten – BA, MSc (Psych), M. Psych (Clinical), A

Member of Australian Psychological Association; Member of the Gay & Lesbian Interest Group of the APS; Member of the Harry Benjamin International Gender Dysphoria Association.

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This paper explores the importance of identity formation based on identity theory and its implications for individuals experiencing Gender Dysphoria. Specifically, it explores how identity theory may predict factors of adjustment in transitioning individuals. The paradigm of identity and its importance in the psychosocial development of a person is discussed based on identity theory. Drawing upon different theoretical perspectives such as symbolic interactionist theory and identity accumulation theory an individual's identity has been linked to the development and maintenance of mental disorders including, depression, and anxiety. Who we are, the roles we enact with each other, our social relationships, give us our sense of identity. These interactions assist us in identifying who we are in different contexts and gives purpose and meaning to our lives. Identity guides our behaviour. A sense of incongruence with our roles or our perceptions that our identity is not validated may lead to negative affect such as depression and anxiety. Furthermore if the incongruence is believed to go against social norms and therefore the self is not validated by society, the consequences can be immense. This theory is applied to Gender Identity Disorder and how identity formation may lead to identity confusion and social isolation in gender dysphoric individuals thus affecting subsequent adjustment. There may be a large psychological impact of the loss of social roles, devalued relationships and loss of identity in the transgender population. The transgender individual's perception of self, their perception of how others perceive them, how they would like to perceive themselves, and how they would like others to perceive them are discussed in the context of a research PhD.

## **Comorbidity and Gender Dysphoria: Results From an MPPI-2 and SCID-1 Study**

Kreukels, BPC, Gijs, L, Cohen-Kettenis – PhD, PT

Department of Medical Psychology, VU University Medical Center, Amsterdam, The Netherlands; [L.Gijs@vumc.nl](mailto:L.Gijs@vumc.nl)

There is debate among clinicians whether GID is an isolated phenomenon or part of broader psychopathology is still going on, but few studies have addressed this issue in large samples of individuals with GID in a systematic manner. The aim of the present study was to investigate the prevalence of Axis I disorders (DSM IV) and dimensional measures of psychological functioning in subgroups of adult transsexuals applying for sex reassignment.

We administered the MMPI-2 to 392 consecutive applicants for SR (male-to-female (MtF): n=283, and female-to-male (FtM): n=109). In a subsample of these applicants (n=107) the Structured Clinical Interview for DSM IV Axis I Disorders (SCID I) was also administered.

Preliminary analyses showed that MtF transsexuals scored higher than FtM transsexuals on all clinical scales except for Scale 9 (Ma). Both groups scored in the clinical range (>65) on Scale 4 (Pd). The items of Scale 4 cover a wide range of topics, including absence of satisfaction in life, family problems, sexual problems, and difficulties with authorities.

Preliminary analyses of the SCID I data showed that 31.45% of the applicants had a current Axis I diagnosis. The most common diagnosis was depressive disorder. So, with regard to Axis I diagnoses, GID and psychopathology do not seem to be inherently associated. However, knowledge about co-morbidity in transsexual subtypes may help us fine-tuning the diagnostic criteria and counselling during SR for applicants for sex reassignment.

*Currently I'm working as a postdoc researcher in the VU Medical Center Gender Clinic in Amsterdam, the Netherlands with Prof.dr. P.T. Cohen-Kettenis.*

## Guidelines for Transgendered Individuals and Employers when Transitioning in the Workplace

Zamboni – PhD, BD

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Transsexual individuals face a variety of challenges in their existing workplace or when looking for employment while they are transitioning. These challenges include various forms of discrimination and harassment, changing restroom habits, managing communication about the transition with supervisors and fellow employees, and decisions related to the timing or overall duration of the transition. Transsexuals often worry about losing their job since the majority of companies do not have policies that protect them. Employers face their own unique challenges in dealing with a transgender employee. In addition to addressing their own emotions and understanding of transgender issues, employers may have concerns about company identity, loss of current valued employees, and reduced productivity. Transgender employees who do not feel that they are valued or are safe at their place of employment may not perform their job to the best of their abilities, which decreases productivity in the workplace. Recently, companies have begun to address biases toward transgender individuals in their non-discrimination policies (e.g., IBM, Nike). Workplace policies are needed in order to make the working environment safe for all individuals. Guidelines for transgendered individuals and employers are presented.

*I work at the Program in Human Sexuality and work with transgender clients in various ways*

## Personality Characteristics of Adolescents Applying for Sex Reassignment; An MMPI-A Study

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Studies reporting on personality characteristics of adolescents attending a gender identity clinic hardly exist. At the moment, a study is conducted at the Amsterdam VU medical centre, to answer the following questions: 1. What are the personality characteristics of adolescents applying for sex reassignment, as compared to normative groups? 2. What are the differences between adolescents who are eligible for GnRH analogues to delay puberty and adolescents with GID who are not (yet) eligible for this treatment, and adolescents referred to the clinic who do not fulfil GID criteria? 3. What are the sex differences in personality characteristics within these various groups? This study assessed personality characteristics of those adolescents seeking SR treatment by employing the Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A).

Preliminary analyses of the MMPI-A data of 84 adolescents, who were referred to the gender identity clinic, showed significant differences between adolescents who were eligible for GnRH analogues (N=58) and adolescents who were rejected or whose treatment was postponed (N=26) for the clinical scales Depression and Schizophrenia. Adolescents were rejected or their treatment was postponed because of no GID diagnosis (N=19) or a diagnosis GID with treatment disturbing co-morbidity (N=7). Adolescents who were eligible for GnRH analogues had a significantly lower score for both scales than adolescents who were rejected or delayed for treatment taken together. Within the group adolescents who were eligible for GnRH analogues (N=58), significant differences were found between boys and girls for the clinical scales Hysteria, Masculinity-Femininity and Hypomania. Boys (N=30) scored significantly higher on the Hysteria and Masculinity-Femininity scales than girls (N=28), whereas girls had a significant higher score than boys for the Hypomania scale.

## Treating Transsexuals: A Psychodynamically-Oriented Model Of Intervention

Valerio – PhD, P; Santamaria F; Zito E

## Relationships between Strength of Gender Identity, Self-Esteem, and Attitude toward Gender Role and Homosexuality

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<sup>2</sup> Division of Human Relations, Graduate School of Keio University. Research Fellow of the Japan Society for the Promotion of Science.

Relationships between Strength of Gender Identity, Self-Esteem, and Attitude toward Gender Role and Homosexuality.

Objective: Transgender/transsexual people have various degrees of gender dysphoria and cross-gender identification. In the present study, we aimed to explore psychological correlates with the strength of gender identity.

Method: One hundred six males and 63 females who are university students participated in the study, and responded to the questionnaire on the strength of gender identity, self-esteem, the attitude toward gender role and homosexuality, and whether knowing personally sexual minority people or not.

Result: Strong and solid gender identity was correlated with higher trait/state self-esteem among all participants, and with preferences for more segregated gender role only among males. The strength of gender identity had nothing to do with attitude toward gender role among females. Although there was no relation between gender identity and the attitude toward homosexuality as a whole, participants with strong gender identity in one's future tended to be more generous to homosexuality only among participants who knew personally sexual minority people. Thirty-six participants reported that they knew personally sexual minority people. Six participants responded that they were not heterosexual, but homosexual, bisexual, or other. They had weaker gender identity only in social relationships than the other participants. There were no participants who themselves were transgender/transsexual.

Conclusion: In the non-transgendered sample, both trait and state self-esteem was correlated positively with the strength of gender identity. The relationships between gender identity and other psychological characteristics were moderated by other conditions.

## Plenary Session on Outcomes Saturday, September 8, 2007 Salons A - D

### Follow-Up of 107 Male-to-Female Transsexuals After Sex-Reassignment Surgery

Loewenberg, H; Krege, S

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Since 1996, the clinical center at the University of Essen administers sex-reassignment surgery for male-to-female transsexuals. In the context of a follow-up study, apart from the surgery results, also the satisfaction with breast augmentation, hormonal treatment, depilation, voice therapy and psychotherapy as well as the psychosocial integration level have been evaluated. A questionnaire developed by experts of different fields was sent to all 107 patients, who received surgical treatment in Essen between 1996 and 2003. Up to now, 58 answers were received. Additional individual re-examinations are currently administered.

The expectations of life as a woman were fulfilled to a great extent. In retrospect, 96 percent would decide to undergo the surgery again. There is only one desire for back transformation, which requires closer examination. 90 percent are satisfied with the results of the surgery; both regarding aesthetics and functionality (90 percent are able to have orgasms after surgery). Smaller complications occurred in 55 percent of the cases; larger ones in 5 percent (e.g. lesion of the rectum). The large majority of patients are satisfied with their role behaviour as a woman and feel accepted in it by others. 90 percent are content with their breast, 76 percent with hormonal treatment, 76 percent with psychotherapy, 56 percent with facial hair and only 49 percent with their voice. Sex-reassignment surgery contributes in a large extent to a content life of male-to-female transsexuals. The few unsuccessful developments require further clarification. Significance and pattern of the psychotherapy is subject to further investigations.

*H. Loewenberg runs a private practice as a specialist in psychosomatic medicine and psychoanalyst. He is chair of an interdisciplinary working group about transsexualism at the Hospital of the University of Essen. He works psychotherapeutically with his transsexual clients and as a consultant for courts and the medical services for the health insurance companies.*

### Transgendered Persons Applying For Sex Reassignment- A 5 Year Follow-Up Study In Sweden

Annika Johansson<sup>1,2</sup>, Owe Bodlund<sup>1</sup>, Elisabet Sundbom<sup>1</sup> and Torvald Höjerback<sup>2</sup>

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The main aim of this prospective longitudinal study was to evaluate the outcome of sex reassignment from different perspective. Differences in outcome between subgroups and the presence of predictive factors for positive/negative outcome were in focus. Forty-two persons who applied for sex reassignment participated. They were followed up 5 years or more after applying, or two or more years after treatment with SRS.

At index as well as at follow up an interview was carried out. In addition different psychiatric and psychological instruments were performed.

At follow-up 32 persons had completed SRS, 5 persons were still in process and 5 had discontinued. None regretted their reassignment. Twenty-five persons were MF and 17 were FM. Twenty-six persons were diagnosed as primary and 16 as secondary transsexual. The mean age at first assessment was 32 years (18-60). The group is described as regards the reassignment process, self perception, partner, family, friends, work, sexuality, body, health and how they evaluate these aspects. Fifty-five percents considered their general health as better, 67% were satisfied with surgical result and 69 % were content with their sex-life. Ninety-five % rated positive on over-all satisfaction with the sex change and the process.

*I am a psychologist at the Clinic of Sexology in the south of Sweden, where the assessment for persons applying for sex reassignment from the south of Sweden is carried out. I am engaged in the assessment and in supportive contacts. I am also engaged in doctoral studies, at the University of Umeå in the north of Sweden.*

## **Before and After Sex Reassignment Surgery: Evaluation of quality of life using WOQOL-100**

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The World Health Organization (WHO) has developed two instruments to measure quality of life: the WHOQOL-100 and the WHOQOL-BREF. This was an open clinical trial conducted by applying the WHOQOL 100 questionnaire to patients at three time points: when they entered the Gender Identity Disorder Program (PROTIG); after 12 months of group therapy; and 12 months after sex reassignment surgery. Twenty one patients met inclusion criteria and accepted to participate in the study. The analysis of results revealed important changes in patient quality of life. Facet 7 refers to bodily image and appearance. Improvement was assigned both to group therapy and to surgery ( $p=0.027$ ). Facet 3 assesses sleep and rest, and 9, which refers to mobility, showed worse results after surgery ( $p=0.022$ ). Facet 16 refers to physical safety and security, and results showed that the patients felt more secure in their environment one year after group therapy, but less secure after surgery ( $p=0.001$ ). Facet 18 refers to financial resources, and showed improvement after one year in group therapy and a decrease after surgery ( $p=0.011$ ). Facet 22 refers to physical environment, and results showed that patients were more concerned about their environment ( $p=0.000$ ). However, the post surgical sample may have been too small to reach significance in the different domains, and one year after surgery may be too short a time to make inferences about improvement in the patients' quality of life.

**Bio:** I belong to the Gender Identity Disorder/Transsexualism Program (PROTIG-HCPA) about four years. The PROTIG-HCPA exists since 1998. Now, PROTIG are beginning some contacts with another researchers professionals who work in this field, as professor Peggy Cohen-Kettenis, for example. As a psychiatry nurse, I work at PROTIG with transgender groups. I also teach at Universidade de Santa Cruz do Sul (UNISC) and at Centro Universitário UNIVATES to the Nurse School. I'm responsible by sexuality subjects. I want to participate of the next 20 the International Symposium for learn, discuss and change experiences.

## **Considerations About the Outcome of Sex Reassignment Surgery in Surgery in G.I.D. Subjects**

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The aim of the study is to assess the outcome of Sex Reassignment Surgery (S.R.S.) in Gender Identity Disorder (G.I.D.) subjects in relation with core +/- characteristics (age of onset, psychiatric co-morbidity, sexual life).

Design and Methods

The study was based on:

- a questionnaire, drafted by the authors, for follow up after SRS
- clinical data referred by clinicians
- WHOQOL-100 (World Health Organization Quality of Life Questionnaire – 100 items)

Study sample: 30 G.I.D. subjects (15 MtF and 15 FtM) at least two years after SRS; control group: 30 subjects without DIG.

#### Results and Conclusion

In our paper we will expose statistically significant differences among subgroups. Preliminary results suggest an improvement in QOL after SRS. This improvement seems to be related to some clinical features and underlines the importance of diagnostic methods and criteria.

*§The author is a MD specialized in endocrinology and andrology, dealing with G.I.D. since 1983, O.N.I.G. (National Observatory of Gender Identity) founding member and past president, WPATH member since 1992.*

*\*The authors are psychologists specialized in sexology and psychotherapy, authors of several papers about GID, counsellors in "CIDIGeM", Centre for Gender Identity Disorder of Molinette Hospital and in Ce.R.N.E., Turin. Helper in GID self-help groups, O.N.I.G. and W.P.A.T.H. members.*

## Physical Treatment Effect on Gender Identity Among Transgender People In Japan --- Follow Up Study 3 Years Later

Sasaki, S

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#### Objectives

The purpose of this study was to reveal physical treatment effects on gender identity among transgender people in Japan. In my results for 2003, it was found that FTM with physical treatments had higher gender identity than FTM without, but this was not true for MTF. MTF had no significant differences by treatment groups. However, this result showed only a correlation between physical treatment and gender identity. If we wish to know the effects of physical treatment, we should use the longitudinal method. So, in this study, transgender people from the 2003 research were requested.

#### Methods

In 2003, the transgender participants were 120 MTF and 155 FTM. According to the psychiatrist, all transgendered in this study had been diagnosed with gender identity disorder. Then, the number of participants who consented to reexamination were 89 MTF and 126 FTM. They were sent questionnaires by mail. Participants answered concerning some types of their physical treatments. They also responded to the "gender identity scale (Sasaki & Ozaki, in print)". The questionnaires are now being collected.

It will be investigated whether the 2003 psychotherapy only group had a higher gender identity when having physical treatment after that.

#### Results & Considerations

If no effect of physical treatment on gender identity is found, it will imply that a moderator and/or mediator variable exists between physical treatment and gender identity. We need to reveal it.

*I work in gynecological clinic as a Clinical Psychologist. The clinic accept Gender Identity Disorder for hormone therapy.*

## Female-to-Male Transgender Quality of Life

Newfield, E; Hart, S; Dibble – MASC, M; Kohler – MD, L

EN - University of California, San Francisco, School of Medicine; SH - University of California, San Francisco, Department of Psychiatry; SD - University of California, San Francisco Institute for Health & Aging; LK - University of California, San Francisco, Department of Family and Community Medicine  
Emily Newfield c/o Lori Kohler, MD, Correctional Medicine Consultation Network  
1940 Bryant Street, San Francisco, CA 94110

We evaluated health-related quality of life in female-to-male (FTM) transgender individuals using the Short-Form 36-Question Health Survey version 2 (SF-36v2). Using email, Internet bulletin boards, and postcards, individuals were recruited to an Internet site ([www.transurvey.org](http://www.transurvey.org)), which contained a demographic survey and the SF36v2. Four hundred and forty-six (446) FTM transgender and FTM transsexual participants were enrolled and completed the surveys. Analysis of quality of life health concepts demonstrated statistically significant ( $P < .01$ ) diminished quality of life among the FTM transgender participants as compared to the United States male and female population, particularly in regard to mental health. FTM transgender participants who received testosterone (68%) and those who received chest reconstruction surgery (37%) reported statistically significant higher quality of life scores ( $P < .01$ ) than those who had not received these therapies. FTM transgender participants reported significantly reduced mental health-related quality of life and require additional focus to determine the cause of this distress. Providing this community with the hormonal and surgical care they request is associated with improved quality of life.

*Transgender people have been part of my practice since 1994. Over the past 13 years, I have cared for more than 700 transgender people. Currently, I see transgender people in my family medicine clinic, run a clinic for transgender women in one of the State prisons, and provide telemedicine consultation for transgender inmates throughout the California prison system. I have given lectures and trainings on various topics related to transgender health care in a variety of forums, including international and national conferences, government and state funding agencies, and departments of health.*

## Parallel Sessions

Saturday, September 8, 2007

### Primary Care – Rock River Room

Moderators: Dr. Jamie Feldman, MD, PhD & Dr. Lori Kohler, MD

#### Negotiating Within Medical Discourses: How Those In The Trans-Community Obtain Needs

Dewey, J

Concordia University  
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Both medical and psychiatric fields have developed into powerful institutions that control labels which both effect identity formation and access to health care. These groups serve as societal functions of social control and norm preservation through their relationships with trans individuals. Interviews of 23 members of trans-communities and participant observation, expanding over one year, at three Chicago-area groups display the unique interaction of power between doctor and patient that uncovers how trans individuals' daily lives are altered by institutions that both have the power to define and distribute resources. It is the "expertise" of the layperson that negotiates aspects of the doctor-patient relationship with the desire to meet medical/psychiatric needs. This article applies a critical analysis to the ways that the medical/psychiatric fields both liberate and constrain identity and how such patient consent to power structures can ultimately reproduce the existing power dynamic.

*My current involvement with Gender Identity Disorder is through the research that I conduct with members of three Trans-organizations. I currently attend various meetings, however, during the data collection of my research I conducted participant observation and interviews.*

#### Development of an Extended Program of Care for Transgender Youth and Their Families

M Preece PhD<sup>1</sup> and G Knudson MD, MPE, FRCPC<sup>2</sup> University of British Columbia, Vancouver, BC, Canada

<sup>1</sup> Sessional Instructor, University of British Columbia, Department of Psychology

<sup>2</sup> Clinical Assistant Professor, University of British Columbia, Department of Sexual Medicine  
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In recent years, increasing numbers of parents have made contact with the Transgender Health Program (THP, Vancouver, BC) seeking support and treatment for their gender dysphoric adolescent children. This paper outlines the development and evolution of a group therapy program for transgender youth, as well as the growth of an informal support network for parents, with a listserv and bi-weekly coffee meetings. The group program was formed by adolescent developmental needs, and focused on strengthening coping and communication skills as well as providing a supportive environment for exploring issues related to all aspects of identity, relationships, and educational and vocational challenges. The program closely follows the suggested clinical guidelines for clinical management of adolescents as developed through the Trans Care Project and published on the THP website (deVries, Cohen-Kettenis, & de Waal, 2006; Holman & Goldberg, 2006). A multidisciplinary aspect to adolescent care was included through consultation with the Hormone Assessors Group and a pediatric endocrinologist at BC Children's Hospital. The Problem-Oriented Screening Instrument for Teenagers (POSIT; National Institute on Drug Abuse, 1991) was used as a screening measure. Results indicated that these youth generally fall into the high risk category for mental health concerns, problems in peer relationships, and deficits in social skills, highlighting the importance of early and effective care, as well as ongoing support over time. Case studies will be used to illustrate the psychological needs of young people with gender dysphoria, and the benefits of using a standardized treatment approach.

*Dr. Preece facilitates the Youth Programs for the Vancouver Coastal Health Transgender Health Program.  
Dr. Knudson is the Medical Director of the Vancouver Coastal Health Transgender Health Program.*

#### Vancouver Coastal Health Transgender Therapy Group



## Wydra, A

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Two groups, one F to M and one M to F, were conducted on a weekly basis, for twelve sessions each. The focus of therapy was the consolidation of new gender identity during the real-life experience phase of transitioning. This included the changing sense of self as well as the effects of this change on family, job, friends and the community at large. Family and community reactions were discussed as well as functioning within these various settings. Other issues of interest included individual sense of loss and on-going fears, transphobia both personal and external, the effects of hormones, sexuality and general mental health.

Clinical material will be discussed, as it pertains to the benefits of addressing therapeutic material with the transgender population in a group setting.

*Alina Wydra is a registered psychologist in full time private practice. She has worked with the entire range of human sexuality, including gender identity disorder. Recently, Dr. Wydra has conducted assessments for hormone and surgery readiness for transgender clients.*

## Improving Access to Care: Transgender Care is Primary Care

Kohler – MD, L

Correctional Medicine Consultation Network  
1940 Bryant Street, San Francisco, CA 94110

Transgender people are one of the most blatantly ignored and reviled group in the United States. Our society actively denies access to basic civil rights for gender variant people, and the medical community unapologetically follows this discriminatory practice. Healthcare disparities exist for people of color and poor people, but within the transgender community, access to care cuts across all racial and socioeconomic lines. Insurance companies exclude coverage for gender transition, physicians routinely refuse to care for transgender people, and the research community has failed to address the many medical and social needs of this population. The few studies that have been conducted show that access to healthcare, including hormone therapy, is the number one health priority for transgender people. Providing medical care is the first crucial step toward social change for this community. Research has shown lower morbidity and mortality and increased quality of life for transgender people with access to culturally competent and medically appropriate health care. The evaluation and treatment of transgender people is within the scope of primary care. Including transgender patients in general practice settings will increase access to care and promote social inclusion for transgender people. In this presentation we will review how we developed transgender programs in various primary care settings including a family medicine residency training program in a community clinic, a private practice, a nonprofit women's clinic and a Planned Parenthood. In addition, we will outline a model for training medical providers and staff working with transgender patients.

*Transgender people have been part of my medical practice since 1994. Over the past 13 years, I have cared for more than 700 transgender people. Currently, I see transgender people in my family medicine clinic, run a clinic for transgender women in one of the State prisons, and provide telemedicine consultation for transgender inmates throughout the California prison system. I have given lectures and trainings on various topics related to transgender health care in a variety of forums, including international and national conferences, government and state funding agencies, and departments of health.*

## Meeting the Needs of Gender Variant Clients with Disabilities

Sargent – MSN, RN, CS, KJ

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Gender variant clients with severe mental illness and developmental disabilities make up only a very small proportion of the clients who seek counseling for gender issues. When they present to a therapist, however, they have more complex financial, employment, housing, and family issues to deal with than the typical client does. In the United States, private sector therapists provide most therapy for gender clients. Clients with persistent mental illness and developmental disabilities usually receive their care in the public mental health sector. This paper presents cases of gender clients with diagnoses of bipolar disorder, post CVA, mild mental retardation, autism, and conduct disorder. Successful and unsuccessful interventions used and partnerships formed are reviewed along with the lessons learned from both. Potential partnerships and methods for providing education on gender variance to mental health therapists, vocational counsellors, housing experts, psychiatrists, and social workers in the public sector are presented.

*Kimball Jane Sargent is an advanced practice psychiatric nurse in Raleigh North Carolina. She has worked primarily with the transgender community for the past 10 years. She has an informal network of medical professionals who provide care for her clients consisting of a psychiatric, psychologist, endocrinologist, dentist, and several family practice physicians. She currently has about 60 open cases of clients dealing with gender issues.*

## User Participatory Research with Transgender Communities: An Australian study

van Houten - BA, MSc, A



Member of Australian Psychological Association; Member of the Gay & Lesbian Interest Group of the APS; Member of the Harry Benjamin International Gender Dysphoria Association.  
PO Box 187, Broadbeach, Gold Coast, Queensland, Australia.: Email: [ash\\_angel@optusnet.com.au](mailto:ash_angel@optusnet.com.au).

This paper explores the importance of developing effective partnerships in research between research institutions and the transgender community when conducting research. A user participatory model is explored for conducting culturally sensitive research within the transgender community. In this Australian study conducted for a PhD, the research design involves user participation and involvement of the transgender community throughout Australia in the design of the study. The paper explores the process of user participation, its significance to the community and the research, and the steps taken to achieve the goal. Furthermore, there is no coherent and comprehensive user participatory model for best practice intervention based on evidence-based practice within the transgender community. The model of the research is aimed at using user participatory action in research for the complex mental health needs of the transgender community. It is aimed to maximize user participation in public mental health services. The paper will draw upon overseas studies which provide evidence that user participation was effective in minimizing psychopathology and the compounding effects of a mental disorder. It is concluded that the user participation model is an effective strategy in sound research design. It empowers the community being researched. The model aims to provide leadership and an independent strong informed voice for the diversity of users within the heterogeneous transgender community.

### **Transgender Health: An Exploratory Study** Sakakibara, T; Ireland, L; Townsend, M

Using the model of community-based participatory action research, this project brings together researchers and members of Vancouver's transgender community to explore health issues of importance to the transgender community and develop plans for future community-led research. The proposed research model includes members of the transgender community in all aspects of the research and considers them experts in this field.

An initial focus group will be held to identify important health issues, set a research agenda, and form a community-based research team with the goal of developing and conducting research pertaining to priority health issues.

The focus group will be audiotaped and the data later analyzed using a constant comparative method of theme analysis. Results will be used to develop a framework for the transgender community to conduct further community-based participatory action research either as part of, or following this research study.

We hypothesize that this study will uncover significant health concerns within the transgender community. We expect to engage the transgender community as an equal partner in a community based participatory action research project that will aim to address these concerns. By involving the community as an equal partner, we expect to improve the community's health and well-being both directly, by identifying and addressing health issues of importance to the community, and indirectly, by empowering community members with increased knowledge and control over the research process.

*Dr. Todd Sakakibara is a Clinical Instructor with the Faculty of Medicine, Dept of Family Practice at UBC and is an experienced transgender health provider at Three Bridges Community Health Centre.*

*Laurie Ireland is a second year family practice resident in the UBC St. Paul's Family Practice Residency Program and she has an interest in transgender health issues.*

*Marria Townsend is a second year family practice resident in the UBC St. Paul's Family Practice Residency Program and she has an interest in transgender health issues.*

## **Disorders of Sexual Development Symposium - Salons A – D** **Moderators: Dr. Heino F.L. Meyer-Bahlburg, Dr. rer. nat**

### **Behavior Problems in Children with Disorders of Sex Development**

Wherrett, D, Neilson, B, Bradley, SJ, Zucker – PhD, KJ., and the Multidisciplinary Urogenital (MUG) Clinic Team

Zucker, K. J.<sup>1,2</sup> and the Multidisciplinary Urogenital (MUG) Clinic Team<sup>2</sup>

<sup>1</sup>Gender Identity Service, Centre for Addiction and Mental Health, Toronto, ON, Canada; <sup>2</sup>Hospital for Sick Children, Toronto, Ontario, Canada

Dr. K. J. Zucker, Gender Identity Service, Centre for Addiction and Mental Health, 250 College Street, Toronto, ON M5T 1R8, CANADA, e-mail: [Ken\\_Zucker@camh.net](mailto:Ken_Zucker@camh.net)

The psychologic research literature on children born with disorders of sex development (DSDs) has largely focused on their psychosexual development, with less attention given to other aspects of their psychosocial well-being, including the presence of clinical range behavior problems (for exceptions, see, e.g., Berenbaum, in press; Berenbaum et al., 2004; Mureau et al., 1997; Sandberg et al., 1989, 2001; Slijper et al., 1998). Children with DSDs may be at risk for behavior problems for

several reasons: (1) the chronic nature of their medical condition; (2) co-morbid medical problems; (3) the need for repeated in-patient hospitalizations and medical evaluations; (4) stigmatization for pervasive cross-gender behavior (when this is an aspect of the DSD); and (5) family stress related to caring for a child with a chronic medical condition.

The present study examined behavior problems in a diagnostically heterogeneous group of children with DSDs, including (1) congenital adrenal hyperplasia in chromosomal females with either a female or a male gender assignment; (2) androgen-deficit syndromes (e.g., pAIS, mixed gonadal dysgenesis; micropenis) in chromosomal males or with mosaicism raised as girls or as boys; and (3) genetic males with either penile agenesis or cloacal exstrophy raised as girls or as boys. Comparison groups were somatically normal children with gender identity disorder, siblings of children with gender identity disorder, and community controls. Behavior problems were assessed with the Child Behavior Checklist, a parent-report questionnaire with excellent psychometric properties. The present study will provide a comparative analysis of behavior problems in children with DSDs. It will include a descriptive analysis of the percentage of children with DSDs whose CBCL scores fall in the clinical range and an identification of correlates of behavior problems, including age at evaluation, IQ, parent's social class and marital status, a measure of poor peer relations, and various biomedical variables.

*Dr. Zucker is head of the Gender Identity Service*

### **Suicidality, Self-Cutting, and Other Psychopathology in Adolescents and Adults with DSD/Intersexuality**

Richter-Appelt, H; Brinkmann, L; Schuetzmann, K

Institute for Sex Research, University Hospital Hamburg, Germany  
Dr. Hertha Richter-Appelt, Institute for Sex Research, Dept. Psychiatry, University Medical Center Hamburg- Eppendorf, D-20246 Hamburg, GERMANY

Psychological distress in subjects with DSD varied in previous studies considerably, with most studies indicating no increased level. A study based on a sample of 37 persons with different forms of disorders of sex development recruited via different strategies is presented. The Brief Symptom Inventory was used to assess self-reported psychological distress. The psychological distress varied broadly across all diagnostic subgroups. Overall, the whole sample was markedly more distressed than non-clinical norm population with 59% of all participants being classified as clinical case according to BSI-criteria. Self-harming behavior and suicidal tendencies were assessed as well; as comparison groups, unaffected and traumatized women with a history of physical or sexual abuse were used. The prevalence rates of self-harming behavior and suicidal tendencies in the sample of persons with disorders of sex development exceeded the rates of the unaffected comparison groups. As possible explanations for the higher distress compared to most previous studies, differences in measures and sample recruitment are discussed. Our results suggest that a subgroup of persons with DSD is markedly psychologically distressed and psychological treatment is strongly recommended.

*Dr. Richter-Appelt is a senior researcher and clinician specialized on GID and DSD.*

### **Lifetime Psychiatric Diagnoses in Women with Congenital Adrenal Hyperplasia (CAH)**

Heino F. L. Meyer-Bahlburg<sup>1</sup>, Rhoda Gruen<sup>1</sup>, Susan W. Baker<sup>2</sup>, & Maria I. New<sup>2</sup>

<sup>1</sup>NYS Psychiatric Institute & Dept. Psychiatry, Columbia University, New York, NY; <sup>2</sup>Dept. Pediatrics, Mount Sinai School of Medicine, New York, NY. E-mail: [meyerb@childpsych.columbia.edu](mailto:meyerb@childpsych.columbia.edu)  
Dr. Heino F. L. Meyer-Bahlburg, Dept. Psychiatry, Columbia University, 1051 Riverside Drive, NYSPI Unit 15, New York, NY 10032

The multiple hormone abnormalities of the HPA axis characteristic of CAH, the difficulties encountered in fine-tuning HRT, and the life stresses associated with an intersex condition, suggest increased vulnerability of CAH women for psychiatric symptom development. The purpose of the current study was to examine psychiatric histories in a relatively large sample of CAH women in the U.S.

Our sample included 60 women with classical CAH (21 with the Simple-Virilizing [SV] and 39 with the Salt-Wasting [SW] subtype), 82 women with non-classical (NC) CAH, and 23 controls (sisters and female cousins of CAH women). Most women underwent the Structured Clinical Interview for DSM-IV (First et al., 1995) including Global Assessment of Function (GAF) administered by trained interviewers. Women enrolled in the preceding pilot study underwent the Schedule for Affective Disorders and Schizophrenia (Endicott & Spitzer, 1978), with results converted to DSM-IV diagnoses, so that both samples could be combined.

Few significant differences were found between groups. NC women and controls did not show any significant differences. SV women were marginally ( $p < .10$ ) lower than NC and control women in several indices of psychiatric disorders, especially mood disorders, and their GAF score was significantly ( $p < .05$ ) higher than that of NC women. Conversely, SW women showed significantly increased depression and anxiety in comparison to controls, and more substance abuse disorder and lower GAF scores, but also less eating disorder, than NC women. We conclude that CAH women with the more severe subtype are at increased risk of psychiatric disorder.

*Dr. Meyer-Bahlburg is a senior researcher and clinician specialized on DSD and GID.*

## Stigma and Psychosocial Trauma in Women with Classical Congenital Adrenal Hyperplasia (CAH)

Jananne Khuri<sup>1</sup>, Heino F. L. Meyer-Bahlburg<sup>1</sup>, Susan W. Baker<sup>2</sup>, & Maria I. New<sup>2</sup>.

<sup>1</sup>NYS Psychiatric Institute & Dept. Psychiatry, Columbia University, New York, NY; <sup>2</sup>Dept. Pediatrics, Mount Sinai School of Medicine, New York, NY. Institute for Sex Research, University Hospital Hamburg, Germany

Dr. Jananne Khuri, Dept. Psychiatry, Columbia University, 1051 Riverside Drive, NYSPI Unit 15, New York, NY 10032  
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Most individuals with disorders of sex development (DSD) are atypical in terms of their reproductive-tract anatomy, secondary sex characteristics, gender-related behavior, and/or sexual orientation. It is widely assumed that such characteristics or the related medical treatment procedures and outcomes evoke curiosity and aversive reactions from others, which may engender embarrassed self-consciousness and internalized stigma and variable coping responses in DSD persons, but this has been documented only in case reports. The current study was designed to systematically identify the kind of trauma and stigma women with classical CAH (the most common DSD) experience.

Sixty women with CAH underwent a clinical-qualitative interview guided by a list of topics that focused on perceived effects of CAH on major domains of living. These interviews were conducted by clinical psychologists at the end of a battery of mostly quantitative psychological assessment methods. Qualitative content analysis of the interview transcripts was used to identify experiences of stigma and psychological trauma and arrive at subcategories related to specific social contexts. This process yielded 125 categories, for which two independent raters coded all interview transcripts, with high inter-rater reliability.

Experiences of negative comments about somatic symptoms of CAH by peers, romantic partners, and health professionals were common. Even more frequent were reports of anticipation of such reactions. Marked romantic, sexual, and social withdrawal to avoid potential curiosity, ridicule, or rejection were frequent coping mechanisms. We conclude that many women with CAH do indeed experience both external and internalized psychological trauma and stigma related to their medical condition.

*Dr. Khuri is a postdoctoral research fellow in Dr. Meyer-Bahlburg's Program of Developmental Psychoendocrinology which deals with DSD and GID.*

## Mental Health – Ohio River Room

Moderators: Dr. Walter O. Bockting, PhD & Dr. Kevan Wylie, MD

## Establishing the First Support Group for Patients with Gender Identity Disorder in Northern Ireland

Ingram, R; Sayers, A; Neill, H

Ms E O'Kane, Youth Development Officer, Ms A Stephens, Youth Development Officer, Ms A Morton, Medical Secretary  
Dr R Ingram, Windsor House, Belfast City Hospital, Lisburn Road, Belfast BT9 7AB, Northern Ireland

This innovative project has taken place within the Northern Ireland Regional Gender Identity Clinic, Department of Mental Health, Belfast City Hospital, Northern Ireland.

Despite many years providing this service no support group services had developed. In particular, patients consistently voiced their concerns about lack of specific support outside of the statutory treatment services. The team became aware of a highly regarded initiative which had already been established; the Sandyford Unit, Glasgow, Scotland. This service was orientated towards a Trans population very similar in character to that in Northern Ireland, and bearing in mind the need to develop peer review opportunities and clinical governance processes, a visit to Glasgow was arranged. This confirmed the benefits of recommendations towards user led services in a recent comprehensive review of mental health services in N. Ireland<sup>1</sup> which included, specifically, services for Transpeople.

It was considered essential that the group should be led independently by service users rather than by any therapist of the team. The objective of this was to encourage a sense of ownership and to reduce potential interference with therapeutic relationships developed between patients and therapists. Through SHOUT, an organisation which is funded through the Department of Education (NI) to provide support services for young people who are lesbian, gay, bisexual and or transgender, two facilitators (voluntary sector funded) were allocated. The first meeting took place in June 2006 and the group has continued to meet twice per month since. The group (of up to 30 members) has established many effective links with voluntary and statutory services. Currently the main emphasis of work concentrates on extending support services to relatives /partners, which had not previously existed. An audit of patient satisfaction is in process at this time.

References:

1. "Services for People with Disorders of Gender and Sexuality" in The Review of Mental Health and Learning Disability (Northern Ireland) - A Strategic Framework for Adult Mental Health Services, Belfast: 2005. Department of Health, Social Services and Public Safety Publication.

*Dr Richard Ingram is a consultant psychiatrist with a special interest in psychosexual medicine, and is based at the Belfast City Hospital. He leads a team of specialist practitioners in N. Ireland's only dedicated gender identity clinic.*

## **Frontline Health Knowledge Network – An On-Line Network for Canadian Health Care Providers**

G Knudson MD, MPE, FRCPC<sup>1</sup> and N Liebs-Benke BSc Pharmacy, MBA<sup>2</sup>

<sup>1</sup>University of British Columbia, Vancouver, BC, Canada

<sup>2</sup>AstraZeneca Canada Inc.

Department of Sexual Medicine, University of British Columbia, Echelon 5, 855 West 12<sup>th</sup> Ave, Vancouver, BC, Canada

Frontline Health<sup>3</sup> seeks to break down barriers such as limited access to information, lack of tools and resources, and inadequate capacity so that the underserved can be better served. The goal is to improve the delivery of healthcare to marginalized people on the rural, remote and inner city frontlines of Canada's healthcare system. Very little infrastructure exists to connect frontline workers so they can share and learn from each other. One of the areas of focus for Frontline Health is to enable frontline workers to establish and expand their networks so they can exchange information and resources and accelerate the transfer of knowledge and best practices.

The Frontline Health Knowledge Network project, initiated in 2006, has enabled the staff, physicians and mental health care workers associated with the Vancouver Coastal Health Transgender Health Program (THP) to communicate in a secured virtual network. This network includes communication and collaboration tools such as e-mail, discussion forums, knowledge depository, contact directory, event calendar and e-learning tools to enable on-line discussions for relevant group topics, access to all of the group members' presentations, transgender care guidelines, and e-learning modules in transgender health.

Frontline Health is working with the THP to recruit health care workers across Canada providing service to the transgender community to join the virtual network. These providers will then be invited to attend a national meeting where people can exchange further ideas, information and establish working groups.

In addition to highlighting the results of this project, a live-feed presentation will showcase the different features of this network.

<sup>3</sup>Frontline Health is AstraZeneca Canada Inc's corporate citizenship initiative

<sup>1</sup>Clinical Assistant Professor, University of British Columbia, Department of Sexual Medicine

*Dr. Knudson is the Medical Director of the Vancouver Coastal Health Transgender Health Program.*

*Ms. Liebs-Benke is the Community Investment Manager for AstraZeneca Canada Inc.*

## **Stigma, Mental Health, and Resilience in an Online Sample of the U.S. Transgender Population**

Bockting – *PhD, WO*; Coleman – *PhD, E*; Benner, A

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Sexual minorities may be at a higher risk for developing symptoms of anxiety and depression as a result of being subject to social stigma associated with their minority status. Indeed, the concept of "minority stress" has been put forth as an explanation for research showing a higher prevalence of symptoms of anxiety and depression among the gay, lesbian, and bisexual population. In addition, research has begun to demonstrate disproportionate rates of depression among certain subgroups of the transgender population. However, in transgender health research, samples tend to be limited in size and few studies have examined the relationship between symptoms of depression and social stigma. This study used to Internet to obtain a large community-based sample of male-to-female and female-to-male transgender persons (N = 1,093), assessed their mental health using standardized measures, and examined the relationship between social stigma and mental health, and identify predictors of resilience (good mental health in the face of adversity). Findings revealed a high prevalence of clinically significant levels of depression (44%), anxiety (35%), and somatization (28%). Social stigma was significantly and positively associated with psychological distress. Individuals who showed good mental health despite high levels of stigmatization reported higher levels of family support and identity pride. Findings offer preliminary support for

the minority stress hypothesis. Prevention needs to confront social stigma and discrimination associated with being transgender, and improve access to transgender-sensitive and competent mental health services.

### **The Emergence Of Transgenders in Politics**

Hotimsky, A

France - Paris

Partly based on empirical research, this paper will present an overview of the emergence of transgender people in politics. This last ten years, we have seen that transgender people invest the ground of politics in any part of the world. We will try to analyse the mechanism of this major change in the visibility of the transgenders and the effects that can provide the participation of transgender people in politics.

*Current involvement with GID: Twelve years involvement with the CARITIG – non profit organization providing information for the transgenders and professionals, preparing a PhD in Political Sciences about the “Institutional public policies and the transgenders”.*

### **Integrating Harm Reduction Strategies into the Assessment and Management of Gender Dysphoria: Apractical solution to reducing health risk.**

Corneil – BA, MD, MHSc, CCRP, FFRC, T

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It has been well documented that transgendered persons face significant barriers to satisfy basic social and health care needs (Lombardi, E. AJPH, 2001). Up to 1/2 are identified as having or experiencing unstable housing, physical violence, and/or depression; 1/3 are identified as having or experiencing economic discrimination, a suicidal attempt, and/or HIV; in some communities 1/5 are known injection drug users. Self-initiated transition via medical and surgical means is also common, carrying significant physical and psychological risks. To reduce the short and long-term impact of this high risk profile, we look to harm reduction theory for practical social support and health care options.

Harm reduction has many definitions, but a common theme involves identifying and accepting risk behaviours while offering practical alternatives to prevent harm before underlying social, medical, or psychological issues are fully addressed. Applying this concept to transgendered persons undergoing assessment and/or reassignment therapies, harm reduction strategies might include: ongoing care and follow-up of persons who choose to transition via their own means; low dose or reversible hormone therapy before mental stability is achieved; semi-reversible surgery to support societal integration before gender consolidation; and more common measures such as needle exchange and social respite.

All approaches to harm reduction must support low-threshold access to providers, involve consumer input and demand, and be individualized to the person accessing support and care.

## **Films – Rock River Room**

**Moderator: Dr. R. George Brown, MD**

### **A film presentation of Cruel and Unusual (2005) – Documentary authors/filmmakers: Janet Baus**

Brown – MD, GR

Professor of Psychiatry, East Tennessee State University and Chief of Psychiatry, James H. Quillen VAMC  
549 Miller Hollow Road, Bluff City, TN 37618

This film is a 50 minute documentary on the status of transgendered prisoners in various prisons around the United States. It is a powerful film that includes in-prison interviews with several inmates that the moderator has had involvement with as part of his forensic work on behalf of these inmates. The film gives first person accounts of the plight of transgendered inmates as they seek, usually unsuccessfully, to obtain access to transgender healthcare while incarcerated. Some inmates' lives are chronicled after their release from prison. Experts are interviewed (attorneys and the moderator for this session) regarding the challenges faced, both medical and legal, in gaining access to appropriate transgender health care for inmates with well-documented GID.

This proposed session fits in the 7<sup>th</sup> category of invited presentations on legal issues in transgender healthcare. I propose this as a concurrent session of 50 minutes for the showing of the documentary and 15 minutes for a moderated discussion thereafter.

*Board of Directors, WPATH; Standards of Care Revision Committee (version 7); practicing psychiatrist and forensic psychiatry, evaluating and treating persons with GID*

**Transgender Coming Out: The powerful stories of men who became women, women who became men, and people all along the gender spectrum who simply became themselves.**

Bockting – *PhD, WO, Producer*

Department of Family Medicine and Community Health, University of Minnesota Medical School  
Dr. Walter O. Bockting, PHS, 1300 South Second Street, Suite 180, Minneapolis, MN 55454, phone 612 624 7869, email [bockt001@umn.edu](mailto:bockt001@umn.edu)

Over the past 15 years, the Transgender Health Services at the University of Minnesota Medical School has worked closely with Minnesota's transgender community to ensure that its services, education, and research activities are responsive to the evolving identities, experiences, and needs of a diverse spectrum of gender variant individuals and their families. Minnesota has been on the forefront of bringing this diverse group of individuals together to affirm transgender identity and promote transgender health. As part of the development of All Gender Health, a sexual health education program the University developed in collaboration with transgender community organizations, we produced a film illustrating life as a transgender person in Minnesota today. Invited transgender community members were given 10 minutes each in front of the camera to tell their story. Subsequently, these stories were edited into three formats on DVD: (1) A 23 minute film illustrating the coming out process transforming shame and isolation into pride and identity integration; (2) a 60 minute film featuring the full stories of participants; and (3) an interactive menu to select individual stories. The 23 minute short version will be shown at the conference. The DVD can be used for the education of transgender clients, their families, students, and health providers.

*Dr. Walter Bockting directs the Transgender Health Services at the Program in Human Sexuality, Department of Family Medicine and Community Health, University of Minnesota Medical School. He served as a consultant for the Transgender Health Program of Vancouver Coastal Health to assist in the development of guidelines for transgender care and train community-based health providers. Dr. Bockting's current research focuses on the HIV risk behaviours of transgender individuals and their partners, and the development of effective HIV prevention interventions. He is editor of several books, including Transgender and HIV: Risks, Prevention and Care (Haworth Press, 2001) and Transgender Health and HIV Prevention: Needs Assessment Studies from Transgender Communities across the United States (Haworth Press, 2005). He is a member of the Board of Directors of the World Professional Association for Transgender Health and co-editor of its official journal: The International Journal of Transgenderism.*

## Parallel Sessions

*Endocrinology and Sexology – Salons A – D*  
*Moderators: Dr. Luk Gijs & Dr. Wylie Hembree, MD*

### **Gender identity disorders and sexuality; and sexuality and gender identity disorders**

Gijs, L

Genderteam, VU University Medical Center  
P.O. Box 7057, 1007 MB Amsterdam

Gender identity disorders and sexuality, and vice versa

What are the connections between sexuality and gender identity disorders. This straightforward question has been answered in very different ways. For example, Bailey (2003) has put forward, again, the hypothesis that autogynephilia is a crucial determinant of F-M transsexuality. Others, on the other hand, are of the opinion that gender identity disorders are not related to sexuality.

This presentation will give an overview of the theoretical models (and empirical data) of the relations between sexuality and gender identity disorders, and vice versa. Not only will there be attention for the possible role of sexuality in the etiology of gender identity disorders, but also for the effects of gender identity disorders (and the treatment of gender identity disorders) on sexuality.

Clinical implications will be outlined.

### **Becoming what we love: Autogynephilic transsexualism conceptualized as an expression of romantic love**

Lawrence – *MD, PhD, AA*

Private practice



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*Autogynephilia*, a term coined by Blanchard (1989), describes the propensity of some male-to-female (MtF) transsexuals to be sexually aroused by the thought or image of themselves as female. Autogynephilia defines a transsexual typology and provides a theory of transsexual motivation, in that Blanchard proposed that (a) all MtF transsexuals are either sexually attracted exclusively to men (homosexual) or are sexually attracted to the thought or image of themselves as female (nonhomosexual or autogynephilic) and that (b) nonhomosexual MtF transsexuals seek sex reassignment to actualize their autogynephilic desires.

Despite growing professional acceptance, Blanchard's formulation is rejected by some MtF transsexuals as inconsistent with their experience. I argue (Lawrence, in press) that this rejection stems in part from an overly narrow understanding of autogynephilia as a purely erotic phenomenon.

Autogynephilia can more accurately be conceptualized as a type of sexual orientation and as a variety of "romantic love," involving both erotic and affectional or attachment-based elements. This formulation understands autogynephilic or nonhomosexual MtF transsexuals to be persons who love women and who want to become what they love. I argue that this formulation addresses many of the objections to Blanchard's theory and is consistent with a variety of clinical observations concerning nonhomosexual MtF transsexualism.

#### References:

Blanchard, R. (1989). The classification and labeling of nonhomosexual gender dysphorias. *Archives of Sexual Behavior*, 18, 315-334.

Lawrence, A. A. (in press). Becoming what we love: Autogynephilic transsexualism conceptualized as an expression of romantic love. *Perspectives in Biology and Medicine*.

### Applicants for partial treatment: Motives and characteristics

Brewaeys, A.; Gijs, L.; Cohen-Kettenis – *PhD*, PT

Dept. Medical Psychology; Genderteam; VU medical center Dept. Medical Psychology; Genderteam; VU medical center. PO Box 7057. 1007MB Amsterdam, The Netherlands [a.brewaeys@vumc.nl](mailto:a.brewaeys@vumc.nl)

The number of applicants requesting a treatment that does not fit into the VUmc treatment protocol has increased in recent years. This protocol excluded patients from treatment who a priori rejected the full treatment option, or had very specific wishes with regard to the surgical interventions. Little is known about the motives and /or psychological background of patients with such alternative requests. No systematic empirical findings are available yet. There is however a growing "transgender community" holding a plea for less rigid treatment options by the gender teams. In their view a male / female identity is a continuum rather than a dichotomy in which a great variety of expressions exist.

This group is now investigated in order to find an answer to the following questions: (1) What are the most reported motives for requesting a partial treatment option? Is this inspired by fear of medical complications, specific sexual desires or an undefined gender identity? (2) Is there a significant difference with regard to psychological functioning and sexual history between the "atypical" group and our "typical" SR applicants?

Data are collected from 20 applicants of both groups by means of standardized instruments and a semi structured interview. The major findings concerning motives, sexuality and psychological background will be presented. Clinical and theoretical implications will be considered.

### Hypoactive sexual desire in transsexual women: prevalence and association with testosterone levels.

Els Elaut<sup>1</sup>, Guy T'Sjoen<sup>2</sup>, Petra De Sutter<sup>3</sup>, Luk Gijs<sup>4</sup>, Michael van Trotsenburg<sup>4</sup>, Gunter Heylens<sup>1</sup>, Jean-Marc Kaufman<sup>2</sup>, Robert Rubens<sup>2</sup>, and Griet De Cuypere<sup>1</sup>

<sup>1</sup>Department of Sexology and Gender problems, University Hospital Ghent, <sup>2</sup>Department of Endocrinology, University Hospital Ghent, <sup>3</sup>Department of Department of Gynaecology, University Hospital Ghent, <sup>4</sup>Centre of genderdysphoria, VU, University Medical Centre, Amsterdam, The Netherlands

Griet De Cuypere - Department of Sexology and Genderproblems, University Hospital Ghent, De Pintelaan, 185, 9000 Ghent, Belgium email: [elselaut@yahoo.com](mailto:elselaut@yahoo.com)

An unknown proportion of transsexual women (post-operative male-to-female transsexuals on oestrogen replacement) suffer from hypoactive sexual desire disorder (HSDD). It has been suggested that lack of ovarian androgen production together with oestrogen treatment-related increase in sex hormone binding globulin (SHBG) levels could be leading to HSDD, due to low levels of biologically available testosterone. The objective of this study was to document the prevalence of HSDD among transsexual women and the possible association to androgen levels.

#### Methods

Transsexual women (N=62) and a control group of ovulating women (N=30) participated in this study at the Ghent University Hospital and the Amsterdam VU Medical Centre. Questionnaires measuring sexual desire (Sexual Desire Inventory) and relationship and sexual satisfaction (Maudsley Marital Questionnaire) were completed. Serum levels of total



and free testosterone, LH, SHBG and oestradiol were measured in blood samples obtained at random in transsexual women and in the early follicular phase in ovulating women.

**Results**

The transsexual group had lower levels of total and calculated free testosterone (both  $p < .001$ ) than the ovulating women. HSDD was reported in 34 percent of the transsexual and 23 percent of the ovulating women. Both groups reported similar levels of sexual desire ( $p = .97$ ). For transsexual women, no significant correlation was found between sexual desire and total ( $p = .64$ ) or free testosterone ( $p = .82$ ). In ovulating women, these both correlations were significant ( $p = .006$  respectively  $p = .003$ ).

**Conclusions**

HSDD is reported in one third of transsexual women. Despite lower serum levels of testosterone, no association between sexual desire and androgen levels were found in this group.

*Griet is the Secretary/Treasurer of WPATH*

**Children and Youth Mental Health – Ohio River Room**  
**Moderators: Dr. Ken Zucker, PhD & Arlene Istar Lev, LCSW, CASAC**

**Please see next page**

## Developing an Ethical Standard of Care for Children, Youth and Families

Lev - LCSW, CASAC, AI

New York University, Arizona State University

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Children and youth expressing gender-variance constitute a unique, underserved population. Issues facing prepubertal children who exhibit cross-gender behaviors and youth articulating gender dysphoria invoke distress for parents, school systems, and the professionals who serve these families. Traditionally, parents have been blamed for their children's behavior, and transyouth are at high risk substance abuse, suicidality, prostitution, and homelessness. There is a growing need to develop a "best practices" ethical standard in working with gender-variant children and youth across that included parental education, school system advocacy, and strong professional treatment team communication across disciplines. "Genderqueer" diversity, lifecycle sexual development, ethical issues of early medical transition, and systemic and narrative treatment modalities for the families of transgender children and youth will be discussed.

*Arlene Istar Lev LCSW, CASAC, is a social worker, family therapist, educator, and writer whose work addresses the unique therapeutic needs of lesbian, gay, bisexual, and transgender people. She is the founder of Choices Counseling and Consulting in Albany, New York, providing family therapy for LGBT people and is on the adjunct faculties of S.U.N.Y. Albany, School of Social Welfare and Vermont College of the Union Institute and University. She is the author of Transgender Emergence: Therapeutic Guidelines for Working with Gender-Variant People and their Families (Haworth Press, 2004) and The Complete Lesbian and Gay Parenting Guide (Penguin Press, 2004). Additionally, she maintains a "Dear Ari" advice column ([www.prideparenting.com](http://www.prideparenting.com)) which is currently published in Transgender Tapestry and serves on the medical Board of the Intersex Society of North America and the editorial Board of The Journal of glbt Family Studies. Her In a Family Way column on LGBT parenting issues is nationally syndicated.*

*I have been working with gender-variant/transgender clients for the past 15 years, and have authored a number of articles, curricula, and a book Transgender Emergence, on the subject.*

## Appropriate Therapeutic Care for Families with Gender-Dissonant Children, Youth, and Adolescents

Vanderburgh - MA, LMFT, R

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Gender dissonance (termed by many "gender variance") as a fact of life emerges at pre-verbal stages of development, for those children whose gender identity does not match the gender assigned them at birth. Such children are often misinterpreted by their parents as being gay or lesbian. This invisibility of identity takes its toll on the developing child, regardless of the level of parental acceptance for such identities; if the parents' interpretation of identity is incorrect, the child remains invisible to the parent, even in the most accepting family systems. Once the family has correctly identified the nature of the child's identity, they often experience great difficulty finding appropriate therapeutic care, often for many of the same culturally-based reasons that caused the original parental misinterpretation of identity. This paper will examine the most common experiences families have in their quest for appropriate care, and what constitutes "appropriate care" in the psychotherapy setting.

*I am a licensed Marriage and Family Therapist with a private practice in Portland, Oregon. I am also a transman ten years into physical transition. Approximately 95% of my clients are transgender in one way or another. My clients range from female to male, and various points in between; the youngest is 6, the oldest 72. I've also worked with partners, couples, polyamorous triads, parents, grandparents, siblings, and entire family systems undertaking the transition process together. Coupled with my own transition process, this range of experience gives me broad knowledge of transgender issues. I am in the process of publishing a book, "Transition and Beyond: Observations on Gender Identity," (Q Press, Portland, Oregon) which is in the final stages of production and should be available in the spring of 2007.*

## Incorporating Transgender Youth Care into a Primary Care Pediatric Practice

Milazzo - MD, CF

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This presentation will define health care needs of transgender youth; list barriers that transgender youth face in accessing health care services; describe my experience in networking with local mental health professionals and support groups;

describe methods to incorporate medical services for transgender youth into a primary care medical practice; and present resources for health professionals who wish to serve transgender youth.

This presentation is intended to be part of a larger transgender youth panel to include presentations from other members of the Transyouth Clinical Support group under the moderation of Arlene Lev.

*Dr. Carol F. Milazzo is a Fellow of the American Academy of Pediatrics, co-founder of the Transgender Health Alliance, and a member of WPATH, the International Foundation for Gender Education and the Gay and Lesbian Medical Association. She has been in the practice of pediatric medicine for 24 years, Assistant Clinical Professor of Pediatrics at the Creighton University School of Medicine and the University of Nebraska College of Medicine, and has been in private practice in child and adolescent medicine in the Sacramento, California area since 2000. She has incorporated a growing transgender adolescent population into her medical practice since 2003 and moderates several support groups for the transgender community.*

### **Building Provider Capacity for Serving Transgender Populations: A Train-the-Trainer Model**

JoAnne Keatley, MSW, Minority Programs Manager<sup>^</sup>, Samuel Lurie, M.Ed, Director,  
Transgender Training and Advocacy

<sup>^</sup>Founder of Transgender Resources and Neighborhood Space (TRANS) at UCSF and co-chair SF Transgender Empowerment Advocacy and Mentorship (SFTEAM)  
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**BACKGROUND:** Transgender and gender non-conforming people have emerged as a significantly impacted population living with and at risk for HIV/AIDS. Studies have shown U.S. seroprevalence rates ranging from 22% - 63% in urban settings. Providers of clinical and prevention services lack accurate, relevant information and, thus, cultural competency to adequately offer treatment and interventions to serve this population. A Train the Trainer program, with members of the transgender community as members of faculty team provided professional quality trainings for clinicians to effectively address the needs of this highly impacted population.

#### **DESCRIPTION:**

AIDS Education and Training Center (AETC) faculty from eight sites in three Western states were paired with local transgender community members, chosen for their potential as trainers, to participate in a two-year Training of Trainers program, with commitments to provide subsequent clinical trainings in their communities. The training model was skills-oriented and empowerment based; adult learning theory as well as content-specific information were incorporated into the training. Participating sites have provided more than 25 follow-up trainings. Successful local trainings led to requests for more training with additional organizations. Economic empowerment and professional growth for the transgender trainers was an important secondary outcome.

**LESSONS LEARNED:** The collaboration of AETC trainers and transgender community members, employed for their expertise, created an authentic training experience. The training teams became more effective over time. The need for standardized clinician training curriculum was identified by trainers, developed by core faculty and is now available.

**Closing Session – Salons A - D**  
**Invited Speaker: Standards of Care Overview (Dr. Eli Coleman.PhD)**

### **Towards Version 7 of the Standards of Care**

Version 6 of the Standards of Care of the Association continues to be a useful resource for promoting and insuring high quality care for transgender persons around the world. The Standards are used by clinicians and laypeople to understand minimal guidelines for the administration of hormones and the provision of surgical care. They detail other guidelines for mental health and medical care. The Standards are also used widely as a reference to explain the nature of gender identity disorders and how they can be treated. In addition, the Standards have been used over and over again to fight legal battles to insure transgender rights for equality, access to care, and to recognize a person's gender status as a legitimate maker of an individual's sexual identity.

While the Standards have been helpful in many ways, they are not accepted favorably by all. Controversy has always surrounded the SOC. Criticisms have fostered healthy debate and have influenced revisions of the Standards over time. Version 6 was the last revision published in 2001.

This presentation will describe the results of the "work group" invited to review the existing literature to better inform the next revision. They have prepared papers to 1) review the evidence (and provide us with references); 2) point out where

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research is lacking and needed and 3) and to make possible recommendations (significant and cosmetic) to the SOC based upon new evidence.

This session will also allow participants to comment, offer opinions, and to provide references to insure the most optimal amount of input from the membership.

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