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DEDICATED TO

PROF. DR. LOUIS GOOREN

(AMSTERDAM)

10 - 13 SEPTEMBER 2003

INFORMATION AND CALL FOR ABSTRACTS www.hbigda.org

This symposium is dedicated to Prof. Dr. Louis Gooren (Amsterdam)

The Harry Benjamin International Gender Dysphoria Association, Inc. (HBIGDA) is an international professional organisation devoted to the understanding and treatment of gender dysphoria including transsexualism.

XVIII BIENNIAL SYMPOSIUM GENT, BELGIUM
ORGANIZED BY THE GENDER TEAM OF THE UNIVERSITY HOSPITAL, GENT

HARRY BENJAMIN

INTERNATIONAL

GENDER DYSPHORIA

ASSOCIATION

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INTERNATIONAL
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ASSOCIATION

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INFORMATION AND CALL FOR ABSTRACTS www.hbigda.org

This symposium is dedicated to Prof. Dr. Louis Gooren (Amsterdam)

The Harry Benjamin International Gender Dysphoria Association, Inc. (HBIGDA)

is an international professional organisation devoted to the understanding

and treatment of gender dysphoria including transsexualism.

Dear friends, colleagues and participants,

The Genderteam of the University Hospital in Gent has started with the care of transgender individuals more than 15 years ago. At the beginning it was just a small outpatient activity for 2 or 3 physicians seeing only occasionally a patients with gender dysphoria. Nowadays, a transgendered person in Gent is served by a multidisciplinary team covering 9 specialties and consisting of more than 15 professionals. For many of these team members the care of patients with gender dysphoria has become almost a full-time activity.

On behalf of this enthusiastic team it is a pleasure to welcome you to this 18th International symposium of the Harry Benjamin International Gender Dysphoria Association. We are convinced that more scientific knowledge will inevitably lead to a better understanding and a better treatment of gender dysphoria. The high number of registrants and the large number of high quality presentations guarantee a very stimulating meeting which we hope you will all enjoy.

Welcome to Gent and thank you for your participation.

**Prof. Dr. Stan MONSTREY, on behalf of the
Genderteam of the Gent University Hospital**

**Prof. Dr. Tom BALTHAZAR
Dr. Katrien BONTE
Dr. Peter CEULEMANS
Dr. Griet DE CUYPERE
Prof. Dr. Petra DE SUTTER
Prof. Dr. Marc D'HONT
Dr. Gunter HEYLENS
Prof. Dr. Piet HOEBEKE
Prof. Dr. Robert RUBENS
Dr. Guy T'SJOEN
Prof. Dr. John VAN BORSEL
Lic. Ps. Heide VANDENBOSSCHE
Dr. Evelien VERHAEGHE
Dr. Steven WEYERS**



Eli Coleman, Ph.D. , President

Harry Benjamin International Gender Dysphoria Association.

Dear Participants,

On behalf of the Harry Benjamin International Gender Dysphoria Association (HBIGDA), I would like to welcome all of you to the 18th International Symposium of the Association. The HBIGDA is a professional organization devoted to the understanding and treatment of gender dysphoria and the promotion of the health and welfare of transgendered individuals. We have approximately 350 members from around the world, in the fields such as psychiatry, endocrinology, surgery, psychology, sexology, counseling, sociology, and law. This symposium is yet another opportunity for us to share our scientific knowledge and to learn about recent developments in our field.

People who work in this field are dedicated, compassionate, and pioneers. There is so much ignorance, intolerance, bigotry, and discrimination around the world towards transgendered persons. We desire better access to care and the very best treatment based upon the best available science. We know that health can not be attained without rights. We come together to continue our zeal to change the world. We do this armed by our scientific knowledge and the support that we receive from our colleagues. These symposiums are opportunities for us to become re-energized for the work that is facing us when we return to our homes.

We know that you will find this scientific program to be stimulating and interesting and are so pleased to see so many people from all parts of the globe to have joined us here. Welcome to Gent!

Eli Coleman, Ph.D.

President

Harry Benjamin International Gender Dysphoria Association.

**THE HARRY BENJAMIN INTERNATIONAL
GENDER DYSPHORIA ASSOCIATION, INC.**

Founded 1977

PAST PRESIDENTS

Paul A. Walker, Ph. D. 1979-1981
Donald R. Laub, M.D. 1981-1983
Milton T. Edgerton, M.D. 1983 – 1985
Ira B. Pauly, M.D. 1985-1987
Aaron T. Billowitz, M.D. 1987 – 1989
Jan Walinder, M.D. 1989-1991
Leah Schaefer, M.D. 1991-1995
Friedman Pfaefflin, M.D. 1995-1997
Richard Green, J.D. 1997-1999
Alice Webb, DHS 1999

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SCIENTIFIC PROGRAM

**18th INTERNATIONAL SYMPOSIUM OF THE HARRY BENJAMIN
INTERNATIONAL GENDER DYSPHORIA ASSOCIATION**

September 10-13, 2003, Gent (Belgium)

Venue: Monastery “Het Pand”

Onderbergen 1

At the Sint-Michiels church (historical city center of Gent)

Wednesday, September 10, 2003:

14h00 – 17h00: HBIGDA Board of Directors Meeting (Sacristie)

15h00 – 17h30: Registration Monastery “Het Pand”

**18h00 – 19h30: Welcome Reception.
Pacification Hall, City Hall of Gent.**

Thursday, September 11, 2003:

08h00 to 18h00: Registration Monastery “Het Pand”

**08h30 – 08h45: Welcome / Introduction.
Stan Monstrey, local organizer
Guy Verhofstadt, Prime Minister of Belgium**

**08h45 – 09h30: Presidential Address
Eli Coleman**

**09h30 – 12h30: PLENARY SESSION: (Refter)
The Transgender Phenomenon
Chaired by: Stan Monstrey and Eli Coleman**

09h30 – 10h00: Epidemiologic-diagnostic viewpoint. - Friedemann Pfaefflin (Germany)

10h00 – 10h30: Anthropological-historical viewpoint - Vern Bullough (USA)

**10h30 – 11h00: Diversity of psychosocial challenges, coping, and styles of
gender-reassignment among transgendered peoples of Samoa,
Tonga and India -Pamela Connolly (USA)**

11h00 – 11h30: Coffee break

11h30 – 12h00 : Psychodynamic viewpoint -Lin Fraser (USA)
12h00 – 12h30 : Biological viewpoint- Louis Gooren (The Netherlands)

12h30 – 13h30 : Lunch

13h30 – 15h30 PLENARY SESSION: (Rafter)
Psychology / Counseling / Children and Adolescents
Chaired by: Richard Green and Griet De Cuypere

**Children with Gender Identity Disorder in Canada and the Netherlands:
A Comparison and Follow-up.**
Peggy T. Cohen-Kettenis, Vanessa G. Kaijser (The Netherlands)
Discussant: Ken Zucker (Canada)

**An Experience of Group Work with Parents of Children and Adolescents
with Gender Identity Disorder**
Domenico DeCeglie & Elizabeth Coates Thummel (United Kingdom)

Debating DSM.
Ken Zucker (Canada)
Discussant: Richard Green (United Kingdom)

15h30 – 16h00: Coffee break

16h00 – 18h00: ABSTRACT PRESENTATIONS

Session 1: Psychotherapeutic Approaches (Rector Vermeylen)
Moderated by: Selma Gonzalez-Serratos and Gunter Heylens

**The Transsexual and ‘the Other’: Who’s who? A Psychoanalytic Exploration of the Impact
of Master-Discourses on Transgender Identity and Care - Georgia Stavropoulos (Belgium)**

**The Binary Gender System And The Total Self In Transgender: A Reflection With A
Jungian Perspective - Selma Gonzalez-Serratos (Mexico)**

**Taoist Narrative Therapy- A Context Free, Multi-Cultural Approach of Counseling
Individuals and Families in the Transgender and Intersex Community- Tarynn M. Witten
(USA)**

**Health Care Providers and Their Transsexual Clients In New Zealand - Jutta Humpfer
(New Zealand)**

**Intraethnic Conflict: Transgender Clinician with a Transgender Patient / Client Part I -
Melanie Spritz (USA)**

**Counter-transference Reactions When Assessing Gender Dysphoria - Arianne van der Ven
(The Netherlands)**

Session 2: Reviewing the Standards of Care (Refter)

Moderated by : George R. Brown and Peggy Cohen-Kettenis

**The Harry Benjamin International Gender Dysphoria Association's Current *Standards Of
Care For Gender Identity Disorders* (Sixth Version): Myths And Controversial Issues - C.
Christine Wheeler (USA)**

**Revisiting the Standards of Care: Guidelines for Psychotherapy and Family Therapy
Arlene Istar Lev (USA)**

**The Evolving Standards of Care/ Public Perceptions of Transgendered Diversity - Marci
Bowers (USA)**

**Do the HBGDA'S Standards of Care suffice for genital surgery? - Refaat B. Karim and J.
Raaymakers (The Netherlands)**

**Application of the Standards of Care to the Prison Setting: Recent Victories for
Transgender Care in the USA - George R. Brown (USA)**

**Flexible Use of the Standards of Care: Evaluation in Lieu of Psychotherapy Katherine
Rachlin and John C. Capozuca (USA)**

Session 3: Sex Reassignment Surgery: General Issues and Long- Term Follow Up (Rector Blancquaert)

Moderated by : Mireille Bonierbale and Piet Hoebeke

**Long Term Follow Up on Physical Health After Sex Reassignment Surgery – Guy T'Sjoen,
R. Rubens, E. Feyen, J. Van Borsel, P. De Sutter, P. Hoebeke, S. Monstrey, G. De Cuypere
& the Genderteam UZ Gent (Belgium)**

**Long Term Follow Up: Psychosocial Outcome of Belgian Transsexuals After SRS – Griet
De Cuypere, E. Elaut, S. Monstrey , G. Selvaggi , G . T'Sjoen, R. Rubens , P. Hoebeke, and
the Genderteam (Belgium)**

**Sexual Functioning After SRS – Griet De Cuypere, R.Beerten, S. Monstrey, G. Selvaggi,
G. T'Sjoen, R. Rubens, P. Hoebeke, and the Genderteam (Belgium)**

Sexuality Before and After Male-to-Female Sex Reassignment Surgery – Anne Lawrence (USA)

Genital Sensitivity in Sex Reassignment Surgery – Gennaro Selvaggi, S. Monstrey, P. Hoebeke, P. Ceulemans, K. Van Landuyt, Ph. Blondeel, M. Hamdi, G. De Cuyper, and the Genderteam of UZ Gent (Belgium)

Sex Reassignment Surgery: Psychic Consequences? – Aude Michel (Belgium)

Regrets after Sex Reassignment Surgery: An Update – Luk Gijs (The Netherlands)


Session 4: Legal Issues

(Oude Infirmerie)

Moderated by : Jamison Green and Chris Uytterhoeven

Britain Still Doesn't Get It - Ashley Bayston (United Kingdom)

The British Connection and the Legacy of John Randell - Dave King (United Kingdom)

Advance of Transgender Movement in Japan - Katsuki Harima (Japan)

Defining Sex and Gender: Basic Issues Underlying The Estate of Gardiner Decision (Kansas, USA, 2002) Rejecting Transsexual Marriage - Louis Swartz (USA)

The Men Who Would Be Men - Jamison Green (USA)

**19h30 – 21h30: Poster Presentations (Kapittelzaal)
with Belgian beer and delicacies.**

A Specific Questionnaire for Voice Problems in Male-to-Female Transsexuals – A.J. Greven, M.D.de Bruin & M.J.Coerts (The Netherlands)

Voice and Communication Therapy for the MTF Transgendered Patient – Richard Adler (USA)

Impact of Voice on Quality of Life in Flemish Transsexual People - Guy T'Sjoen, M. Moerman, J. Van Borsel, E. Feyen, R. Rubens, J.M. Kaufman, S. Monstrey, P. Hoebeke, P. De Sutter, G. De Cuyper & the Genderteam UZ Gent (Belgium)

What Happened to the Middle Sized Stone? – Elsa Almaas and Esben Esther Benestad (Norway)

Help for Transpersons Seeking Religious Affiliations and Spirituality – Alison Laing (USA)

The “Genderstichting” (Gender Foundation Belgium) and an Overview of the Situation of Transgenders in Belgium – Koen Tallieu (Belgium)

Primary Versus Secondary Distress Regarding Cross-Gender Behaviours and Cross-Sex Wishes in Fa’afafine: A Retrospective Pilot Study – Paul Vasey & Nancy Bartlett (Canada)

Retrospective Analysis about 200 Cases of Gender Dysphoria – Mireille Bonierbale & Noelle Magaud Vouland (France)

Prevalence and Epidemiological Data of Transsexualism in Belgium – Griet De Cuypere, A. Michel, S. Monstrey, B. Carael, & the Gent Genderteam (Belgium)

The Presentation of Transvestic and Gender Dysphoric Patients in an Irish Psychology Clinic- James Kelly (Ireland)

Experiences of Working Group for Gender Identity Disorder at University Clinical Center at Ljubljana (Slovenia) - S. Zihelr, F. Planinšek, M. Čavič, A.Kocjančič, M. Mihelič, & M. Šolinc (Slovenia)

Group Psychotherapy for Gender Identity Patients: Method and Main Themes Treated – Joanna Smith, Sandrine Coussinoux, Thierry Gallarda & Jean-Pierre Olié (France)

Body Experience and Sexuality in 46,XY Women - Hertha Richter-Appelt, Olaf Hiort, Sandra Reinecke, & Daniela Schön (Germany)

Transmasculine Individuals’ Experiences with Hysterectomy/Oophorectomy Gabriel Fenigsohn, Griffin Hansbury, Katherine Rachlin (USA)

Emotional Response to Erotic Stimuli in Transsexuals – MT Molo, E. Cappai, L. Castelli, P. Perozzo, O. Sassu & S. Vighetti (Italy)

Measuring Sexual Arousal in Postoperative Male-to-Female Transsexuals using Vaginal Photoplethysmography – Anne Lawrence (USA), Elizabeth M. Latty, M.A (USA), Meredith Chivers (Canada), & J. Michael Bailey (USA)

Gender Identity Disorder: Social, Sexual and Relational Aspects – Anna Ravenna, Annamaria Acocella, Luca Chianura, Maddalena Mosconi, Laura Bongiorno & Valeria Magarelli (Italy)

Transsexualism and Personality - M. Bonierbale, Nathalie Parola , Sophie Vial, Aude Michel, Noelle Magaud Vouland & Christophe Lancon (France)

Because of the Way We Look...And Because of the Way Society Sees Us – Lorraine Sade Baskerville (USA)

Towards transpositivity in Dutch media representations - Kam Wai Kui and Tim de Jong (The Netherlands)

International Research on Transsexuals - 2004 – 2006 – Cathy Pittman (Canada)

Adolescence and Gender Identity: Need for a New Focus by the Spanish Public Health Care Service – T. Bergero, G. Cano, F. Giraldo, I. Esteva, J. Lara, MV Ortega & M. Gomez (Spain)

Acceptance, socialization and identity work in groups of young persons from the first gender identity unit in Spain - G. Cano, T. Bergero, I. Esteva, F. Giraldo, J. Lara, MV Ortega & M. Gomez (Spain)

Clinician Judgement in Diagnosing Gender Identity Disorder in Children – Randall Ehrbar (USA)

What were the consequences for children, adolescents and young adults in the UK who were treated for intersex conditions and/or gender identity disorder? – Michelle O'Brien (United Kingdom)

Primary and secondary vaginoplasty with special reference to our novel vagina dilator - Ako Takamatsu, Takao Harashina & Yoshiharu Inoue (Japan)

Hanging Tree of the Penis – Yukako Ohtsuki, Takao Harashina & Ako Takamatsu (Japan)

Harashina Vagina Dilator - Takao Harashina (Japan)

Morbidity and Mortality of Male to Female SRS Patients – Christine McGinn (USA)

Friday, September 12, 2003:

08h00 to 18h00: Registration Monastery “Het Pand”

**09h00 –10h40: PLENARY SESSION: Endocrinology (Refter)
Chaired by: Robert Rubens and Walter Meyer**

09h00 – 09h15: Introduction and Laudatio by Robert Rubens

09h15 – 10h20: Long term effects of preoperative and postoperative hormonal treatment - Louis Gooren (The Netherlands)

10h20 – 10h40: Intersex and HBIQDA

Are we really interested?

Results of Intersex Committee Survey -Tom Mazur (USA)

10h40 – 11h15: Coffee break

11h15 – 13h15: ABSTRACT PRESENTATIONS

Session 1: Psychotherapeutic Issues (Rector Blancquaert)

Moderated by : Barbara Warren and Griet De Cuypere

TRANS-itions: 1990-2003, The Evolution of Community-Building Models of Care - Eleanor C. Nealy and Barbara E. Warren (USA)

Development of Transsexual Patient Group Support - P. Eaglesham, N. Laird, C. MacKillop & S. Carr (United Kingdom)

Necessity of Self-Help Groups and Psychosocial Counseling for Gender Dysphoric and Transsexual Adolescents – Annerike Gorter (The Netherlands)

Marital Therapy and the Transgender Relationship - J. J. Miles and Cathy Pittman (Canada)

Families of Transgenders in Turkey: Experience From an Secular Islamic Country Between East and West - Sahika Yuksel and Aslihan Polat (Turkey)

Life Course Analysis: The Courage to Search for Something More - Middle Adulthood Issues in the Transgender and Intersex Community and Their Impact on Later Life - Tarynn M. Witten (USA)

Session 2: Endocrinology (Rector Vermeylen)

Moderated by : Louis Gooren and Jamie Feldman

Evidence-based Transgender Medicine: Are we ready? - Jamie Feldman (USA)

**Sex Offending and Secondary Transsexualism : A Peculiar ‘self-therapy’
Joanna Smith, Thierry Gallarda, Sandrine Coussinoux, Catherine Brémont & Jean-Pierre Olié (France)**

Effects of Long-term Testosterone Administration on Sexual Behavior and Mood in Female to Male (FtM) Subjects - A.M. Perrone, S.Cerpolini, L. D'Emidio, F. Mollo, G. Pelusi & M.C. Merigiola (Italy)

Medical and Psychological Management of Adolescent Transsexualism - Wylie C. Hembree and John C. Capozuca (USA)

Side Effects of the Cross-Gender Self-Therapy in Male-to-Female Transsexuals – A. Becerra, M.J. Lucio, J.L. Llopis, E. Sarmentero & C. Garaizábal (Spain)

Testosterone Increases Bone Mineral Density at the Hip and Spine in Female to Male Transsexuals - Adrian Turner, Tai C. Chen, Alan Malabanan, Tom W. Barber, Michael F. Holick, Vin Tangpricha (USA)

Androgel for Treatment of Gender Dysphoria in FTM Transsexuals – Vin Tangpricha (USA)

Session 3: Male-to-Female Sex Reassignment Surgery (Refter) Moderated by Francisco Giraldo and Michel Seghers

Long Term Hair Removal by Intense Pulsed Light in Male-to-Female Transsexuals: Effective, Efficient and Well-Tolerated – E.M. de Boer, J. Megens & L.J.G. Gooren (The Netherlands)

Long-term outcome of augmentation mammoplasty in male-to-female transsexuals: a questionnaire survey of 107 patients -R. C. J. Kanhai, J. J Hage & J. W Mulder (The Netherlands)

Male-to-Female Transsexual Surgery Based on a Neurovascular Island Flap of Penile Skin – Jalma Jurado (Brazil)

Surgical Therapy in Transsexual Patients: A Multi-Disciplinary Approach – C. Trombetta, G. Liguori, S. Bucci & E. Belgrano (Italy)

Clitoroplasty in Intersex Repair Using Disassembly Technique – Sava V. Perovic, M.L. Djordjevic, Dusan Stanojevic & Milan Milenkovic (Serbia)

Male-to-Female SRS – The Ideal Final Result – Eugene Schrang (USA)

New Refinements and Modifications of Vaginoplasty in Male-to-Female Transsexuals: The Last Experiences in Amsterdam – E.B.H. van Onselen (The Netherlands)

Corona Glans Clitoroplasty and Mucosa Vestibuloperineoplasty in Male-to-Female Transsexuals: The Vulval Aesthetic Refinement by the Andalucia Gender Team – Francisco Giraldo, Trinidad Bergero & Isabel Esteva (Spain)

Functional Outcome of Neo-clitoris in Male-to-Female Gender Re-assignment Surgery – P.J. Thomas, J Bellringer & M Royle (United Kingdom)

Complex Repair in Failed Male Transsexual Surgery – M.L.J. Djordjevic, S.V. Perovic, D. Stanojevic & M. Milenkovic (Serbia)

Cricothyroid approximation and the use of other phonosurgical procedures to alter the perception of the sexual orientation of the voice – James P. Thomas (USA)

Session 4: Ethics (Prior)

Moderated by : Elizabeth Anne Riley and Robert Rubens

**Intraethnic Conflict in the Transgender Clinician/Transgender Patient Dyad Part II
Boundary Violations and Ethical Guidelines – Melanie Spritz (USA)**

The Role of Relational Ethics in Contextual Therapy for Transgender Issues – Maureen Osborne (USA)

Counseling Clients with Gender Dysphoria: An Ethical Approach – Elizabeth Anne Riley (Australia)

11h15 – 13h15 *Satellite Meeting of Transgender Community Organizations to Network: see pp.171-172.* (Oude Infirmerie)

Chaired by Stephen Whittle and Jos Megens.

**13h15 – 14h15: Lunch
(HBIGDA Committee Meetings) (Sacristie)**

14h15 – 16h00: PLENARY SESSION: Surgery (Refter)

Chaired by: Guido Matton and Toby Melzer

14h15 – 14h45: Sex-reassignment surgery: historical review - Joris Hage (The Netherlands)

14h45 – 15h10: Phalloplasty: is it a worthwhile operation? - Stan Monstrey (Belgium)

15h10 – 15h35: Vaginoplasty-Preecha Tiewtranon (Thailand)

15h35 – 16h00: Phonosurgery - Felix de Jong

16h00 – 16h30: Coffee break

16h30 – 18h30: ABSTRACT PRESENTATIONS

Session 1: Transgender Identity and Implications for Treatment

Moderated by Randi Ettner and Petra De Sutter (Rector Vermeulen)

Definition and Synopsis of the Etiology of Adult Gender Identity Disorder and Transsexualism - Terry Reed (United Kingdom)

Concordance for Gender Identity Among Monozygotic and Dizygotic Twin Pairs - Milton Diamond & Skyler T. Hawk (USA)

Internet Pornography, Virtual Identity and the 'Male Femaling' Gaze -Richard Ekins (Northern Ireland)

Gay and Bisexual Identity Among Female-to-Male Transsexuals in North America: Emergence of a Transgender Sexuality – Walter Bockting, Autumn Benner & Eli Coleman (USA)

Assessment of Transgender Identity and Role – Richard Docter (USA)

Client's View of Gender Identity Life and Treatment Status and Outcome - Lee E. Emory, Collier M. Cole, Eric Avery, Olivia Meyer & Walter Meyer (USA)

The Wish for Children and the Preservation of Fertility in Transsexual Women: A Survey - Petra De Sutter, K. Kira, A. Verschoor & A. Hotimsky (Belgium)

Family and Systems Aggression Towards Therapists Treating Patients with Gender Dysphoria - Randi Ettner (USA)

Session 2: Endocrinology (Rector Blancquaert)

Moderated by Antonio Becerra and Guy T'Sjoen

From Genital Ambiguity/Intersex Disorders in Infancy to Gender Identity Disorder in Adolescents and Adults—A Pediatric Endocrinologist's Perspective – Norman Spack (USA)

Gender Dysphoria in Spain: Ten Years of Experience in 278 Cases - A. Becerra, J.L. Llopis, M.J. Lucio E. Sarmentero, L.Enríquez, J.E. Campillo, & Gender Dysphoria Work Group of Spanish Society of Endocrinology and Nutrition (Spain)

Changes on Fat Body Distribution After Cross-Gender Hormone Therapy in Transsexuals- A. Becerra, J.L. Llopis, E. Sarmentero, R. Abenoza & M.J. Lucio (Spain)

Evolution of the Gonadal Axis after Genital Plastic Surgery in Transsexual Patients - Isabel Esteva, T Bergero, F Giraldo, G Cano, J Lara, S Ruiz de Adana, G Rojo, E García Escobar, C Crespillo & R Nuñez. (Spain)

Risk Assessment of Breast Cancer in Male-to-Female Transsexuals - MCM Bunck, AWFT Toorians & LJG Gooren (The Netherlands)

Type of Estrogen and Risk of Venous Thrombosis - MCM Bunck, AWFT Toorians & LJG Gooren (The Netherlands)

Effects of Cross Gender Hormonal Therapy on Prostates of 20 Male-to-Female Postoperative Patients – Melanie Spritz (USA)

Session 3: Female-to-Male Sex Reassignment Surgery (Refter) **Moderated by: Stan Monstrey and Peter Ceulemans**

How to Shape a Male Chest; Experiences and Literature Analysis on the Subcutaneous Mastectomy – M.F.C. Kersten & JW Mulder (The Netherlands)

Subcutaneous Mastectomy in Female To Male (FTM) Transsexuals : A New Algorhytm – Gennaro Selvaggi, S. Monstrey, P. Ceulemans, P. Hoebeke , K. Van Landuyt, Ph. Blondeel, M. Hamdi, G. De Cuyper & the Genderteam of UZ Gent (Belgium)

TLH and BSO (Total Laparoscopic Hysterectomy and Bilateral Salpingo-Oophorectomy) Should Become The Standard Technique For Female-To-Male Sex Reassignment Surgery- Michael van Trotsenburg (Austria)

Rethinking Phalloplasty for the FTM: The feasibility of “Utero-Conversion” – Christine McGinn (USA)

Metoidplasty: A Variant of Phalloplasty in Female Transsexuals – Save V. Perovic, Miroslav L. Djordjevic, Dusan Stanojevic & Milan Milenkovic (Serbia)

Thoracodorsal Flap for Phalloplasty – Aleh V. Stasievich & Vladimir N.Podgaiski (Belarus)

Technical Aspects of Phalloplasty with Suprapubic Flap: Personal Experience – Aldo Felici, Giorgio Maggiulli, Giuliana Sciortino, Loredana Cavalieri & Marco Felici (Italy)

One-Stage Sex Reassignment Surgery in Female-to-Male Transsexuals – C. Trombetta, G. Liguori, S. Bucci, M. Pascone & E. Belgrano (Italy)

A Novel Scrotoplasty in Combination with the Radial Forearm Flap Phalloplasty – Peter Ceulemans, M.Hamdi, K.Van Landuyt, Ph. Blondeel & S.Monstrey (Belgium)

A Secondary Scrotoplasty In Female-to-Male Transsexuals Using an Anterolateral Thigh Flap – Peter Ceulemans, M. Hamdi, K. Van Landuyt, Ph. Blondeel & S. Monstrey (Belgium)

Dribbling Post Voiding in Phalloplasty: Can It Be Avoided? – Piet Hoebeke, P. Ceulemans, S. Monstrey & the Gender Team of UZ Gent (Belgium)

Urinary Changes After Gender Reassignment Surgery in Female to Male and Male to Female Transsexuals – Gennaro Selvaggi, P. Hoebeke, S. Monstrey, P. Ceulemans, K. Van Landuyt, Ph. Blondeel, M. Hamdi, G. De Cuypere & the Genderteam of UZ Gent (Belgium)

16h30 – 18h30 *Satellite Meeting of transgender community organizations to network: see pp.171-172. (Oude Infirmerie)*
(Continued) Chaired by Stephen Whittle and Jos Megens.

18h30 – 19h30 HBIGDA BUSINESS MEETING (Sacristie)

20h00: Banquet Dinner
Grand Ballroom, Gent Opera House

Saturday, September 13, 2003.

08h00 to 18h00: Registration Monastery “Het Pand”

09h00 – 11h00: PLENARY SESSION: (Refter)
Legal and Ethical Issues.

Chaired by: Tom Balthazar, Stephen Whittle and Friedemann Pfäfflin.

New Law, New Ethics, New Practice? – Stephen Whittle (United Kingdom)

Reversal of Fortune (Or, Catching Up to the Past – The Transsexual Journey) - Alyson Dodi Meiselman (USA)

The Creation of Institutional Inequality for Transsexuals and Transgenders via Medicalization and Legalization In Early 21st Century European union and U.S. Transgender Policy-Jillian Todd Weiss (USA)

Legal and Illegal Discrimination Against Transsexuals - Richard Green (United Kingdom)

11h00 – 11h30: Coffee Break

11h30-13h30: PLENARY SESSION: Intersex Conditions (Refter)
Chaired by: Heino F.L. Meyer-Bahlburg and Piet Hoebeke

Measurement of Gender Role, Gender Identity, and Gender Dysphoria in People with Physical Intersex Conditions - Ken Zucker (Canada)

Gender dysphoria and gender change in 46, XX females with CAH - A.B. Dessens and F.M.E. Slijper (The Netherlands)

Gender Dysphoria and Gender Change in 46,XY Persons with 5Alpha-RD or 17beta-HSD- P.T. Cohen-Kettenis (The Netherlands)

Complete Androgen Insensitivity Syndrome (CAIS), Partial Androgen Insensitivity Syndrome (PAIS), Micropenis: Gender Dysphoria and Gender Change - Tom Mazur (USA)

Gender Dysphoria and Gender Change in 46,XY Persons with Non-Hormonal Genital Abnormalities - Heino F.L. Meyer-Bahlburg (USA)

13h30 – 14h30: Lunch

14h30 – 16h00: PLENARY SESSION: Transgender Health and HIV Prevention. (Refter)
Chaired by Walter Bockting and Guy T'Sjoen

Internalized Transphobia As a Health Hazard: Development of the Transgender Identity Scale - Bean Robinson, Dianne Berg, Walter Bockting, Mike Miner, Siv Raman & Eli Coleman (USA)

Mental Health Issues Among Transgenders: Implications for Clinical Care - JoAnne Keatley, Tooru Nemoto, Don Operario & Toho Soma (USA)

Gender Identity and HIV Risk: Using the Internet to Reach the Transgender Community for Prevention Research - Walter Bockting, Bean Robinson, Mike Miner, Laura Gurak, Siv Raman, Noelle Gray, Simon Rosser & Eli Coleman (USA)

Smoking cessation among transgender persons receiving hormone therapy: A pilot study - Jamie Feldman, Walter Bockting & Sharon Allen (USA)

Video presentation: Taking the last drag - Barbara Warren, Stephen Israel, and Kate Bornstein (USA)

16h00 – 17h00 PLENARY SESSION: Transgender organizations, activism, health providers and scientists: Working together.
Chaired by Stephen Whittle

17h00: CLOSING CEREMONY

18h00 – 19h00: HBIQDA Board Meeting (Sacristie)

20h00: Faculty Dinner

ABSTRACTS & PRESENTATIONS

(in order of appearance on the program)

Friedemann Pfaefflin Germany

Epidemiologic-Diagnostic Viewpoint

Most epidemiological data on transgenderism and transsexualism rely on either literature reviews or are based on the patients treated at smaller or larger treatment centers. Thus, the numbers vary widely. In the first years of treatment of transsexuals, prevalences were reported in the 1:100,000 (MF) and 1:400,000 (FM) range (Pauly, 1968). Later studies indicate higher prevalences, e.g. in the Netherlands 1:10,000 (MF) and 1:330,000 (FM) (Bakker et al., 1993) and in Scotland ((Wilson et al., 1999). The highest prevalence was reported in Singapore with about 1:3,000 in MF and 1:8,000 in FM. In papers of self help organizations, sometimes even much higher prevalences are reported, although mostly without empirical evidence.

According to most studies, transsexualism is more common in men than in women, and usually a 3:1 ratio is reported (Landen et al., 1996), although there are also reports about a reverse sex ratio (Brzek & Sipova, 1983, Godlewski, 1988).

The paper will discuss how the diversity of of prevalence rates may be explained and what might be learned from these diversities.

Vern Bullough USA

Anthropological-Historical Viewpoint

A brief overview of attempts to change one's sexual identity in the past. Success was dependent upon developments in medicine and science from the envelopment of anesthesia and the introduction of antiseptic techniques to the discovery and isolation of hormones. Necessary developments were not fully in place until the 1940's although surgical change had been done earlier. The Christine Jorgensen case represented a major turning point in large part because of the massive publicity she received. The paper also looks at the Erickson Foundation, the establishment of gender identity clinics, and the foundation of the Harry Benjamin Foundation. Some of the early problems which occurred in surgical transformations and the growth of specialists in the field. The influence of such non sexual organizations as the ACLU and the organizations of transsexuals themselves are analyzed as well as that of the HBIGDA. The paper concludes with a brief discussion of transgenderism.

Pamela Connolly USA

Diversity of psychosocial challenges, coping, and styles of gender-reassignment among the *fa'afafine* and *fa'afatama* of Samoa, the *fakaleiti* of Tonga, and the *hijra* of India

Three recently-completed field studies have found that the Samoan *fa'afafine*, the Tongan *fakaleiti* and Indian *hijra*, all essentially peoples with male bodies, female gender identity and 'heterosexual' male partners, have developed idiosyncratic coping styles to deal with contemporary psychosocial challenges that are unique to each group, as have the *fa'afatama* of Samoa, anatomical women with male gender identity who choose female partners. Comparisons will be made, along with thoughts that some *fa'afafine* and *fakaleiti* may hold the key to hitherto elusive elements regarding the formation of gender. The studies produced data suggesting that maternally-influenced gender reassignment, either active or passive, occurs in the case of some individuals in both Samoa and Tonga. By contrast, castration is widely practiced among *hijra*, and findings show a range of physiological and psychological results.

Lin Fraser USA

Psychotherapy with TG People/Across the Lifespan

This paper presents a brief overview of a developmental model for doing psychotherapy with TG people from a psychodynamic/Jungian perspective. This model focuses on health rather than pathology and has, as a goal, the Jungian concept of individuation, “being who the person was meant to be” (Wheelwright, 1982). Moreover, the model presupposes that the TG self is an authentic self and not a defense.

Issues that emerge in psychotherapy for TG people are the same as for anyone else—issues of **self and self-in-relation** (e.g. basic trust, identity/intimacy) but the path to individuation is more complicated due to the trans person’s unique developmental path. Moreover, the issues are both psychological and physical, because theirs is both a mind and a body condition (a body that does not fit the mind).

The life path of a TG person from a developmental perspective (early life, adolescence, coming out, post-transition and aging) along with the concomitant issues that emerge in therapy, will be described.

The unique challenge for the TG person is that the developing self is hidden from others, so that the person develops the self in secret and alone and then to avoid stigma after coming out, often hides again (At least their unique history remains secret throughout the life span).

In early life, the developmental path for everyone involves developing a) a sense of a gendered self, b) basic trust of self and others and c) the ability to attach and relate. For the TG person, a parallel and dual line of self-development occurs: 1) An internal sense of a gendered self that does not match the body develops in secret over time and is invisible, thus is unmirrored, along with 2) a false self that society sees and validates. As these two developmental lines progress, the person faces the impossible task of a) developing an authentic identity while others mirror the inauthentic shell and b) learning how to relate when nobody can see the authentic self. One common solution (for some) is a self-mirroring and erotic connection that both resolves and exacerbates this split. For many, the identity and relational problems that occur across the lifespan emerge from this initial major identity split and mind/body disconnect.

This paper describes the stages of trans identity development, the psychological issues in each stage, and their treatment in psychotherapy. The primary task of the therapist (who is often the first person to do so) is to see and relate to the emergent, often fragile and vulnerable, authentic self, creating a space for trans identity or bigender development and growth-in-connection. Issues of transference, intersubjectivity and the role of therapeutic neutrality vs. active engagement will be discussed. (For example, not seeing the emergent self denies its existence, a state all-too familiar to the trans person). Later concerns involve negotiating how to live authentically and relationally in a transphobic society. Thus, psychotherapy may be long-term. Ultimately, however, the solution requires a change in the culture and speaks to the need for education and activism on the part of HBIQDA members.

Louis Gooren The Netherlands

Transsexualism: Biological Viewpoint

Transsexualism is the condition in which a person with an apparently normal somatic sexual differentiation of one gender is convinced that he or she is actually a member of the opposite gender. It is associated with an irresistible urge to become a member of the self-experienced gender and to transition hormonally, anatomically and psychosocially. Traditionally, transsexualism has been conceptualized as a purely psychological phenomenon, but research on the brains of male-to-female transsexuals has found that the sexual differentiation of one brain area - the bed nucleus of the stria terminalis has followed a female pattern. This finding supports the concept of transsexualism as an intersex condition, where the sexual differentiation of the brain is not consistent with chromosomal pattern and gonadal sex. Thus, one could postulate that transsexualism is a variant of sexual differentiation. Sexual differentiation in mammals takes place in distinctly different steps, each with a critical period and each contingent upon the previous one. From studies in rats, mice and other lower mammals, it appears that the sexual differentiation of the brain follows the paradigm of the sexual differentiation of the internal and external genitalia: male in the presence of androgens, female in the absence of androgens. Studies in intersexed subjects show that androgen exposure has an impact on brain functioning, depending on the degree of androgen exposure. For instance, in 46, XY subjects with 17 β -hydroxysteroid dehydrogenase 3 and steroid 5 α -reductase 2 deficiencies develop not rarely a male gender identity after having been originally assigned to the female sex on the basis of the appearance of their female looking genitalia. 46,XX subjects with prenatal androgen exposure often demonstrate masculinized behavior later in life but their gender identity is not necessarily male. The phenomenon of transsexualism questions the absolute necessity of a proper androgen stimulus for the formation of male gender identity and, conversely, its absence for the formation of a female gender identity. In transsexuals there is no evidence of an abnormal endocrine milieu prenatally that could acceptably explain their condition. The endocrine evidence that androgens are a factor in the formation of male gender identity has been reliably demonstrated, but is unlikely to be the sole determinant. In cases of transsexualism the other determinant(s) could be so powerful that they override the effects of androgens (or its absence in the case of females) on the formation of gender identity. Research on the brains of male-to-female transsexuals has found that the sexual differentiation of one brain area (the bed nucleus of the stria terminalis) follows a female pattern. The latter finding may lead to a concept of transsexualism as a form of intersex, where the sexual differentiation of the brain is not consistent with the other variables of sex: chromosomal pattern, nature of the gonad and of internal/external gonads. It is presently unknown what the determinants are of cross-gender differentiation of the brain in transsexuals.

Peggy Cohen-Kettenis The Netherlands

Co-authors: Vanessa Kaijser (The Netherlands) & Ken Zucker (Canada)

Children with GID in Canada and the Netherlands: A Comparison and a Follow-up

Most of the research that has been done since the introduction of Gender Identity Disorder (GID) in children to the DSM, has been carried out on children in the United States and Canada. Because of the relatively low prevalence, as compared to other child psychiatric disorders, it has been difficult to establish what are probably more universal characteristics of children with GID or what characteristics are specific to North American samples. In 1987, a hospital-based gender identity clinic for children and adolescents was established in Utrecht, The Netherlands. This created an opportunity to carry out a cross-national, cross-clinic comparative analysis of GID.

Data that were collected at the first assessment showed that the Canadian sample (N=358) was, on average about a year younger than the Dutch sample (N=130) and had a higher percentage of boys. Some of these differences may be due to cultural factors. The groups were similar with regard to the percentage of children having behavioral and emotional problems. In both clinics boys had poorer peer relations than girls. Poor peer relations were the strongest predictor for having behavior or emotional problems in both samples.

Follow-up data from both clinics show that the gender dysphoria did not disappear in about 20-25% of the children, who are now adolescents or young adults. This percentage is substantially higher than the 6% that has been reported in earlier studies.

Domenico Di Ceglie United Kingdom

Co-author: Elizabeth Coates Thummel (United Kingdom)

An Experience of Group Work With Parents of Children & Adolescents with GID

This paper gives an account of an experience with parents and carers of children and adolescents with gender identity disorder who attended a group. The history of this intervention within the context of a service for children with gender identity problems is outlined as well as a review of the relevant literature. Group meetings were held monthly for 6 months, facilitated by two therapists (the authors). Selection criteria for group participants, the aims of the group and the methodology for achieving those aims are described. Details of the group's composition, including brief clinical vignettes are provided. The structure and content of the group sessions is outlined together with details of some group interactions. Finally, we present the results of an evaluation of the intervention through feedback questionnaires and discuss the value for the children and young people of running such groups

Ken Zucker Canada

Debating DSM

Georgia Stavropoulos Belgium

The Transsexual and ‘the Other’: Who’s who?

A Psychoanalytic Exploration of the Impact of Master-Discourses on Transgender Identity and Care

According to the theory of desire of the French psychoanalyst Jacques Lacan, one’s ‘personal’ desire is always moulded by the desire of ‘the Other’ (members of one’s social system but also the culture, media, institutions, men’s ideal of women, women’s ideal of men and so on...). Following this line of thinking, it’s only evident that you desire what others desire or... perhaps what others want you to desire. What then with the transsexual longing for SRS and other forms of body-modification? Who desires what in the context of transgender identity and care? And for whom?

This paper will expose the results of semi-structured interviews with transgendered subjects from Belgium, the Netherlands and the US. During these interviews the impact is assessed of Master-discourses (‘wrong body’ story, the formal diagnostic criteria, the view of medical experts, society’s perception of gender...) on the lives of gender-variant persons in terms of their:

- (1) sense of identity
- (2) client-behaviour
- (3) self-perception
- (4) decision-making for body-modification
- (5) subjective sense of postoperative satisfaction

These results will be further discussed from a psychoanalytic (Lacanian) perspective. The purpose of this study is to contribute to a deeper and critical understanding of (1) the dynamics of the clinical encounter within the context of transgender care and (2) the formation-process of a person’s identity as transsexual.

Selma Gonzalez-Serratos Mexico

The Binary Gender System And The Total Self In Transgender: A Reflection With A Jungian Perspective.

Transgenderism has come to subvert the established order in erotic and affective relationships and also in gender identity among human beings.

In accordance with Carl Jung, anima and animus are archetypes that are expressed in both, men and women. Interaction of these two archetypes, is very significant to find out the own gender identity, because in every men and women inhabits something feminine and something masculine, thus, people can live with both at the same time.

the idea that a men can have feminine characteristics and a women can have masculine aspects, has irritated to traditional ,radical, rigid, and intolerant people, as far as the homophobia.

Never the less, with a Jungian perspective of the psychic integration of anima and animus, the present reflection suggests that transgenders have both archetypes much more integrated and can live more fully with them.

It is true that Jung did not mention anything about transgender, but we can think around an enlightening explanation towards the right of mental and sexual health of the transgender people, because an intolerant society to de difference and diversity, has done a lot of harm to transgenders and transsexuals.

Tarynn Witten USA

Taoist Narrative Therapy-A Context Free, Multi-Cultural Approach of Counseling Individuals and Families in the Transgender and Intersex Community

In this presentation we present and discuss a new counseling/therapeutic approach called Taoist Narrative Therapy (TNT). We will demonstrate how, unlike most of the standard methodologies, this approach is context free and multi-culturally sensitive as it implicitly acknowledges the client or clients' world view/metaphors of reality and provides metaphors that are easily morphed to meaning within other metaphors of reality, thereby allowing the client or clients to absorb the power of one meaning structure within the safety of the client or clients' current meaning structure. Additionally, TNT is a synergetic (enzymatic) construct in that it can be used with other intervention strategies such as structural therapy or solution focused therapy and the co-use will actually enhance the intervention. Moreover, Taoist Narrative Therapy introduces into the counseling and therapeutic literature the meta-concept of the co-construction of the meaning of and the process of the therapeutic intervention itself. In this presentation we will briefly examine some of the flaws of the various standard therapeutic modalities as applied to the transgender/intersex communities. We will introduce the basic principles of Taoist Narrative Therapy, and we will illustrate their application with some case studies.

Jutta Humpfer New Zealand

E-mail: jutta.humpfer@wnmeds.ac.nz.

Health Care Providers and Their Transsexual Clients In New Zealand

Transsexuality has been researched in the clinical area with regard to aetiology, diagnosis, sex reassignment surgery, client profiles and pathology. Occasionally the literature acknowledges that the therapeutic relationship between transsexual clients and health/mental health professionals is not ideal. Professionals are criticized for lacking adequate knowledge; applied diagnostic criteria have been questioned; healthcare providers are perceived as gatekeepers to hormone treatment and sex reassignment surgery and lacking flexibility in their therapeutic approach. Transsexual clients are often perceived as being dishonest, manipulative or antagonistic towards health care providers. However the professional relationship between healthcare providers and their transsexual clients is largely disregarded by scientific research. This study aims to develop a theoretical model of the nature and consequences of the therapeutic relationship between transsexual clients and health care providers in New Zealand. Applying a grounded theory framework, I aim to discover and explore conditions and circumstances within the client-professional contact that might work for or against a positive therapeutic relationship. Transsexual clients and health care providers have been interviewed through focus groups and in-depth open-ended interviews. Interview data from both groups will be compared and preliminary findings introduced.

Melanie Spritz USA

E-mail: mspritzdo@aol.com

**Intraethnic Conflict: Transgender Clinician with a Transgender Patient / Client
Part I**

This presentation is presented for trans- clinicians as well those who work with them to see the unique interactions of this dyad. The audience should be interested in dealing with transgendered clients/patients and attempts to present transference and countertransference conflicts within a specific ethnic group using race as a model and applying it to transgendered therapists and their patients / clients. This workshop will also cover conflicts of different age groups, different communities that fall within the transgendered umbrella, gender itself as an issue between therapist and patient, as well as differences in class, and education. The participant will leave with a knowledge base of the different transference and countertransference problems that exist within this dyad as well as ways to be aware of such pitfalls in their practice of the different resources for the transgendered, differences within groups within the transgendered umbrella, as well as how the Standards of Care, The DSM – IV TR, and how it relates and can be a reason for conflict within this unique therapeutic dyad

Educational Objectives

The participants will gain knowledge of the transgender and the transsexual subculture and conflicts that may be present in both transference and countertransference between psychotherapist and patient when both are transgendered. Participants will also become aware of conflicts of race, gender of birth and destination, economics, class and education play a role in therapy, as well as conflicts between different communities within the transgendered umbrella

Arianne van der Ven The Netherlands
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Counter-Transference Reactions When Assessing Gender Dysphoria
Counter-transference Reactions When Assessing Gender Dysphoria

This workshop is set up to further sensitize ourselves as helping professionals, by exchanging our experiences with transference and more particularly with counter-transference. The presenter will start by giving a number of examples of counter-transference and reactions she experienced herself. Next the group will divide up in pairs to will discuss the matter and jointly report their findings to the group. After making an inventory, we will discuss self-reflective strategies to neutralize negative effects on our behavior and assessment.

Background

Clients who have experienced hostility in the real world or who have struggled long and hard with doubts and worries may transfer these anxieties onto the gatekeeper-role of the helping professional and perceive her not as an ally but as a threat. They may share information about doubts and insecurities only selectively, making our diagnoses and our support less comprehensive.

On the other hand, as helping professionals we may take more or less distance from the client as he or she matches more or less with our ideas of femininity or masculinity. Some clients' uncertainties may disconcert us, urging us to give premature advice; others may show much pain, urging us to "save" a client in the way he or she requests.

A specific circumstance in this workshop is that the presenter is diagnostician and counselor, as well as a TS herself. She encounters a different set of transference reactions than her non-TS colleagues do, making her better suited for some and less suited for other clients. Her presence may inhibit clients with stronger dependency traits to look for an alternative self-diagnosis. Those who feel the gatekeeper setting as hostile, however, often feel safer with her, and share more information with her, than they may with a non-TS diagnostician. Her counter-transference reactions also tend to be different from those she sometimes sees in her non-TS diagnosticians. But both she and her non-TS colleagues need neutralizing, self-reflective strategies to become better diagnosticians and give the support we owe to our clients.

C. Christine Wheeler USA

The Harry Benjamin International Gender Dysphoria Association's Current Standards of Care For Gender Identity Disorders (Sixth Version): Myths And Controversial Issues

The most major revision in the history of the Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders was accomplished at the end of the 1990's. This document articulates a consensus of professional expectations to increase positive outcomes for those changing gender presentation, taking hormones, and having reconstructive surgeries. Since their inception, the Standards of Care – by the very nature of the time and place in history when written and the changing needs or demands for 'state of the art' guidelines – have evolved in their multiple revisions to reflect the ever-changing nature of health care in a technologically savvy and competitive world. Influences for change in the Standards include responses to new research data, increased understanding of gender problems, and political sensibilities. This paper presents some highlights of the current contents of the Standards of Care (Sixth Version, 2001) and discusses some of the controversial issues surrounding and underlying the document's use effectiveness for both providers and those who seek professional guidance. Myths and ethical tension between those "wishing to do no harm" and need for increasing autonomy are discussed.

Arlene Istar Lev USA

Revisiting the Standards of Care: Guidelines for Psychotherapy and Family Therapy

The Standards of Care offer a broad outline for the role of the mental health professional in assessing for gender identity disorders and making appropriate referrals for hormonal and surgical treatments. The SOC have come under criticism from transgendered activists, and an emerging community of gender-variant people who are seeking, indeed insisting on, greater autonomy, respect, and self-determination. Psychotherapists have traditionally been caught in what has been called “gate-keeping” between the medical communities need for evaluation and the transgendered community’s need for actualization. It has been well-established that this can interfere with the ability for therapists and clients to develop an honest and collaborative relationship.

Gender specialists are acknowledging the need to recognize a greater diversity of transgender expression, as well as a less stringent evaluative process for those seeking medical treatments with no comorbid mental health problems. However, many clients seek therapy, not necessarily motivated by wanting medical treatments, but in distress regarding their gender dysphoria. They often exhibit complex symptomatology including depression, anxiety, and substance abuse. Filled with shame and fear, they are seeking amelioration of their dysphoria, but not necessarily interested in gender transition. Additionally, many people are seeking assistance coming out to family and friends, coping with struggles of maintaining intimate marital and committed relationships through the process of transition, and dealing with post-transition issues including employment, the rearing of children, and spiritual and religious uncertainty.

The HBGDA Standards of Care do not adequately address psychotherapeutic issues outside of gender transition. People coping with gender issues—families of intersexed children, adults addressing childhood surgeries for intersexuality, couples attempting to negotiate gender transition within an intimate relationship, children of transsexual parents who are moving through their own developmental processes, transyouth coping with adolescence as well as gender dysphoria and the difficulty of obtaining parental support and medical assistance—are needing the services of skilled clinicians to guide them through these immense psychosocial challenges. They often seek services through community mental health clinics and private therapists who are unskilled in sex and gender specialties.

HBGDA’s commitment to gender-variant people must expand to educate social workers, psychologists, psychotherapists and on-line staff from diverse disciplines to work with the expanding transgender community. What does “good” psychotherapy mean when clients are struggling with gender dysphoria? What does competent family therapy for spouses and family members look like during transition? What models should be guiding psychotherapists? Where do we discuss these issues within our professional organization? How do we develop guidelines for psychotherapists that are not rules or mandates for treatment but rather guiding principles that recognize that transgendered people are coping with a multitude of environmental and familial assaults while contemplating and negotiating transition. Good therapy requires—in addition to psychological assessment and diagnosis—

the utilization of a diversity of skills often thought of as “social work” including advocacy, emotional support, education, referral, bibliotherapy, marital and couple counseling, legal advice, and consultation with employers. Case examples of working with transgender people who are not seeking medical treatments will be provided, as well as suggested psychotherapeutic guidelines that respond to HBIIGDA’s mission of promoting “the health and welfare of persons with gender identity disorders.”

Marci Bowers USA

The Evolving Standards of Care/ Public Perceptions of Transgendered Diversity”

Dr. Marci Bowers, MD, Gynecologist, contrasts the evolution of the Benjamin Standards of Care with changing individual and public perceptions of Gender Diversity. Drawing from clinical and personal experiences in working with the MTF and FTM communities over the past 17 years in Seattle and now, Trinidad, Colorado, Dr. Bowers reflects upon the past, present, and Future of Transgendered Medicine. Dr. Bowers also speaks from the perspective of having herself transitioned publicly in a large, multi-specialty clinic in downtown Seattle.

Refaat B. Karim The Netherlands

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Do the HBIGDA'S Standards Of Care suffice for genital surgery ?

Since its original draft in 1979, the HBIGDA's Standards of Care (SOC) include recommendations regarding the basic requirements for professionals working with gender dysphoric persons. The latest version of the SOC features no less than three chapters considering the knowledge, therapeutic skills, and scientific interest of surgeons involved in gender confirming surgery. By now, these are to be generally accepted and common practice.

Still, rather than implicitly accepting the possibility of a single-surgeon approach the basic requirements ought to advocate a surgical team approach. Everyday practice proves that the versatility and ability of a single-professional approach of the complicated techniques and problems involved with surgical gender confirming treatment is easily overrated. Taking the wrong decision when faced with relatively limited problems early during primary surgical treatment, may lead to a complicated sequela adding up to a devastating outcome of surgery. Rather than just reflecting a lack of knowledge in recognizing and solving minor problems, this may reflect the necessity of surgical intervention or a professional sounding-board.

Our argument that genital surgery should always be done in a set-up that provides the input of at least two skilled surgeons is illustrated by a case history in which we were personally involved.

George Brown USA

Application of the Standards of Care to the Prison Setting: Recent Victories for Transgender Care in the USA

Transgendered persons who are incarcerated in jails, prisons, and penitentiaries in the United States often do not have access to basic evaluation or treatment services for gender identity disturbances. Some inmates are already in transition and taking cross-sex hormones, while others attempt to receive evaluation and treatment during lengthy incarcerations. There is no uniform policy between states, and individual states also vary in their approach compared to federal facilities (e.g. Federal Bureau of Prisons).

In recognition of these difficulties in accessing services, the 5th version of the Standards of Care was the first to specifically address this issue. Version 6, the current iteration, more extensively addresses it as states attempted to get around the SOC due to the lack of detail regarding evaluating and treating incarcerated persons with GID in version 5.

This paper reports on three successes of the application of the SOC in the forensic setting that have resulted in significant advances in access to services for transgendered inmates. The author was the key witness in the case of *Kocilek vs. Mass. Dept. of Corrections* (Federal District Court case), the major elements of which will be reported. Advances in the Departments of Correction in Idaho and Wisconsin will be discussed as well. In all three states, the SOC section on treating incarcerated persons with gender identity disorder played a critical role in the courtroom or the settlement conference room, resulting in greater access to evaluation and treatment services, including hormonal treatment and monitoring. Unfortunately, suicidality (present in all three cases) and complete genital autoamputation (one attempted, one completed) were the context required to raise the cases to legal attention.

Conclusions: The last two versions of the SOC have been important to improving access to medically necessary evaluation and treatment services for incarcerated persons with GID. However, this section should be expanded and made more specific in the next revision, based on the author's, and others', experience with the legal maneuvers used to exploit loopholes in the 6th version of the SOC.

Katherine Rachlin USA

Co-author: John C. Capozuca (USA)

Flexible Use of the Standards of Care #1: Evaluation in lieu of psychotherapy

The HBGDA Standards of Care (SOC) (HBGDA, 2001) have undergone substantial revision over the last several years, yielding a flexible document with broad applications. For most gender specialists the SOC is part of daily practice, but there is undoubtedly variation in the way they are applied. The Standards state that departures may evolve from a worker's experience and that such departures should be documented "to help the field to evolve". Towards this end, the current study reviews a series of cases in which the SOC were used flexibly in supporting clients requesting surgery. In each case, departures from the traditional protocol, reasons for doing so, and the treatment outcome to date were noted.

In the course of authors' collaborative work as gender specialists, they have identified a particular pattern among a subset of patients. These patients presented to the authors as women of transsexual experience. They demonstrated that they had firmly established themselves as women and had already concluded that sex reassignment surgery (SRS) was essential. They came not for psychotherapy, nor even for practical information to assist in their transitions (though much was often provided). They came only because their surgeons required a letter in support of their candidacy for SRS.

The authors developed a protocol that meets both professional standards and the needs of these patients. In this group all SOC requirements were met except the recommendation for psychotherapy. On intake it was concluded that psychotherapy was not indicated. Instead, each patient was seen briefly by both authors (separately) to assess the candidate's readiness and eligibility and each author wrote a letter to the surgeon. This study examines a set of cases seen jointly by the authors.

Shared traits of the individuals in this group included: many years of living as women, high social functioning, friendships with peers who have been through SRS, disinterest in psychotherapy, backgrounds in which psychotherapy is atypical, good enough/strong support from family, prior surgical experience (such as breast augmentation), early onset GID, no psychiatric diagnosis. The individuals all presented in what could be conceptualized as "Stage 5" of a six-stage model of gender evolution (Rachlin, 1997). Stage 5 is "Acting to Make Changes", and is characterized by the statement "I want to make a change and I need your help".

After reviewing records, follow up contact with subjects was initiated to obtain outcome data based upon personal report. All reported satisfaction with surgical results and improved quality of life post surgically.

Implications and limitations of this research will be discussed.

G. T'Sjoen Belgium

Co-authors: R. Rubens, E. Feyen, J. Van Borsel, P. De Sutter, P. Hoebeke, S. Monstrey, G. De Cuypere and the Genderteam UZ Gent (Belgium)

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Long term follow up on physical health after sex reassignment surgery.

Background:

Sex steroid treatment is known to be associated with several side effects. Contrary to the usual practice, whereby an inclination to maximise hormone dosage by patients as well as physicians is seen, the Genderteam UZ Gent has always treated their patients with a mild but effective dual-model hormonal scheme, aiming at no or minimal side-effects. Cyproterone acetate 50 mg in male-to-female patients, and lynestrenol 5 mg in female-to-male patients are given for 1 year. Estrogens (in different forms) in male-to-females and testosterone in female-to-males completes the hormonal therapy, and are continued as a single treatment after sex reassignment surgery. A long term follow-up investigation of 48 patients post sex reassignment operation was carried out to evaluate social, psychological, health and surgical outcome.

Methods:

107 patients were contacted to participate in the follow-up study. 28 male-to-female transsexuals and 20 female-to-male patients agreed to complete questionnaires and blood testing. Hormonal parameters, lipids, glucose, liver and renal function tests were examined. A questionnaire addressing current and past hormonal treatment, smoking and drinking habits, other medical treatment and general health issues such as thrombosis and thrombogenic accidents, heart conditions, hypertension, depression, hyperprolactinaemia, thyroid problems, hyperlipidemia, liver function problems and osteoporosis was completed by all patients.

Results:

Mean age of male-to-females (42 ± 9 years), was significantly higher than in females-to-males (33 ± 5 years). BMI was comparable (27 kg/m^2) in both groups. 72% of male-to-females were on oestradiol, while others were taking conjugated oestrogens, oestradiol-cyproterone acetate, oestrogen-progestagen or no treatment. 65% of female-to-males were treated by intramuscular testosterone, 30 % by oral testosterone undecanoate.

Alcohol intake was mild and similar in both sexes. More than half of male-to-females compared to only 20% of female-to-males smoked cigarettes. LH and FSH levels were 18.4 and 34 mU/mL in male-to-females, and 38.5 and 96.6 mU/mL in females-to-males. At random mean testosterone value in this group was low (259 ng/dL), only 25% of patients reaching the cut-off value for hypogonadism of 320 ng/dl. Hematocrit was significantly higher in female-to-males (44.9 vs. 40.2%).

Female-to-male patients rarely reported complications, with one patient being treated for hypertension and one for depression. One patient reported liver problems, already present before hormonal treatment.

21.4% male-to-female patients were treated for hypertension, 14.3% reported a prolactin increase. Thyroid function problems or hyperlipidemia were mentioned by 7.1 % of patients, while one patient had suffered a stroke. No further abnormalities were observed on the blood examination. We are not aware of any deaths in our total patient group of transsexuals since the initiation of the Genderteam at our centre.

Conclusion:

Relatively few and minor morbidities were observed in our patient group which were mostly reversible with appropriate treatment. A trend towards more general health problems in male-to-females was seen, which could be explained by the older age and smoking habits of this group.

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Long-term Follow-up: Psychosocial Outcome of Belgian Transsexuals After SRS

Although the benefit of Sex Reassignment Surgery (SRS) for transsexuals is well-documented, there is still a need for long-term follow-up of larger numbers of operated transsexuals (only few articles exceed 50 patients).

In 1985 the Genderteam of the University Hospital of Gent started treating persons with a genderidentity disorder in a multidisciplinary approach : psychological-psychiatric assessment and psychotherapeutic sessions, endocrinological evaluation and hormonal treatment, sex reassignment surgery, voice training, vocal cord operations, epilation-lasertherapy

Between 1987 and 2001, 107 transsexuals (63 M-to-F and 44 F-to-M) from the Flemish speaking part of Belgium underwent SRS in our Clinic. All these patients were contacted for a long-term follow-up study. A delay of at least one year after SRS was respected. 62 persons (58 %) agreed to cooperate for this multidisciplinary long-term follow-up study. The mean follow-up period was 5,65 years.

Psychosocial functioning was evaluated by a personal interview, clinical observation (GAF of DSM- IV and a subjective physical appearance evaluation), a structural questionnaire (BVT = biographic questionnaire for transsexuals and transvestites used in the Netherlands) and was rated by the General Health Questionnaire, Symptom Check list, Body Image Scale, Regret-List and Genderidentification scale.

After SRS none of the patients suffered from any genderdysphoric feeling. The younger transsexuals are when they apply for SRS, the better they were functioning on a psychosocial level. No distinction could be noticed between the well-being of our patient-group and a normal (non-transsexual) population , they scored even better than psychiatric outpatients. The suicidal attempt rate had diminished significantly. Nearly all patients felt satisfied with their new body (the M-to-F as well as the F-to-M) and could identify themselves in the wished gender. On a social level patients noticed a positive change : M-to-F as well as F-to-M had a stable relationship in more than 50 % and had a job in more than 70 %.

Only one patient (F-to-M) expressed regret about the SRS at the moment of evaluation. These feelings were temporary in the context of a break-up with his girlfriend. Differences in the results between the F-to-M and M-to-F transsexuals on the one hand and between the homosexual and non-homosexual group on the other hand will be discussed more in detail.

In summary, sexual orientation (homosexual), age of applying for SRS, social support and an attractive physical appearance could be computed as positive prognostic factors. For the F-to-M transsexuals the results of the mastectomy were of more importance than the phalloplasty in order to identify themselves in the male role.

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Sexual functioning after SRS

Although good sexual functioning is universally considered as a part of a healthy mental life few studies have been performed to investigate what happens sexually to transsexuals after SRS.

In 1985 the Genderteam of the University Hospital of Gent started treating persons with a genderidentity disorder in a multidisciplinary approach . Between 1987 and 2001, 107 transsexuals (63 M-to-F and 44 F-to-M) from the Flemish speaking part of Belgium underwent SRS in our Clinic. All M-to-F had a vaginoplasty, near all F-to-M (40) had a functional phalloplasty . In order to perform a long-term follow-up evaluation, all these patients were contacted. A delay of at least one year after SRS was respected. 62 persons (58 %) agreed to cooperate for this multidisciplinary study. The mean follow-up period was 5,65 years. For the sexual part of our research, we invited 54 persons, who were interviewed on a face to face basis. They completed also a sexual functioning questionnaire and a regret list.

More M-to-F (59 %) than F-to-M transsexuals (43 %) reached a stable sexual relationship postoperatively, a difference which is nevertheless not significant. All partners , except one partner of a M-to-F transsexual, were informed about their transsexual past. In most cases they were very supportive. Although the expectations about SRS were reached on a emotional and social level, the outcome was less convincing on the physical and sexual level. 80 % of all transsexuals (M-to-F as well as M-to-F) expressed their satisfaction with their sexual life, when they had a partner. 20 % of all transsexuals were definitely not satisfied about their sex life in general, although a large number of transsexuals (80 %) admitted that their sexuality had improved after SRS. We could notice a correlation between a good sex life and an overall feeling of satisfaction and happiness.

After genital operation the F-to-M (19/23) masturbate significantly more than their M-to-F counterparts and also more than prior to SRS. All F-to-M were orgasmic when they masturbate, only 17/23 M-to-F reached orgasm regularly. The frequency of reaching orgasm was very similar when the transsexuals had sexual intercourse. The orgasmic feelings differed postsurgical for both groups : more powerfull and shorter for the F-to-M's, more intense, smoother and longer for the M-to-F's.

We compared the F-to-M patients who had an erection prothesis with those without erection prothesis on several sexual items : it seems clear that the transsexuals who chose for a prothesis have more sexual partners, think of sex as a more important aspect of their life, are often preoccupied with sex, experience a large improvement of their sex life compared to earlier. Nevertheless, they both have the same feeling of satisfaction with their sex life. Transsexuals who have a prothesis are often confronted with pain during intercourse.

Conclusion: Although most of the patients are satisfied with their sex life after Sex Reassignment Surgery it is clear that the meaning and the importance of sexuality undergoes an evolution during the gender reassignment process. The transsexual patient does not only undergo genital surgery but also a hormonal remodelling. During the preoperative period more attention must be paid to sexual expectations and possible sexual changes after SRS in order to let the patients cope better with these new sensations.

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Sexuality Before and After Male-to-Female Sex Reassignment Surgery

Introduction: There is limited information concerning sexual orientation and sexual behaviors in male-to-female (MtF) transsexuals before and after sex reassignment surgery (SRS) This paper presents self-report data from a mailed survey of 232 MtF SRS patients concerning their sexuality before and after SRS.

Method: All survey participants had undergone SRS during the years 1994-2000 with the same surgeon. All were at least one year postoperative. The 232 valid questionnaires returned represented 32% of persons who underwent SRS during the period studied, and 65% of eligible persons believed to have received a questionnaire. Relevant survey questions concerned sexual orientation, number of sexual partners, prevalence of stable partnered relationships, prevalence of sexual arousal to cross-dressing or cross-gender fantasy (autogynephilia), and frequency and characteristics of postoperative orgasm.

Results: Demographics: The mean age of participants at time of SRS was 44 years (range, 18-70 years) and their mean age at time of survey completion was 47 years; 67% of participants had been married to a female before SRS. **Sexual orientation:** 12% of participants were not sexually attracted to other persons before SRS; after SRS 9% reported this. Before SRS, 54% of participants had been exclusively or almost exclusively attracted to females; after SRS this figure declined to 25%. Before SRS, only 9% of participants had been exclusively or almost exclusively attracted to males; after SRS this figure rose to 34%. **Number of sexual partners:** The median number of sexual partners before SRS was 6. Six percent reported no partners before SRS, 11% reported one partner, 51% reported 2-10 partners, and 32% reported 11 or more partners. After SRS, in the previous 12 months, 32% reported no partners, 39% reported 1 partner, 19% reported 2-4 partners, and 10% reported 5 or more partners. **Partnered relationships:** 45% of participants were in a stable romantic or partnered relationship at the time of survey completion, and 62% had been in such a relationship at some time following SRS. Participants with female partners only were significantly more likely to have been in a stable relationship than participants with male partners only. **Autogynephilic arousal:** 48% of respondents reported hundreds of episodes or more of autogynephilic sexual arousal before SRS; after SRS only 3% so reported. **Orgasm after SRS:** 85% of respondents had been orgasmic at least occasionally after SRS, and 55% reported that they sometimes ejaculated with orgasm.

Discussion: Most participants were sexually attracted to females before SRS, but many reported that their pattern of sexual attraction changed after SRS. Because sexual orientation is thought to be established early in life and to be virtually unchangeable in adulthood, the reported changes may reflect an erotic interest in the validation provided by male partners rather than a genuine change in somatotypic preference. The number of pre-SRS sexual partners participants reported was male-typical rather than female-typical, and conformed closely to male data from the National Health and Social Life Survey. The percentage of participants reporting no sexual partners in last 12 months following SRS was high relative to population norms, suggesting a significant degree of

isolation after SRS. Autogynephilic arousal was common before SRS, less common afterwards. Most participants reported being orgasmic after SRS, but these reports should be interpreted cautiously in light of the relatively low reported frequency of ejaculation with orgasm.

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Genital sensitivity in Sex Reassignment Surgery

Sensibility of the reconstructed phallus (for the FTM transsexuals) or clitoris and vagina (for the MTF transsexuals) is one of the major goals in Sex Reassignment Surgery (SRS). In our technique for FTM surgery, the medial and the lateral antebrachial nerves of the forearm are taken together with the radial forearm flap, and are anastomosed to the ileoinguinal nerve and to one of the two dorsal clitoral nerves. The clitoris is denuded of its dorsal skin, which is repositioned to create the anterior part of the scrotum; the clitoris itself is repositioned and buried underneath the phallus. In this way both protective and erogenous sensations are maintained.

In our technique for MTF surgery, a penoscrotal skin flap is used to create the vagina and a neurovascular pedicled flap of a part of the glans is used to reconstruct the clitoris. In this way protective sensation and erogenous sensation are also maintained.

To evaluate the effective sensation of the neophallus and of the new clitoris, we tested the superficial sensibility (by using the Semmes-Weinstein monofilament test) and the deep sensibility (by using a vibrator machine), of the reconstructed phallus and clitoris respectively in 27 FTM and 30 MTF operated transsexuals (follow up time: 1 - 12 years). Results showed the best mean value of 3.38 (E) (range A -T) for the Semmes - Weinstein monofilament test and the best mean value of 14.37 (range: 3 - 50) for the vibration test, respectively for the tip and the center of the neophallus, and the mean value of 3.09 (E) (range A - K) for the monofilament and the mean value of 7.79 (range 2 - 30) for the vibration test of the reconstructed clitoris.

With this tests, we objectively evaluated the sensibility of the neophallus and neoclitoris after SRS, confirming the importance of the surgical technique used. The relationship between absolute measurements and capacity to come to an orgasm are discussed.

Aude Michel Belgium

Sex reassignment surgery: psychic consequences ?

The studies about the psychic of sex reassignment candidates are very rare: at this day, only three studies have been realized with the Rorschach (test re-test method) (Fleming, Jones, & Simons, 1982 ; Lothstein, 1983 ; Cohen & Cohen-Kettenis, 1999).

The surgery transformation that asked transsexual consist on a radical mutation of his sex by a concrete intervention on and by the real. Thus, the psychic difficulties about a conflict between gender identity and anatomic reality was resolved only by surgery.

The 14 sujets (7 FMale, 7MFemale) passed a first time the Rorschach during the diagnostic phase and on a second time, two years after the corporate transformation.

On hypothesis, the results show any psychic fundamentals modifications. Some changes has been observed and connected with the demand of change: after the surgery transformation, the defense mecanism witch consist to reality on refuge on fantasy a déplaisant situation of dependance (Snow White Syndrom) are was abandoned.

Luk Gijs The Netherlands

Regrets After Sex Reassignment Surgery: An Update

In 1992 Pfafflin published a very thoroughly review of the literature on regret after sex reassignment surgery (Pfafflin,F. (1992). Regrets after sex reassignment surgery. *Journal of Psychology and Human Sexuality*, 5, 69-85). He found that in female to male transsexuals 1% and in male to female transsexuals 1,5% regretted sex reassignment surgery. Risk factor were poor differential diagnosis, failure to carry out the real-life test and poor surgical results. In this presentation the literature on regret after sex reassignment surgery between 1992-2002 is reviewed. Attention is also given to new data on regrets from patients of the gender-team of the Free University Medical Center (Head: prof. dr. P. Cohen-Kettenis) in Amsterdam. Special consideration will be given to two topics that untill now have not received much attention in the scholarly literature: (1) how can the processes that lead to regret be conceptualized theoretically, and (2) which therapeutic interventions can be used to treat patients who regret their gender reassignment surgery effectively.

Ashley Bayston United Kingdom

Britain Still Doesn't Get It

At the time of the XVI symposium in London in 1999, when I gave a similar paper, the European Court of Human Rights had failed 3 times to rule that the legal position of transsexual people in the UK was not in violation of Articles 8 (right to respect for private and family life) and 12 (right to marry). In the case of Sheffield and Horsham (1998) 27 EHRR 163 the Court was divided on the question of Article 8. As in the earlier cases of Cossey and Rees, the UK was admonished for not reviewing the current state of the law as it affected transsexual people in regard to scientific and societal changes.

The current state of the law was then and now (April 2003) based on the 1970 case of *Corbett v Corbett* [1971] P83, which decreed that a person's sex was based on chromosomes and fixed at birth. There is no statutory definition of "male" or "female" in UK law.

In October 2000, Elizabeth Bellinger's request to have her marriage to Michael Bellinger, performed by a registrar in 1981, declared valid was heard in the Family Division of the British High Court before a single judge. After 2 days of arguments by counsel and expert medical evidence from Professors Gooren and Green, Johnson J upheld the 30 year old judgment and refused to declare the marriage valid on the grounds that Mrs Bellinger remained legally male.

Mrs Bellinger appealed to the Court of Appeal. [2001]EWCA Civ 1140. The appeal was heard by the President of the Family Division, Dame Elizabeth Butler-Schloss, Thorpe and Robert Walker, LJJ. In July 2001 the majority again upheld Corbett. Whilst sympathetic and concerned about the legal position of transsexual people any remedies would have to be legislative. Thorpe LJ's dissenting judgment, however has had an impact that has reached beyond the island's shores.

In Australia, Chisholm J preferred this judgment to the majority in *Re Kevin* (validity of marriage of transsexual) [2001]Fam CA 1074. This was affirmed by the full court of the Federal Family Court in February 2003.

In July 2002 the European Court of Human Rights also preferred Thorpe LJ's views in *Goodwin v United Kingdom* (2002)35 EHRR 18 and held unanimously that UK law violated Articles 8 and 12 of the European Convention on Human Rights.

Mrs Bellinger's appeal to the House of Lords, the highest court in the country was heard in January 2003. On 10 April all 5 Law Lords who had heard the case unanimously refused her petition and held that until changed by Parliament, Corbett remained law.

However they did grant a declaration of incompatibility with Articles 8 and 12 against the statute which does not define "male and female" and prohibits transsexual people from marrying. This is meant to fast-track legislation to remedy the violation. The

government's response to this litigation has been to promise remedial legislation as soon as Parliamentary time permits.

When this paper is delivered in September 2003 the author hopes to be able to report on the progress of UK legislation. In the mean time, Mrs Bellinger has decided to take her case to the European Court of Human Rights and has until the opening date of the Symposium to file her application.

Dave King United Kingdom

The British Connection and the Legacy of John Randell

Charing Cross Hospital in London may have other claims to fame, but to many members of the transgender community and many professionals, at least in Britain, it has been for many years the first hospital to spring to mind when transsexualism or sex reassignment is mentioned. During the 1960s and 70s these topics were also inseparable from the name of the subject of this paper - John Randell, a Consultant Psychiatrist at that hospital.

In this paper I chart Randell's career and his involvement with transsexual patients from the 1950s to his early death in 1982 by which time he had seen over 2,500 such patients. I discuss his publications, his relation to other professionals working in the field and his involvement with the media.

I go on to outline Randell's role as an expert witness in the infamous Corbett v Corbett case (the April Ashley case), in which the judgement was strikingly in line with Randell's own view of transsexuals. I then discuss Randell's approach to his patients which was controversial, often arousing strong dislike, although he also had his champions.

Finally, I make an assessment of his place in the history transgenderism in Britain. Despite his contribution to the April Ashley decision, his publications and media appearances played a key part in influencing what little information people had about transsexualism in those days, and for twenty years he kept alive the possibility of surgery in Britain even though it was to be a reality for only a small number of the people who made it to his door.

Katsuki Harima Japan

Advance of Transgender Movement in Japan

In Japan, publicly announced SRS have just begun in 1998. Therefore, transgender had been suffering from miserable social settings as well as poor medical situations for a long time.

However, situations are now changing. Recently, our transgender movements are becoming to change our society. In this presentation, I will introduce 3 topics which have strong impacts on this change.

First, in January 2003, transgender and their supporters have teamed up to seek public acknowledgment of transgender and to pressure the government into allowing sex changes to be recorded in official documents. This team or NAO group, which takes its name from a character in a popular TV drama focusing on a junior high school transgender student have begun “blue sky ribbon campaign” and this campaign was widely reported on TV news and newspapers.

Second, in April 2003, Kamikawa Aya, MTF transgender was elected as an assembly member of Tokyo Setagaya Ward. During election campaign, she came out she was FTM transgender and advocated equal rights for all sexual minorities. Her victory was also nationally announced.

Last, thanks to NAO group, Kamikawa Aya, and all other transgender movements, lawmakers from both the governing and opposition parties have seriously begun to discuss a new law which enables transsexuals to change their sex registration. Now, I am not sure whether we will realize to have this new law or not. I hope, however, I will bring good news when I make a presentation in the symposium.

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Defining Sex and Gender: Basic Issues Underlying The Estate of Gardiner Decision (Kansas, U.S.A., 2002) Rejecting Transsexual Marriage

Sex change medicine, asserting a scientific basis for sex reassignment of transsexuals that ought to be recognized by the community and by legal institutions, has been seriously confused concerning how contemporary science defines its terms and how law should define its terms. These terms include sex, gender, man, woman, boy, girl, male and female. Examination of the Kansas Supreme Court's decision in *Matter of the Estate of Gardiner* (2002), refusing to grant legal recognition to the marriage of a biological man and a post-operative male-to-female transsexual woman, offers an opportunity to clarify basic points concerning definitional theory that cut across law, science and medicine, and to identify legal problems underlying the definitional disputes in this case.

The paper describes the *Gardiner* case, distinguishes between instrumental, essential, traditional, charismatic, and conventional modes of defining terms, and discusses why the differences between them are important.

Definitional quarrels often mask, or are treated as a vehicle for resolving, larger substantive problems, in this instance problems in societal legal governance, including: (1) requirements for legal marriage; (2) relations between courts and legislatures; and (3) maintenance or fundamental alteration of existing modes of male-female status classification for a multitude of purposes that affect the entire community, not just the small segments of it preferred by sex change medical and psychological professionals.

The aims and concerns of law and medicine with respect to transsexualism and transgender differ substantially, and from an instrumentalist point of view concerning terminology and definitions, it is thus to be expected that the meanings given to words by these two disciplines will often differ accordingly

Jamison Green USA

The Men Who Would Be Men

This paper analyzes the findings of J. Michael Bailey's recently published book "The Man Who Would Be Queen," from the perspective of a transsexual man (FTM transsexual). Based on the logic presented in that book, this paper anticipates the findings that Bailey may one day present from his current research-in-progress on "tomboys," and further demonstrates how such findings may, in fact, be off-base due to their reliance on premises rooted either in faulty assumptions or in ordinary bias masquerading as politically or (scientifically) "correct" dogma. Results of a survey of transsexual men intended to validate specific premises are provided, and commentary on how such findings may affect law and policy regarding transsexual people is also offered.

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A specific questionnaire for voice problems in male-to-female-transsexuals

Introduction

At the phoniatic department of the medical centre Vrije Universiteit we have seen about 500 male-to-female transsexuals for assessment and voice therapy. A lot of patients did not turn up for a follow up after voice therapy, but at least 60% of those who were seen initially, achieved a good or acceptable female voice.

Problem

Sometimes there is a discrepancy between the patient's own evaluation of her voice and that of the diagnostic team.

Recently the subjective feelings of patients are used as an important outcome measurement. The so-called Voice Handicap Index is a validated questionnaire for patients with voice problems. This instrument, however, is not suited for the specific voice problem in transsexuals (a normal voice, but not consistent with the desired gender).

Solution

We designed a specific questionnaire for male-to-female transsexuals. In the presentation the experience with this instrument over a period of one year will be discussed, as well as the use of this instrument in measuring the effect of speech therapy in a pilot group of patients.

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Voice and Communication Therapy for the MTF Transgendered Patient

Research has shown that voice is one of the most revealing factors about an individual's personality, feelings, emotional state, and credibility. In short, one's persona is often revealed through voice. In addition to voice, our communication abilities include how we use verbal language including vocabulary and sentence structure, how we use non-verbal language to express our feelings and mood, and how we use intonation, rate, and volume as critical components to our total voice and communication repertoire. This presentation will outline a Voice and Communication program that addresses the components outlined above for the MTF and FTM Transgendered Patient. It will show how to build credibility through voice and communication changes and establish the desired communication and/or voice necessary to pass as a male or female.

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Impact of voice on quality of life in Flemish transsexual people

Background

In transsexual people an anatomically normal individual feels that he or she is actually a member of the opposite sex. Treatment usually includes sex reassignment surgery, along with hormone therapy and real-life experience. Voice modification surgery may be necessary, as passability is still in a large extent dependent on the aspects of voice in transsexual people. Often male-to-female patients report being addressed in telephone conversations as their genetic gender, which is experienced as a disability. In personal conversation with visual contact this seems less striking. The purpose of this study was to evaluate the impact of voice on quality of life in Flemish transsexuals.

Methods

In order to detect disability caused by a voice disorder, the Voice Handicap Index (VHI) was used. VHI is a validated tool to assess the patient's judgement about the relative impact of his or her voice disorder upon daily activities (1). Handicap is defined as a social, economic or environmental disadvantage resulting from an impairment or disability. The VHI consists of a 10-item functional subscale, a 10-item emotional subscale, and a 10-item physical subscale. A Dutch validated translation was used (2). Scores range from 0-40 for no to mild disability (M. Moerman, unpublished data). Cronbach's alpha varied between 0.72 and 0.95 for the subscales and the total scale. As we studied a specific population, an additional question evaluating the way patients were addressed in a telephone conversation was added.

Patients

In a follow-up study done at the Ghent University Hospital Belgium, a total of 49 patients were evaluated. All patients underwent their sex reassignment surgery for at least since 1 year. An additional hormonal evaluation was done. All 29 male to female (mean age 41.9) and 20 female to male transsexuals (mean age 32.5) completed the VHI.

Results:

Female to male: Median scores (and interquartile range) were 1 (0-4), 0 (0-2), 3 (0-6) and 4 (0-10) for functional, emotional, physical and total score of the VHI respectively. The extra question was rated 0/4 (0-1). These low scores suggested that testosterone treatment led to an acceptable voice alteration, with (due to anatomical changes) a voice perceived as a normal male voice as result; even though in our group hormonal treatment was subtherapeutic with a median testosterone 259 ng/dl (IQR 151.3-753.0), and LH 38.5 IU/l (± 20.0). A higher total score of the VHI correlated significantly with a lower dihydrotestosterone (p: 0.045; cc: -0.49).

Male to female: Median scores (and interquartile range) were 4 (2-8), 2 (0-13), 6 (2-11) and 12 (6-31) for functional, emotional, physical and total score of the VHI respectively. The extra question was rated 2/4 (0-3). These scores were significantly higher than those of the female-to-male transsexuals, but still indicated no real disability/handicap. The emotional subscore correlated significantly with higher dihydrotestosterone levels ($p < 0.05$; $cc: 0.48$).

Conclusion:

This study evaluated the impact of voice on quality of life, by means of the Voice Handicap Index in 49 transsexuals. A specific question 'are you addressed as your genetic gender in telephone conversations' was added.

The VHI in female-to-male patients was very low, suggesting that androgen therapy had the desired voice lowering effect. The additional question revealed that these patients are addressed as their desired gender, and as such do not experience a disability. Male to female patients had significantly higher VHI scores, although again within the range of no/slight disability. The additional question related to telephone conversations was scored significantly higher. This suggests that male to female patients experience a disability caused by their voice, in contrast to female to male patients. An explanation for the general low scores may be that this patient group has a normal anatomical and functional voice organ, albeit in a 'wrong' body. As such there is no real voice disorder inducing a voice related handicap. However, the extra question indicated that male to female patient's perception is that they did experience a disability. Where scores of VHI were low, an explanation for this discrepancy should probably be found in the fact that in telephone conversations passability is totally dependent on voice, without possible correction by physical appearance.

Overall we can state that the VHI is a valid tool to assess disability caused by a voice disorder, but it is not a reliable tool in this specific population as transsexual patients do not have a real voice disorder.

Elsa Almaas & Esben Esther Benestad Norway

What Happened to the Middle Sized Stone?

When God had created heaven and earth, light, grass, herbs and trees, the sun and the moon, water animals and birds, he created animals and finally he created human beings - in his own picture - as man and woman he created them.

Even Genesis is an example of how stories change. The Bible offers two versions of how woman was created. In the first version she is made on equal terms with the man, in the next version she is made from man's rib to keep him company.

In the times that came, this history was re-written many times.

In different cultures stories about sex and gender exist in many versions. The ever present question is: "How do we become what we are?" A question of interest to philosophers, educators and psychologists, but also for each and every one of us.

Norwegian mythology states that when God had ended his task of creation, he rubbed sand and dust off his hands. This fell over Norway, and made all the islands, hills and rocky mountains.

Norway is a country rich on stones, very rich on stones.

Imagine your back yard filled with a huge pile of rounded stones. Imagine that you were to divide this pile in two: - one for the big stones and one for the small ones.

Most people would start with the real big and the very small ones, in order to get well started on the two piles. Then they would carry on, always careful that the stones in the one pile are the biggest and the ones in the other the smallest.

At some point there may be a need for a weight or some other measuring devices.

Finally your space will be filled with two piles, one pile of big stones only, the other containing but small ones.

You may feel satisfied;- or you may experience some sense of discomfort. Discomfort on behalf of all the middle sized stones

Alison L. Laing USA

Help for Transpersons Seeking Religious Affiliations and Spirituality

Many individuals who deal with gender variant issues find themselves feeling or actually experiencing rejection from their life time religious affiliation. In addition because of this disenfranchisement, they suffer additional guilt, shame, embarrassment and melancholy. What many do not know is that there are numerous opportunities that can aid them in finding a satisfying outlets for their deep rooted desire to express their faith in a meaningful way and acceptance in a spiritual community of their gender variant lifestyle.

This poster session will present assistance in five general categories.

1. There are literally hundreds of main stream Churches that are now welcoming Transpersons into their fellowship. Furthermore there are churches that cater to people of sexual and gender diversity. Contact information for locating these churches and meeting places will be made available.
2. There are special conferences, convocations and religious celebrations that include programs especially for Transpersons. Some have attendance of over a thousand people with dozens of gender variant persons; smaller events may have only a few Transpersons, but those who attend will find new friends and possibly religious fellowships that open their hearts and doors to all people.
3. There are a number of unaffiliated religious organizations including those that branch off from the more conservative and orthodox faiths that welcome Transpersons into their fellowship. In addition there are other organizations which foster activism to change policies regarding diversity within some faiths.
4. There is a growing body of literature that ranges from deep theological analysis to fundamental rationales that may help Transpersons to deal with their own internal self image with regard to their spirituality. A list of these resources along with summary review material and some of the relevant web sites will be available.
5. Finally there are alternative possibilities where the Transgendered may find spiritual fulfillment. These include eastern meditative groups and assemblages that refer to themselves as Kindred Spirits. These latter groups hold sessions ranging from small gatherings of a hour or so to week long retreats. These tend to be based on an amalgam of Native American and Celtic traditions, which honor the "two spirited persons". Literature and contact information for participating in this Kindred Spirit movement will be provided.

Counselors and therapists should find the materials, resources and references on religious and spiritual need as aids in their counseling of Transpersons seeking a spiritual home or dealing with their personal issues in regard to their faith. Additional information about Trans friendly religious institutions and literature references will be collected from those conference attendees who are willing to share their information

Koen Taillieu Belgium

The “Genderstichting” (Gender Foundation Belgium) and an overview of the situation of transgenders in Belgium

- The Genderstichting (Gender Foundation Belgium): short presentation
 - History
 - Objectives
- Informing
- Assistance of people who suffer of gender dysphoria
- Development of a suitable assistance network
- Self-help
- Situation of transgenders in Belgium
 - Short overview of problems in general
- Society
- Legal issues
- Medical issues: - transsexuals
- transgenders
- Social security
 - Objectives for the future
- legal issues
- social issues
- child issues
- transgender issues

Paul L. Vasey & Nancy H. Bartlett Canada

Primary versus secondary distress regarding cross-gender behaviours and cross-sex wishes in fa'afafine: A retrospective pilot study

In this pilot study, gender-atypical males (fa'afafine) in Independent Samoa were interviewed to obtain retrospective information on their experiences as children, as well as current information. The focus of this study was to evaluate the presence of primary versus secondary distress among the fa'afafine. As adults and as children, these biological males generally identify as females, and, though they are not pathologized in their own culture, they would likely meet DSM criteria for Gender Identity Disorder (GID) in Western cultures.

One of the criteria for GID is that it "causes clinically significant distress" and, as a general rule, for a condition to be considered a mental disorder in the DSM, it must be "associated with present distress." It is not evident from these criteria whether the condition itself must cause distress, or whether distress can be caused by situations that are secondary to the condition, such as social disapproval. Additionally, in the DSM criteria for GID, there is ambiguity and confusion regarding sex (biological status) and gender (a sociocultural construct). Should wishing to be/believing that one is the other sex, and engaging in behaviours deemed culturally inappropriate for one's biological sex be given equivalent diagnostic significance? It seems important to examine these criteria separately.

To this end, 20 fa'afafine (M age = 32) were interviewed about their experiences as children (pre-puberty). The average age at which participants stated that they knew they were fa'afafine was 7 years. Interview questions focused on the DSM-IV criteria for GID in children, including whether they engaged in cross-gender behaviours (e.g., playing with girls, playing girls' games, dressing in female attire, and taking the female role in make-believe play); had cross-sex wishes/beliefs; and whether they experienced distress about the above, and if so, was it primary or secondary, as a result of parental disapproval. Questions were also asked about their current lives.

Results indicated very little evidence of primary distress related to engaging in cross-gender behaviours. Three participants (15%) reported some primary distress (i.e., a 4 or 5 on a 5-point Likert-type scale; 1 = I loved it, 5 = it upset me a lot/I hated it) regarding one or two of the seven cross-gender behaviours in the questionnaire. The modal answer for how participants felt about engaging in cross-gender behaviours was 1 ("I loved it"). On the other hand, eleven participants (55%) reported primary distress regarding engaging in gender-typical behaviours. Thirteen participants (65%) reported that their parents tried to stop them from engaging in cross-gender behaviours. Of these, ten (77%) reported some secondary distress related to their parents' disapproval. With respect to cross-sex wishes and feelings, 13 participants (65%) reported being upset "a little bit" or "a lot" about being a boy, 15 (75%) wished to be a girl, 9 (45%) consistently believed that they were girls, and 7 (35%) did not like their sex parts. As adults, only 2 participants (10%) reported any dislike of their sex parts.

The results of this retrospective pilot study indicate the fa'afafine, who live in a society that does not pathologize gender-atypicality, experience very little distress as a direct result of their cross-gender behaviours, but do experience secondary distress as a result of the censures placed on them by their parents. On the other hand, a significant proportion do seem to experience distress directly related to their biological sex as children, although the majority of fa'afafine do not continue to experience such distress as adults.

Mireille Bonierbale & Noelle Magaud Vouland France

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Retrospective Analysis about 200 cases of gender dysphoria

A retrospective Analysis about 200 cases of gender dysphoria, over one 20 years period of follow-up, enables us to discuss;

The relevance of clinical criteria of diagnosis

Are there biography's specific criteria

The relevance of psychological tests as criteria of diagnosis

In the the evolution on the long term

The factors of risk concerning the decision of sexual reassignment

The differences between male to female and female to male

This reflexion will be put in parallel with the data of the literature

Griet De Cuypere Belgium

Co-authors: A. Michel, S. Monstrey, B. Carael, and the Gent Genderteam

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Prevalence and Epidemiological Data of Transsexualism in Belgium

Whereas in Western European Countries such as the Netherlands, Germany, Sweden, and England, the prevalence of transsexualism has been well documented, there is no comprehensive survey of epidemiological data on Belgian transsexuals. One of the main reasons for this lack is that Belgium has no special legislation pertaining to transsexuals. Our aim has been to gather data on all the individuals who have undergone Sex Reassignment Surgery (SRS) since 1990, when the Belgian medical world started to recognise the diagnosis of transsexualism and SRS as the treatment of first choice. The data we present have been obtained by sending all plastic surgeons in Belgium (188) a questionnaire (with demographic items) to be completed for each of their transsexual patients.

James Kelly Ireland

The Presentation of Transvestic and Gender Dysphoric Patients in an Irish Psychology Clinic

Between January 2000 and July 2002, a total of 34 patients presented in clinic with behaviours consistent with either Gender Identity Disorder (GID, 302.85) or Transvestic Fetishism (TF, 302.3) as described in the DSM-IV, and similarly in the ICD-10 (F64.0 and F65.1 respectively). Several have described difficulties in attaining treatment and/or evaluation in Ireland. Of these, 47.058% (n=16) were determined to have met the diagnostic criterion for GID(1) and were referred to Endocrinology for the second phase of the triadic treatment protocol as described in Myer et al (2001). Of this sample, 25% (n=4) have experienced clinically remarkable depression. Each of these have engaged in either self-injurious behaviours, or suicidal ideations and gestures, and one Male-to-female(MtF) patient self-administered a unilateral orchidectomy. This presentation focuses primarily on the patients who met the diagnostic criterion for GID. Those who have had difficulties in attaining treatment in Ireland, referral sources, social and demographic descriptions, endocrinal profiles and treatment, and other remarkable case highlights are detailed.

S. Ziherl Slovenia

Co-authors: F. Planinšek, M. Čavič, A.Kocjančič, M. Mihelič, & M. Šolinc (Slovenia)
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Experiences of Working Group for Gender Identity Disorder at University Clinical Center at Ljubljana (Slovenia)

The Working Group (WG) for Gender Identity Disorder (GID) at University Clinical Center was set up in 1997. In the same time the guidelines for the procedure of the treatment of GID were made. The purpose of forming the WG and making the guidelines was to better select the candidates for surgical change of gender and thus to influence the better outcome of the treatment.

WG consists of the following specialists: psychiatrist (leader of WG), endocrinologist, gynecologist, urologist and two plastic surgeons.

A patient is first met by the psychiatrist. The history is taken and the diagnosis of GID according to DSM-IV and ICD 10 is made. Furthermore the psychological tests and the hormone status is done. This first step of the procedure lasts at least one year. During the regular psychiatric interviews the motivation of the patient is checked up, the insight into the patients social support is reviewed and stimulated.

When the psychiatrist decides that a patient is suitable for further procedure the WG meets and set the next steps. Then, the hormone therapy is performed for the second year of the procedure. After this is successful the WG meet again and surgical team takes over.

During the whole procedure the psychiatrist is obliged to meet the patient regularly, which means also immediately after surgery and in the rehabilitation period thereafter. The WG helps the patient also with the administrative procedures in the community (the change of the name and all needed changes at authorities).

At the end of our presentation there will be a short presentation of the whole procedure by one of the patients.

Joanna Smith France

Co-authors: Sandrine Coussinoux, Thierry Gallarda & Jean-Pierre Olié

Group Psychotherapy For Gender Identity Patients: Method and Main Themes Treated

Many patients asking for sex reassignment in our Gender Identity Consultation do not correspond to the DSM-IV criteria for specific gender identity disorder, and will therefore not be reassigned by our team. Very few present DSM-IV Axis I psychiatric disorders and need psychotropic drugs. However, many gender identity patients do present DSM-IV Axis II disorders (narcissistic personality disorder, borderline personality disorder...). Most of them could benefit from psychotherapy sessions but do not want to get involved in individual psychotherapy either because they can absolutely not consider any other solution than sex reassignment straightaway or because they do not have sufficient introspective abilities for psychoanalytical-orientated psychotherapy.

Moreover, some patients meeting the diagnostic criteria for specific gender identity disorder could benefit from psychotherapy but do not want to get involved in individual psychotherapy either.

In all cases, these patients seem to benefit from meeting other patients suffering from similar gender identity disorders, particularly in reducing their sense of loneliness and of social stigmatisation.

These observations led us to offer group psychotherapy sessions to gender identity patients who seemed particularly confused and / or lonely about gender identity issues.

Patients quickly got involved in the group and immediately identified with one another. They were also quite relieved to meet patients sharing the same problems. However, patients seemed ambivalent concerning the group sessions as they were also confronted to their inconsistencies.

In this communication, we will present the frame used for this group (progress of sessions, frequency, rules...) and the therapists' aims. We will also present the different themes that stood out during the sessions.

Hertha Richter-Appelt Germany

Co-authors: Olaf Hiort, Sandra Reinecke, & Daniela Schön

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Body Experience and Sexuality in 46,XY Women

No differences between individuals with complete androgen insensitivity syndrome (CAIS) and controls have been found on broad measures of quality of life recently (Hines et al. 2003). Therefore more attention is needed in research to more detailed aspects of body and sexual experiences for the psychological well-being in 46,XY women. First results of adolescents and adults with CAIS ($n > 15$) participating on a follow-up study with different forms of intersexuality will be presented.

Method: A semi-standardized questionnaire has been developed to study socio-demographic aspects, physical, psychosocial and psychosexual development (including items on gender identity and gender role), traumatic and non traumatic experiences with medical interventions and quality of life. The standardized Body experience questionnaire (Strauss & Richter-Appelt 1996) and the Body assessment scale (Richter-Appelt, Reinecke & Schön unpublished) a modified version of Ferriman & Gallweys assessment of body hair growth in women has been filled out by the participants. Sexual behaviour, subjective sexual experiences and imaginations were asked for.

Subjects: 46, XY women with androgen insensitivity syndrome participated in the study. First results on body and sexual experiences will be presented and discussed. Women living in a partnership will be compared to women without a partner. Conclusions will be drawn for further research in this field.

Gabriel Fenigsohn USA

Co-authors: Griffin Hansbury & Katherine Rachlin (USA)

Transmasculine Individuals' Experiences with Hysterectomy/Oophorectomy

Introduction:

Hysterectomy/Oophorectomy may impact the endocrine, gynecologic, and overall health of FTMs, transmen, and masculine-identified transgender people. Though there have been papers written about the surgery itself, there is no research which documents the experiences of the transmen who have this surgery. This research used a survey to obtain information about the experience of hysterectomy and/or oophorectomy in transmasculine individuals. The purpose was to provide information which would be useful to those considering the surgery and to professionals involved in such treatment.

Method:

A survey was designed to explore such topics as reasons for undergoing surgery, access to care, surgical complications, and post-operative changes. The survey was distributed at conferences and online via a variety of trans community e-mail lists and websites. The survey is ongoing at this time. To date there have been 86 responses.

Preliminary Results (taken from the first 82 respondents; updated results will be presented in September):

The primary reason given for undergoing surgery was concern about the potential for future medical problems (26%) or to address a preexisting medical problem (17%). Fewer people said gender incongruence (15%) was most important and 11 percent had hysterectomy/oophorectomy to prepare for phalloplasty or metaoidioplasty.

Were the individuals following the recommendations of the Standards of Care? We asked respondents which of the below conditions were true at the time of the surgery.

Taking hormones for at least 12 months: 49%

Living as a man for at least 12 months: 57%

In psychotherapy at least 6 months: 51%

A mental health provider wrote a letter to the surgeon: 24%

Two letters were written by therapists: 15%

Already had top surgery: 44%

None of the above: 11%

Discussion:

The current Standards of Care (Meyer et al. 2001) treats hysterectomy/oophorectomy in female-to-males as equivalent to other gender-confirming genital surgery. Letters from two mental health professionals are recommended to assess the eligibility and readiness criteria. Results of this study indicate that most individuals are making decisions about hysterectomy/oophorectomy with their doctors without such a letter. The majority of respondents were on testosterone at the time of the survey (76%), but less than half were on it at the time of their surgery. For many, this surgery came before full-time real-life experience, hormones, or chest reconstruction.

MT Molo Italy

Co-authors: E. Cappai, L. Castelli, P. Perozzo, O. Sassu, S. Vighetti (Italy)

Emotional Response to Erotic Stimuli in Transsexuals

The aim of this study was to evaluate the emotional response to erotic visual stimuli in a sample of MtF and FtM transsexuals compared with a control group. Emotional sensations activate the Autonomic Nervous System, therefore we can measure emotional responses through the variations occurring in that system.

According to Lang's model, response is organised along the two main dimensions of valence and arousal, considered as primitive motivation parameters involved in subcortical brain areas. Heart rate varies by both sympathetic and parasympathetic system and previous studies report an increased rate during pleasant events and a general deceleration viewing unpleasant stimuli. Facial muscles response seems to be more correlated to the affective valence of stimuli with a higher zygomatic activity associated with pleasant pictures and a greater corrugator activity during unpleasant views. Twenty-one transsexuals (12 MtF and 9 FtM) and 21 control subjects (9 men and 12 women) were submitted to some colored photographic pictures selected from the International Affective Picture System (IAPS). The whole experimental session consisted of different slides across the affective dimension of valence: 20 pleasant (landscapes, happy babies etc.), 20 unpleasant (mutilated bodies) and 20 neutral (common objects). Eight of the pleasant slides represented erotic stimuli (4 female and 4 male nudes). During the session, heart rate and facial electromyography were recorded.

In the present study we analyzed only the autonomic response to erotic stimuli. We found MtF showed a heart rate pattern similar to F controls and FtM and M controls: the difference was significant for female nudes but not for male ones. The zygomatic response was particularly higher during the presentation of female nudes in FtM and M controls respect to MtF and F controls while MtF and F controls showed a greater activation viewing male nudes. Differences between groups were more evident when female nudes were presented.

Anne Lawrence USA

Co-authors: Elizabeth M. Latty, M.A (USA), Meredith Chivers (Canada), & J. Michael Bailey (USA)

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Measuring Sexual Arousal in Postoperative Male-to-Female Transsexuals using Vaginal Photoplethysmography

Human males typically display significantly different physiological responses to male vs. female sexual stimuli (category-specific sexual arousal), whereas human females typically do not. We used vaginal photoplethysmography to examine patterns of sexual arousal in 11 male-to-female transsexuals following sex reassignment surgery (SRS), and in 72 natal females. Subjective arousal was measured with a continuous response lever. Video clips depicting sexual activity between 2 males, 2 females, or 1 male and 1 female were used as erotic stimuli. All transsexual participants displayed category-specific sexual arousal. Five homosexual transsexual participants (attracted exclusively to males before sex reassignment) showed greater genital and subjective responses to male than to female stimuli, while 6 nonhomosexual transsexual participants showed the opposite pattern. Vaginal pulse amplitude was lower in transsexual participants than in natal females. The mean correlation between genital and subjective responses was high in nonhomosexual transsexuals, but was significantly lower in homosexual transsexuals and in natal females. One transsexual participant who reported a change in sexual orientation following sex reassignment displayed genital and subjective responses consistent with her pre-reassignment sexual orientation. We conclude that male-to-female transsexuals display male-typical category-specific sexual arousal following SRS, and that vaginal photoplethysmography is a promising methodology for studying patterns of sexual arousal in postoperative transsexuals.

Anna Ravenna Italy

Co-authors: Annamaria Acocella, Luca Chianura, Maddalena Mosconi, Laura Bongiorno, Valeria Magarelli (Italy)

Gender Identity Disorder: Social, Sexual and Relational Aspects

It is only in the past few years that transsexualism has been deeply studied in a systematic way. In fact, in Italy there is a lack of data on both the incidence of transsexualism and on the behaviour of transsexual individuals. In this paper we present our experience on this topic.

Within the Servizio per l'Adeguamento tra Identità Fisica e Identità Psicica (SAIFIP) Unità Operativa di Chirurgia Plastica e Ricostruttiva Azienda Ospedaliera S.Camillo-Forlanini, between 1997 and December 2002 we observed 311 patients. All the patients were observed according to social, sexual and other points of view. The following data were also collected: distribution of sex and age, place of birth, residence, family, social and cultural environment. The data were obtained with "Psychological Case History" and "Survey on Motivation and Expectations" method. These instruments were utilized in such a way as to provide a cognitive comprehension of the personal and social history of the person requesting sexual reassignment surgery, in particular as regards the psychological problems related to the gender identity disorder and the expectations connected to the reassignment itself.

M. Bonierbale France

Co-authors: Nathalie Parola , Sophie Vial, Aude Michel, Noelle Magaud Vouland, Christophe Lancon (France)

Transsexualism and Personality

Transsexuals suffer with the unswerving conviction to belong to the opposite sex. Therefore, in our study, we researched to know the relation of this feeling with the personality of transsexuals. To operate the transsexuals could bring to them a best social adaptation and a psychological adjustment because body and spirit are in harmony. We wanted to verify the presence of such harmony of personality before operation. It would be a good predictive factor for the acceptance of changing sex.

Methodology

We used the Minnesota Multiphasic Personality Inventory (M.M.P.I.). With this test, we could obtain a descriptive approach of the personality. We have decided to establish two profiles of personality for each subject. That is why we have analyzed the results of the MMPI according to the biological sex and the psychological sex.

We have selected 30 subjects diagnosed transsexuals with the DSM-IV.

We have created two groups: a first group of 15 transsexuals Male to Female and a second group of 15 transsexuals Female to male.

Results

We have found different profiles for a same subject. In fact, we have obtained different notes standard "T" for several scales. The analysis of the M.M.P.I. showed profiles of personality, which are more in harmony when they are taken according to psychological sex. Moreover, we have found differences between the two groups. The profiles of personality of transsexuals Female to Male were more in harmony than the other group before operation.

Lorraine Sade Bakerville USA

Because of the Way We Look....And Because of the Way Society Sees Us
A Trans Perspective

OBJECTIVES

To increase awareness about the transgender (trans) community and their unique experiences of trans individuals in our society.

To explore issues of gender identity, passing privileges, barriers and politics of health care access, and disparities, also look toward the development of trans-specific programs and service needs.

PRESENTATION AGENDA

transGenesis Social Services and it's Innovative Programs

Our Destructive Psychological MOODS and STRESSORS

An Overview: Concepts and Language of Gender

Transphobia and Its Effect on Trans People

Discrimination and Negative Cycle of OPPRESSION

The HIERARCHY: Privileges and Issues of "Passing" in the Trans community

Challenging Psychiatric Stereotypes of GENDER DIVERSITY

Addressing Trans-specific Health DISPARITIES

Getting The Point About Liquid Silicone & Hormone [Ab]use

Best Practice Recommendations

Conclusion

Question-and-Answer session

Kam Wai Kui & Tim de Jong The Netherlands

E-mail: ntgf@cs.com

Towards Transpositivity in Dutch Media Representations

How can an improved representation of the transgender phenomenon contribute to a better understanding and acceptance of the diverse transgender community? Health care providers, community members and the general public: what sort of information does each group need on gender variance? How do we obtain a transpositive climate in the consulting room and in society at large?

The Netherlands have a long history of representing transsexuals in the media with the help of the medical establishment. But for issues of gender variance in a broader sense, the Netherlands lack a similar media attention due to the limited resources provided by the medical establishment to transgendered individuals who don't fit within the medical model. Organisations like the Netherlands Transgender Film Festival and the web-based magazine *het Continuüm* aim to provide documentation and information on transgender issues from a cultural perspective.

Based on results of surveys conducted during the Netherlands Transgender Film Festival 2003 in Amsterdam among the festival audience, the presenters will take up questions of representations of transgender people and how this community perceive themselves.

Cathy Pittman Canada

International Research on Transsexuals - 2004 - 2006

The purpose of this poster presentation is two-fold. First, the presentation will provide information about this exciting new research that will be conducted on an international level for a period of two years, 2004 to 2006. This proposed Doctoral research study will investigate possible changes in body image and self-concept that might occur following medical interventions offered to transsexual individuals. The second purpose of this presentation is to solicit for subjects for this research from other mental health professionals around the world working with transsexuals. It is hoped that with the assistance of world collaboration this research will provide major contributions to the understanding of transsexuals.

T. Bergero (Spain)

Co-authors: G. Cano, F. Giraldo, I. Esteva, J. Lara, MV Ortega, M. Gomez (Spain)

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Adolescence and Gender Identity: Need For a New Focus By the Spanish Public Health Care System

INTRODUCTION: Gender identity disorders frequently commence during childhood and adolescence. However, in Spain young persons rarely seek attention either for general health problems or for problems related with gender unease.

AIM: To present the results of a descriptive study of the appearance of depressive symptoms and attempts at self-mutilation during adolescence and to evaluate the response of the Spanish public health service.

METHODS: We undertook a structured interview of 200 medically diagnosed transsexual patients (122 male to female [MF] and 78 female to male [FM]) aged 15-61 years. Data were collected about the appearance of depressive symptoms, suicide thoughts and attempts during adolescence, attendance at health care centers for these reasons and referral to the mental health service following suicide attempts.

RESULTS: 61.5% of the MF and 73.3% of the FM had seen mental health care professionals at some time in their life due to having had episodes of depression or anxiety or for attempts at self-mutilation. Transsexuality was diagnosed at these visits in 32% of the MF and 37% of the FM. 33.6% of the MF and 30.7% of the FM had attempted suicide at least once and the mean age at which these attempts were made was 19 years. 6.8% first thought of suicide between the ages of 10-15 years and 11% between 16-19 years. 80% of the patients who attempted suicide did not start mental health therapy afterwards.

CONCLUSIONS: These results confirm the early age of onset of symptoms. In order to diagnose and treat these problems correctly from the beginning professionals working with children and adolescents should undertake specific training in the subject of gender identity disorders. Furthermore, the Spanish health and education services should provide the necessary resources to address this question and orient these young persons. This educational task is one of the main aims of the Gender Identity Unit of Carlos Haya Hospital in Malaga, which is the first and still the only unit of this type in Spain.

G. Cano Spain

Co-authors: T. Bergero, I. Esteva, F. Giraldo, J. Lara, MV Ortega, M. Gomez (Spain)

Acceptance, Socialization and Identity Work In Groups of Young Persons From the First Gender Identity Unit In Spain

INTRODUCTION: Group therapy has been confirmed as a fundamental therapeutic strategy in the integral care of transsexual persons.

AIM: To present the group therapy program undertaken with transsexual persons in the first and only Gender Identity Disorder Unit in the Spanish health service.

METHODS: Two-year longitudinal follow-up of a structured program of support groups with male to female transsexuals and another with female to male transsexuals. Their ages ranged from 18-23 years during the pre-surgical period. The program began two years ago, is in a closed group format, takes place monthly and lasts 90 minutes. There are 12 transsexual participants who are all at the same phase of treatment.

RESULTS: After trying out several different modes of psychotherapeutic, group and individual intervention we have chosen a format of support groups coordinated by psychologists, based on the therapeutic benefits resulting from sharing similar experiences. The different modes of intervention include psychoeducational, transition and personal growth. Clinical improvement was seen in the following variables: learning adequate behavior patterns in the role of the desired sex, improved information about and preparation for risks, side effects and limitations of post-surgical results, greater stability at work, relationship with partner and interpersonal relations, a marked reduction in suicide attempts, better adhesion to treatment and better quality of life.

CONCLUSIONS: The common experience of the members provides emotional support, information, and advice, enables joint action, and promotes feelings of control, self esteem, and socialization. This latter is one of the most important aspects for persons whose condition involves high degrees of isolation or margination. Group work helps them recognize and adjust to a hostile social environment as is found in Spain and to acquire new patterns of sexual role behavior. They are supported in living their daily lives more realistically and more completely as men or women. Social comparison and validation enable them to reduce their feelings of isolation and to learn the most efficient coping strategies to resolve their problems.

Randall D. Ehrbar USA

Clinician judgment in Diagnosing Gender Identity Disorder in Children

A convenience sample of 73 licensed psychologists was given vignettes to diagnose and rate on the Global Assessment of Functioning Scale (GAF). The vignettes vary as to how gender typical the child is described as, whether or not the child reports a desire to be another gender, and sex of the child. This is an exploratory study of how clinicians use this diagnosis. It was found that even for those vignettes which met the DSM-IV-TR criteria for diagnosis with GID, there was significant and dramatic under-diagnosis among respondents, for example, clinicians were reluctant to use GID as a diagnosis. Under-diagnosis occurred both when vignettes met purely behavioral criteria for diagnosis as well as when vignettes included self-report of desire to be the other gender. Various reasons for this under-diagnosis are discussed.

Michelle O'Brien United Kingdom

What Were The Consequences For Children, Adolescents and Young Adults in the UK Who Were Treated for Intersex Conditions and/or Gender Identity Disorder?

My research is being undertaken for my Mphil/PhD in Social Sciences, and is an exploratory study asking:

- “what happened?”
- “were many people affected?”
- “what was the effect on the development of their identity?”
- “what are human rights the implications?”
- “how far does this still happen in the same way?”
- “what other ways might there be to deal with such things?”

I will gather the stories of twenty-five to thirty people here in the UK, and use qualitative analysis to see what emerges, and learn what they have to say to us today. Autobiography is a powerful form with a long history, I will be collecting people’s ‘stories’ and supplementing these with follow-up interviews. I will also be interviewing professionals and activists in the field. I will use a grounded theory approach to let the data inform any theory that emerges. I will look at how the participants’ gender identities evolved and developed using their memories. I am also looking at what has been professional practice in this field, and trying to ascertain the scientific rationale and motivation behind the approaches.

The work comes under the “British Sociological Association Statement of Ethical Practice” and the University’s own guidelines. All information is confidential and held securely in a way that cannot be traced back to participants. Signed consent will be sought as appropriate. Because the research has yet to reach a point of calling for participants, I have no findings to report as yet. The Poster Presentation will be used primarily to outline the research project, to notify professionals of it, and as an opportunity to invite potential UK participants (including professionals and activists) to make contact.

I have begun reviewing relevant narratives from the case studies of Krafft-Ebing, Ellis, Hirschfeld, etc. before 1945 (and the advent of reassignment surgery). I have reviewed the work of Ulrichs and Carpenter on the idea of the intermediate or third sex, as well as more recent writings on this subject. My starting point in beginning to explore this area has been the writing of Michel Foucault on Sex and Control. My initial intention was to explore whether a legitimized intermediate state in society would be helpful for both intersex and transsexual children, as well as for adults in transition. The process of focusing down my research during the last nine months has given rise to these more open-ended research questions. The current investigation seems to be quite important, in that there appears to have been no such work done in the UK before.

Ako Takamatsu Japan

Co-authors: Takao Harashina & Yoshiharu Inoue (Japan)

Primary and secondary vaginoplasty with special reference to our novel vagina dilator

To obtain satisfactory results in primary or secondary vaginoplasty it is essential to continue postoperative dilation of the neovagina appropriately. However there is still no ideal vagina dilator commercially available.

We have developed a novel vagina dilator and our experiences of using it after primary or secondary vaginoplasty will be presented.

Yukako Ohtsuki Japan

Co-authors: Takao Harashina & Ako Takamatsu (Japan)

Hanging Tree of the Penis

One of the reasons why phalloplasty is difficult is that the penis can be too small, too fragile or too unstable to be stabilized securely and manipulated appropriately during the surgery.

Our method to solve the problem will be presented.

Several sutures are placed on the coronary sulcus and these sutures are tied together and connected with rubber bands. The other end of the rubber band is fixed on to the sterilized handle of the surgical light with adhesive tapes. By moving the surgical light back and forth or right and left the necessary aspect of the penis always faces the surgeon.

This technique is especially useful when performing metaidoioplasty as the clitoris is too small to be manipulated appropriately even if it is enlarged with hormone therapy.

Takao Harashina Japan

Harashina Vagina Dilator

It is not always easy to obtain satisfactory results in vaginoplasty as neovagina is surrounded by circumferential scars and these scars are doomed to contract and narrow the lumen. To obtain satisfactory results it is essential to continue postoperative appropriate dilation of the neovagina. However there is still no ideal vagina dilator commercially available.

We have developed a new inflatable vagina dilator. It is composed of three parts, main dilator which is constructed with tough rubber, hand-powered pump which sends air to the dilator and a tube which connects these two parts and transmits air from the pump to the dilator.

The dilator can be purchased from
SIGMA NAGATOISHI SURGICAL INSTRUMENTS CO.,LTD.
3-25-1 Hongoh Bunkyo-ku Tokyo Japan
Tel 81-3-3815-8275
Fax 81-3-3815-8699

Christine McGinn USA

Morbidity and Mortality of Male to Female SRS patients

Transgender medicine and surgery has not been considered mainstream even though it has been in existence for over 50 years and has an incident rate as high as Multiple Sclerosis. In order to improve surgical techniques analysis of outcomes are necessary. This paper studies the correlation between subjective and objective outcomes of genital reassignment surgery in over 200 patients in order to quantify and qualify post op complications based on technique and surgeon.

Louis Gooren The Netherlands

Long term effects of preoperative and postoperative hormonal treatment

Hormonal reassignment has two aims:

1) to reduce the hormonally-induced secondary sex characteristics of the original sex as much as possible and 2) to induce the secondary sex characteristics of the new sex].

Male-to-female transsexuals: To male-to-female transsexuals, elimination of sexual hair growth, induction of breast formation and a more female fat distribution are essential. To accomplish this, a near-complete reduction of the biological effects of androgens is required. Administration of estrogens alone will suppress gonadotropin output and therefore androgen production, but dual therapy with one compound that suppresses LH and or androgen secretion / action is more effective. Adult male beard growth is very resistant to inhibition by combined hormonal intervention, and in Caucasian subjects additional measures to eliminate facial hair are necessary. Sexual hair growth on other parts of the body respond more favorably. Breast formation starts almost immediately after initiation of estrogen administration. Androgens have an inhibitory effect on breast formation and, therefore, estrogens will be most effective in a milieu devoid of androgen action. After two years of estrogen administration, no further development can be expected. Breast development is quantitatively satisfactory in 40 to 50 percent of the subjects. The attained size is often disproportional to the male dimension of the chest and height of the subject, so the subject may desire surgical breast augmentation. Older age also impedes full breast formation.

After reassignment surgery, including orchiectomy, hormone therapy must be continued. Some subjects still experience regrowth of sexual hair in a male pattern, and antiandrogens appear to be effective in reducing it, although the dose may be reduced. Continuous estrogen therapy is required to avoid symptoms of hormone deprivation and, most importantly, to prevent osteoporosis. Estrogens alone are capable of maintaining bone mass in male-to-female transsexuals. There was an inverse relationship between serum LH concentrations and bone mineral density.

Female-to-male transsexuals The goal of treatment in female-to-male transsexuals is to induce virilization, including a male pattern of sexual hair and male physical contours, and to stop menses. The principal hormonal treatment is a testosterone preparation. The most commonly used preparations are testosterone esters in doses of 200 to 250 mg intramuscularly every two weeks. Occasionally, menstrual bleeding does not cease with this regimen, and addition of a progestational agent is necessary. If a transdermal testosterone preparation is used, addition of a progestational agent is nearly always necessary. Alopecia may occur to a degree and pattern as in male members of the same family. Acne occurs in approximately 40 percent. The increase in lean body mass averages 4 kilograms, but the increase in body weight is usually greater. There is a shift from subcutaneous to abdominal fat.

After bilateral oophorectomy, androgen therapy must be continued to maintain virilization and prevent osteoporosis. Serum LH concentrations indicate the adequacy of androgen administration.

Tom Mazur USA

**Intersex and HBIGDA, Are We Really Interested?
Results of Intersex Committee Survey**

The HBIGDA Intersex Committee has completed two tasks since its creation shortly after the last HBIGDA Conference in Galveston Texas, 2001. The first task was to craft a mission statement and the second was to survey the general membership about their level of interest in and involvement with individuals born with *sex-atypical variants of genital differentiation*, traditionally referred to as ambiguous genitalia.

All members of the Organization (326) as of July 23, 2003 were mailed the survey. Of these 326, 241 are within the USA and 85 are outside the USA.

The overall response rate is 42% (138/326). Of those 138 responders 54 (39%) indicated that in the past two years, they had provided services to persons born with ambiguous genitalia and/or their parents." The numbers of such individuals seen in two years ranged from 1 to 10+ and the types of services provided were many. In addition HBIGDA members indicated plans to either continue providing services or starting such services within the next year. A number of members expressed interest in continued education and training in this domain of sexology.

The purpose of this presentation is to provide the results of the survey with respect to the professional status of those 54 individuals providing services to individuals with ambiguous genitalia and specifically what types of service rendered and to how many individuals. I will also report what type of training and education HBIGDA members are interested in as well as what tasks the Intersex Committee can perform which would be helpful to them.

Limitations of the survey will be presented along with conclusions.

Eleanor C. Nealy & Barbara E. Warren USA

TRANS-itions: 1990-2003, The Evolution of Community-Building Models of Care
When the New York City LGBT Community Center founded the Gender Identity Project in 1990, there were no community building models of care for transgender individuals. Since then, many groups have emerged. This grassroots movement has changed both the culture of the Trans community and HBIQDA. This paper takes a historical look at the concept of transgender empowerment and how it has shaped the state of community-based and professional services for transgender persons. Through a snapshot of the New York City GIP, this paper will explore how community-building models have evolved from initial goals of service such as identity formation and visibility, to include more recent goals of inclusion and integration in the LGBT movement and communities. Client demographic data from the early 1990's will be compared to more recent data in an effort to understand how the community itself has changed and recent program innovations will be described.

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Development of Transsexual Patient Group Support

AIM

To develop a facilitated, peer led, community based support group for transsexual patients.

Objectives

- Identification of psychosocial need for support in patient caseload.
- Qualify needs within attendees regarding; clinical support for stage of transition, initial entry, access to and use of clinic services, needs of partners and family members, development of credible patient literature, issues specific to MtF vs FtM attendees.
- Monitor impact of facilitation and support service development.

Results

- Initial low attendance quickly grew and frequency of meetings was increased.
- A range of emotional, social, employment and clinical needs were quickly identified.
- The variance in gender specific issues was noted.
- Inclusion of both TS and non-TS facilitators was seen as advantageous.
- Separate services for partners and families were suggested and supported.
- The need for 'inspiring' post-transition TS people for peer support.
- The range and depth of life experience within such patient groups.
- The suitability of incorporating such groups in user involvement and research.

Discussion

A need was identified for psychosocial support within a Gender Clinic at the Sandyford Initiative in Glasgow, Scotland. The patient group requested an informal space to meet, and agreed to facilitation of meetings. Aside from individual impact, the group has successfully improved access to and use of services, produced literature and plans to run community events to network and support TS people in Scotland.

Annerike Gorter

Necessity of Self-Help Groups and Psychosocial Counseling for Gender Dysphoric and Transsexual Adolescents

Genderdysphoric and transsexual adolescents are often hindered in their normal development because of their extreme genderdysphoria. Firstly, their gender problems affect interaction with peers; these are often limited. In the second place, gender problems can affect their school functioning. Thirdly, these adolescents often experience problems in their sexual development. Aversion and alienation from their own body will grow, especially in puberty, because in that period genderdysphoric adolescents are confronted with the development of those secondary sex characteristics that don't belong to their gender identity. Besides depression occurs, as a reaction to the problems they face in relationships and because of the long, intensive counselling and medical procedure they have to go through.

Once the genderdysphoric adolescents have come-out and seek help, they are often referred by a doctor or a health care institution to the Genderteam of the VU Medical Centre in Amsterdam. But waiting lists have increased considerably and the adolescents sometimes have to wait for a year before their first intake.

The problems and mental suffering with which the adolescents come forward are usually so serious that stress will increase when hearing they have to wait such a long period before getting help (for their body develops very fast and a waiting list is a waste of valuable time).

Additionally, the medical care institutions usually can't offer supplementary psychosocial assistance for these adolescents.

Therefore our Work group Transsexualism and Genderdysphoria started a project in September 2002 for genderdysphoric and transsexual adolescents between 12 and 18 years old. We don't have a waiting list so the adolescents can make an appointment for a consult almost immediately. However, we do work closely with the VU Medical Centre in Amsterdam.

The aim of this project is to counsel adolescents who got stuck in their development or who need some extra support/care. We try to realize this aim by having consulting hours and organizing group meetings. The group meetings are based on self-help, as the other groups of our Work group. The most important aim of the group meetings is to encourage contact with peers who are dealing with the same gender problems. This can be a great relief for genderdysphoric and transsexual adolescents.

Additionally, by giving information and mediation at the school of a genderdysphoric adolescent, we try to further understanding, integration and contact with peers. Finally the project leaves space for counselling children of a transsexual parent.

J. J. Miles and Cathy Pittman Canada

Marital Therapy and the Transgender Relationship

The purpose of this paper presentation is two-fold. First, a brief overview of the research regarding transsexuals and their spouses will be offered in order to provide the participant with some background information with which to form a frame of reference for the topic. The second purpose of this paper is to present and clarify issues relevant to the case management and provision of therapeutic support to couples dealing with one spouse being transgendered. Case examples and the paradigm utilized in assisting resolution for these couples will be presented.

Sahika Yuksel Turkey

Co-author: Aslihan Polat (Turkey)

Families of Transgenders in Turkey: Experience From an Secular Islamic Country Between East and West

In this paper we shall draw attention to the tension experienced by transgenders in Turkey and their families, as well. An individual who displays a 'problematic' gender identity are often stigmatised by and isolated from society. The family, as a microcosm of society, largely reflects and reinforces these negative views.

The aim of this study is to investigate the attitudes of families towards their transgender relatives and the important role of family counselling in managing transgenders.

Method: This study group is composed of family members of individuals who applied to Istanbul faculty of Medicine, Psychiatry Department, which is a specialised unit offering counselling and treatment for gender identity disorders. During the interview with the family member family relationships, professional development, social and sexual relationships of the transgender were explored. 47 relatives of 39 transgender individuals (14 biologically male, 25 biologically female) were interviewed. Half of the relatives who came to the interview were mothers. Only six fathers, all of whom had M-to-F transexual children, attended the interview.

Apart from the interviews family members were also invited to the family groups which were consultation and information oriented and were held twice a year.

Results: All of this was possible because of the non stigmatisation of the issue by the 'medical authorities' which the families had come to trust and respect. The main benefit from family psychoeducation meetings the relationship of transgender individuals with their family improved.

These sessions create a non-threatening environment for the families and they also make the process of accepting their transgender relative easier. In these groups families are also allowed to engage with their feelings of grief and anger in a safe and encouraging environment. These educational meetings provide the support that families need as they witness the process of change that their transgender relative goes through.

Family counseling should always be considered during the management of TG individuals.

Most of the professionals working in this field emphasize the need for informative work with parents of transgender individuals. These psychoeducative groups increases the acceptance of sexual identity differences by the families of transgender individuals and also help them to improve their relationship with their TG relatives.

Tarynn M. Witten USA

Life Course Analysis: The Courage to Search for Something More - Middle Adulthood Issues in the Transgender and Intersex Community and Their Impact on Later Life

In this paper presentation we will discuss middle-to-late life issues of the transgender and intersex communities. We will demonstrate that these mid-to-late life issues are richly complex, full of courage, coping, risk and resilience, and are grounded in a socio-ecological landscape of systemic actual and perceived violence and abuse. We examine how this socio-ecological environment affects the “normative” mid-life cycle processes, particularly as they may impact family dynamics (children, careers, caretaking, for example). Practical examples and demographics/statistics are drawn from the author’s field interviews and survey research over the past decade. We will close the paper by examining the effects of such a landscape on the middle-age life stage and examine its potential ramifications for old age as well.

Jamie Feldman USA

Evidence-based Transgender Medicine: Are we ready?

Background: This paper will offer an overview of evidence-based medicine and its application to the transgender setting. Evidence-based medicine is a structured approach to finding, appraising and utilizing the best available scientific evidence for making clinical decisions. Equally significantly, evidence-based medicine provides professional bodies with a fair, scientifically rigorous method for making best-practice decisions and to develop more transparent working practices to establish guidelines and standards. How do we apply the precepts of evidence-based medicine to transgender health, consistent with other professional medical organizations?

Methods: Five multi-specialty evidence-based databases (The Cochrane Library, Clinical Evidence, the TRIP database, National Guideline Clearinghouse and the National Electronic Library for Health), were searched for systematic clinical reviews involving “transgender,” “transsexual,” and “gender identity disorder.” Next, a sample clinical question —“What is the risk of osteoporosis among transgender persons receiving hormone therapy, and is bone density screening indicated for this population?”—was framed and an evidence-based critical literature review was performed. Finally, a model framework for critical appraisal of the transgender health literature was adapted from Centre for Evidence-Based Medicine guidelines.

Results: Only one systematic review, on gender reassignment surgery, was located in the database search, indicating that current evidence-based resources do not address clinical questions specific to transgender medicine. A critical literature review utilizing a representative clinical question revealed few patient-oriented Level 1 or 2 studies specific to the transgender setting. However, by incorporating Level 1 evidence from physiologically similar, non-transgender studies, a sufficient degree of evidence is available to reach a reasonably high-grade recommendation, while highlighting the need for rigorous, patient-oriented clinical trials. Physicians, researchers and professional organizations should be familiar with the tools and precepts of evidence-based medicine in order to address important clinical questions in individual patients and the field as a whole.

Joanna Smith France

Co-authors: Thierry Gallarda, Sandrine Coussinoux, Catherine Brémont, Jean-Pierre Olié (France)

Sex offending and secondary transsexualism : a peculiar “self-therapy”

In our Gender Identity Consultation, patients’ motivations for sex reassignment are of a great variety. In this presentation, we will describe the case of a 40 year-old biological male sentenced for sexual offences on male adolescents and subsequently asking for sex change. Although surgical castration has sometimes been performed on sex offenders, and anti-androgens are sometimes prescribed to reduce relapse, very few cases such as this have been reported in the literature.

This patient has taken hormonal treatment for more than 20 years for professional reasons, i.e. to perform in transsexual shows, and obtained breast implants from an accommodating doctor.

Today, the motivation of this patient is ambiguous, as being mixed to an unspecific gender identity disorder and to a fear to relapse.

In our Gender Identity Consultation, we have met other patients sentenced for sex offences and asking for sex reassignment, but who did not present their demand as aiming to prevent relapse. As gender identity is often disturbed in sex offenders, we wonder whether other unspecific gender disordered patients asking for sex reassignment could be trying to deny their sexual fantasies by asking for castration.

This patient is currently treated as a sex offender and not as a transsexual, but has been feminised by previous treatment and breast surgery, and still asks for sex reassignment. What kind of therapeutic strategies should we use in such cases ? What prognosis should we expect, in terms of relapse prevention and quality of life, with or without sex reassignment ? This case draws our attention to the major problems specialised gender identity teams meet when patients have taken hormonal treatment for several years without any previous psychiatric diagnosis.

A.M. Perrone Italy

Co-authors: S.Cerpolini, L. D'Emidio, F. Mollo, G. Pelusi, M.C. Merigliola (Italy)

Effects of Long-Term Testosterone Administration on Sexual Behavior and Mood in Female to Male (FtM) Subjects

Activating effects of short-term T administration on sexual functions of FtM subjects have been reported. More conflicting effects on mood parameters were found. In this study we analyzed some aspects of sexual behavior and mood in transsexual subjects (FtM, n=10) before and after 100 mg/weekly of testosterone (T; Testoviron), in normal men (n=10) and in normal women (n=10). All subjects filled out a questionnaire on sexual behavior and mood in the pre-treatment period and FtM subjects repeated the questionnaires after at least 12 months of hormonal therapy (post-T). Results of selected questions are reported (score = frequency/week):

SCORE Women (0min-8max)	FtM		Men
	Baseline	Post-T	Baseline
Intercourse	0.8±0.4##+	0.8±0.4##+	2.7±0.9
Masturbation	1.3±0.7	4.6±1.2*##+	1.6±0.7
Sexual fantasies	2.1±0.7	7.0±0.5*##+	2.8±0.9
Arousability	3.2±1.1	6.6±0.7*	5.1±0.9
Depression	1.4±0.3##+	0.6±0.3*	0.2±0.1
Anger	1.1±0.4	0.4±0.2	0.5±0.3
Irritability	1.1±0.4	0.8±0.3	0.5±0.2
T(ng/ml)	0.8±0.2+	5.2±1.0*##	6.1±0.3

*= P <0.05 vs. baseline; ##= P <0.05 vs. women; += P <0.05 vs. men

SUMMARY: We found: 1. no differences in baseline characteristics of sexual behavior between normal and transsexual women, except for frequency of intercourse. 2. significantly higher levels of depression in FtM women compared to normal men and women. Levels of depression decreased in the post-T period in all FtM subjects. 3. significantly higher levels of sexual fantasies and arousability after T treatment in FtM subjects compared to baseline and to men and women. 4. tendency to decreased levels of depression, irritability and anger in FtM subjects after T treatment.

CONCLUSIONS: Our study confirms the idea that T has activating effects on sexual behavior. Our data suggest that T administration decreases level of irritability and anger in FtM subjects. These changes may be due to an increase of well-being and decrease of depression in these subjects due to T administration.

Wylie C. Hembree USA

Co-author: John C. Capozuca (USA)

Medical and Psychological Management of Adolescent Transsexualism

Medical and psychological management of transsexuals requires a close collaboration between psychology and endocrine specialists. This is especially important in treating a specific subset of the transgender community: adolescents who identify as transsexuals. The risk of treating someone with transient gender identity disorder must be weighed against the positive opportunity to reverse more readily an undesired evolving physical appearance. During the past three years, we have utilized treatment protocols based upon the principles published by Cohen-Kettenis (J Amer Academy of Child & Adolescent Psychiatry 36: 263, 1997), with reversible ablation of endogenous sex steroid production preceding hormone treatment with steroids of the desired gender. The patients were screened and selected by one of us (JCC). Endocrine and somatic aspects of pubertal development are complete in most patients. Parents signed consents for treatment when patients were not living independently.

We present herein the medical management of two prototypical cases from our practice. An 18-year-old MTF transsexual began evaluation for GID 6 years prior to treatment during the onset of pubertal milestones. He was treated with progressively increasing doses of oral Provera for 5 months prior to estrogen treatment. Provera 80 mg/day virtually eliminated testosterone production without side effects. Thereafter, estrogen treatment yielded the desired skin and breast changes over a 9 month period of time at an estrogen dose only slightly above physiologic replacement doses (Premarin 1.25 and 2.5 mg/day). Applying the same pharmacological principles, a 16-year-old FTM transsexual, Tanner Grade 4 with regular menses, was treated for 8 weeks with daily Lupron injections to suppress ovarian function, whereupon satisfactory virilization was achieved with physiological amounts of exogenous testosterone (testosterone enanthate 60 mg /week IM). Testosterone levels were between 500-650 ng/dl.

This strategy yields rapid hormonal changes, avoids the need for anti-androgens and anti-estrogens, is associated with few side effects of the desired sex steroid and is especially effective in adolescent transsexuals in whom the habitus changes produced by endogenous sex steroids are still in transition from the pre-pubertal appearance. Large amounts of sex steroids are often used to overcome the resistance of the reproductive endocrine system to suppression by exogenous sex steroids that oppose endogenous sex steroids. FTM transsexuals administered large doses of testosterone may continue to ovulate and menstruate, thereby producing estrogen and progesterone that counters the desired virilization of the exogenous androgen. Estrogen suppresses gonadal testosterone in MTF transsexuals only after using pharmacological amounts known to alter clotting, lipids and endocrine control of blood pressure. Thus, to reduce morbidity of sex steroid treatment in transsexuals, pharmacological ablation of endogenous sex steroid production prior to the initiation of exogenous sex steroid treatment is desirable. The studies presented provide, for the first time, endocrine data that support the feasibility of this treatment paradigm.

A. Becerra Spain

Co-authors: M.J. Lucio, J.L. Llopis, E. Sarmentero & C. Garaizabal (Spain)

Side Effects of the Cross-Gender Self-Therapy in Male-to-Female Transsexuals

In recent decades, the demand for sex reassignment in transsexual patients has increased as have the number and variety of possible psychologic, hormonal and surgical treatments. However, these patients run into troubles to be treated in Spanish public hospitals and so endocrinologists have not sufficient experience about this condition; there, patients usually make use of self-therapy and frequent side effects as hyperprolactinemia are observed. Side effects of sex steroid therapy in more conventional categories of patients have been extensively reported, but in transsexuals have been few. We conducted a prospective study of 53 male-to-female transsexuals, average age of 28.5 ± 8.2 years, range 18-56 y, treated with ethinyloestradiol (50-200 mg per day) and cyproterone acetate (100 mg per day) for 6 months to 10 years before. Basal levels of prolactin varied markedly between individuals: Mean \pm SD was 68.2 ± 41.3 ng/dL, range 19.1-144, and 21/53 (40%) patients had hyperprolactinemia (>20 ng/dL). Only in one case these levels were >100 ng/dL, obtaining a negative pituitary CT. After interrupting the therapy for 6.3 ± 3.6 months (3-9), the levels of prolactin descended a 51.3%, significantly to 31.3 ± 21.2 ng/dL ($p=0.012$). In conclusion, our findings show that the treatment with high doses of oestrogens in male-to-female transsexuals causes frequent hyperprolactinemia, which is reversible after interrupting the therapy, suggesting a non-autonomous production of prolactin.

Adrian Turner USA

Co-authors: Alan O. Malabanan, Tom W. Barber & Michael F. Holick Vin Tangpricha (USA)

Testosterone Increases Bone Mineral Density at the Hip and Spine in Female to Male Transsexuals

Estrogens are important for preserving bone density in males and females. However, the role of testosterone in the preservation of bone density is less clearly defined. Since bone osteoblasts possess the androgen receptor and express 5 α - reductase activity, circulating androgens should be able to activate target genes in the bone. Our study was to investigate the effects of testosterone on bone mineral density at both the hip and spine and on markers of bone turnover in female to male (FTM) transsexuals. We obtained approval for the study from the IRB. The study was conducted through the General Clinical Research Center at Boston University School of Medicine. All FTM transsexual subjects were eligible for participation. Each patient gave written informed consent to have annual testing of bone mineral density (BMD) by dual-energy x-ray absorptiometry (DEXA) at the hip and spine and semi-annual serum and urine markers of bone turnover. Markers of bone formation and turnover included osteocalcin, alkaline phosphatase and urine N-telopeptide (NTX). The duration of the follow-up period was 2 years. Eleven subjects out of 20 subjects have completed the two year study. The subjects were an average age of 35.0 ± 9.0 . These patients used an average weekly dose of between 50 to 100 mg of testosterone esters (testosterone enanthate or cypionate) given by intramuscular injection. The mean increase in BMD was $1.08\% \pm 2.0$ and $9.16\% \pm 4.0$ at the hip by the first and second year, respectively. The mean increase in BMD was $2.60\% \pm 1.0$ and $3.56\% \pm 2.0$ at the spine by the first and second year respectively. (table 1) As expected, the mean serum testosterone levels rose by 180 % (410 ng/ml to 730 ng/ml). Mean estradiol levels decreased by 40% (88 pg/ml to 53 pg/ml). The mean urinary N-telopeptide was 30.0 ± 10 and was unchanged during the two year study in these 11 subjects. These results suggest that testosterone therapy in the FTM transsexual may increase BMD at both the hip and spine. The increases in BMD occur in spite of decreased serum estradiol concentrations. The potential beneficial effects of testosterone on BMD are either a direct effect of testosterone or indirect via aromatization to estrogen. The completion of our study and further analysis the data will provide insight to the effects of testosterone treatment on the skeleton.

Table 1: Mean bone density changes in study patients receiving testosterone

	1 year	2 years
HIP	$1.08\% \pm 2.0$	$9.16\% \pm 4.0$
SPINE	$2.60\% \pm 1.0$	$3.56\% \pm 2.0$

*BMD measurements performed by a Norland Eclipse Densitometer

Table 1. Scores for hair removal after several treatments

VAS score for hair removal

	<u>lip/chin</u>	<u>cheeks, neck</u>
<u>GroupI (n=91)</u>		
visit 4-5	3.59	3.91

GroupII (n=36)

visit 4-5	3.31	3.69
visit 8-10	4.19	4.65

- VAS score:**
- 1: many terminal hairs present
 - 2: slightly diminished hair growth
 - 3: moderate reduction
 - 4: considerable reduction
 - 5: scattered terminal hairs remain

Jalma Jurado Brazil

Male to Female transsexual surgery based on a neurovascular island flap of penile skin.

To lining the new-vagina cavity all the skin tissues needed elasticity, hair free and size to give normal sexual intercourse. We use the inverted penile skin flap; with a narrow strip of the dorsal albugínea carry on the neurovascular bundles (artery, vein and dorsal nervous of the penis). We remove the corpora spongiosum and the gland remains into the vagina bottom (like de uterus cervix). In this way the procedure allows in the post-operative phase normal sensibility in the skin vagina and gland, increasing de orgasms possibility. Recently, we add two strips of the albugínea (like the round ligaments) passing under the pubis bone in order to maintain the gland in deep position and prevent skin herniation. The vulvae is reconstructed with the scrotum skin flap, including the superior vagina commissura, and sitting the new urinary meatus in normal position. We use the exceeding dorsal urethral, like a narrow flap to building the clitoris. In more than 200 patients, with only two hospitalization days, the functional and aesthetic results were pleasant, and we need some minor aesthetical revision in 30% of the patients.

C. Trombetta Italy

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Surgical Therapy In Transsexual Patients: A Multi-Disciplinary Approach

INTRODUCTION: Although urological treatment of male transsexual is becoming more common, few follow-up studies have been reported in Literature.

MATERIAL & METHODS: Between December 1994 and February 2003, 81 male transsexuals underwent male-to-female SRS. All patients had been cross-dressing, living as women and receiving estrogens and progesterone for a long time. Patients were at least 21 years old (mean age 31, range 21- 59). Before surgery each of them underwent a complete psychosexual evaluation. Hormonal therapy was discontinued one month before the intervention. Procedure includes bilateral orchiectomy and penectomy and consists of the creation of the urethostomy, neovagina (vaginoplasty), labial structures and sensate neoclitoris. To create the neovagina, inverted penile skin vaginoplasty has been used in the first 9 patients, in the other cases penile and scrotal skin inversion technique has been adopted. An inflatable silicon vaginal tutor was introduced in the vaginal cavity and was maintained all day long for 30 days and during the night for three months. Time of the procedure was 4 ½ hours. Patients were discharged home on the 9th postoperative day (range 8-11).

RESULTS: Mean follow-up is 32 months (range 4-72). 2 patients showed partial necrosis of the scrotal flap; in another one there was a minimal bleeding from the neoclitoris that was treated surgically. In the long term, neomeatus stricture occurred in 6 patients and was treated with meatotomy. 2 patient developed stenosis of the neovagina, one after 3 years and the other after 1 year. Hematoma of the labia majora of the neovagina occurred in 1 case that resolved spontaneously. One patient developed a right leg muscular contusion (due to the prolonged jackknife position during operation), which required fasciotomy of the peroneorum communis fascia. 17 patients have been evaluated by a questionnaire after 12 months: physical and functional results of surgery were judged to be excellent and patients were satisfied with the quality of the functional genitalia as well as cosmetic result. 95% of patients had orgasm. Pallesthetic sensation of genitalia has been evaluated by means of biothesiometry: all patients had a good sensation to vibration that was similar to the corresponding areas before the intervention.

CONCLUSIONS: In order to avoid stenosis of the neovagina it is very important to use the vaginal tutor regularly after the intervention. Using the scrotal flap technique, a much deeper and wider neovagina can be created. The neoclitoris lead to wide functional sensation. It is extremely important to shorten the urethra as much as possible to avoid painful swelling during intercourse and to spatulate the neomeatus in order to prevent strictures.

Sava V. Perovic Serbia

Co-authors: M.L. Djordjevic, Dusan Stanojevic & Milan Milenkovic (Serbia)

Clitoroplasty In Intersex Repair Using Disassembly Technique

OBJECTIVES: We present clitoroplasty in 23 years old male intersex patient. Ambiguous genitalia involve enlarged clitoris i.e. penis, urogenital sinus with hypospadiac meatus and testis located in right hemiscrotum. Left testis is nonpalpable.

Method: Surgery is started with laparoscopy. Left testis is revealed in abdominal position and removed. Mullerian remnants were completely absent. Right testis is removed through the scrotal incision. Degloving of the penis is made. Urethral plate remains intact. Fundiform and suspensory ligaments are released. Erection induced by Prostaglandin E1 demonstrates true size of the penis with marked ventral curvature. Penile disassembly includes dissection of urethral plate, glans and neurovascular bundle of corpora cavernosa. Urethral plate with its spongiosal tissue is lifted together with Bucks fascia. Dissection is continued toward glans cap. Neurovascular bundle is dissected under Bucks fascia in order to preserve all its structures. It enables excellent vascularization and sensitivity of glans cap that is neoclitoris. Glans cap is separated from the tips of the corpora cavernosa. Special attention should be paid to avoid injury of the arteries that run lateroventrally. Completely free erect corporal bodies have eagle appearance. Crura of the corpora cavernosa are released from the attachments to the bone. Remaining erectile tissue is destroyed using cautery in order to completely prevent erection. Clitoris with neurovascular bundle is fixed. Labia minora are created from the remaining penile body skin and fixed to the clitoris. Reduction of the clitoris, which can reduce blood supply, resulting in ischemic atrophy and loss of sensation is avoided. Urethral plate, which is in continuity with clitoris, provides better vulvar sensitivity and esthetic appearance. Female hypospadias in the urogenital sinus is of mild degree and lengthening of the urethra was not necessary.

Results: Three months after surgery good esthetic result is achieved. Well-vascularized clitoris is hooded with excellent sensitivity.

Conclusion: Complete disassembly technique is feasible and very useful for clitoroplasty. This approach leaves the dorsal neurovascular bundle untouched and completely preserves the glans cap and urethral plate blood supply and sensation.

Eugene Schrang USA

Male to Female SRS — The Ideal Final Result

The ideal final result of Male to Female SRS must be genitalia which display:

- A. A vulva that looks authentic and realistic with the “Golden triad” of:
 - Highly visible, pink wet mucosa
 - Well formed Clitoris
 - Nicely shaped, full Labia Minora
- B. A centrally located, wide open Urethral orifice with smooth edges for comfortable urination.
- C. Adequate neovaginal depth for trouble free, effortless sexual intercourse,
- D. Orgasmic capability

Absence of any of the above compromises a satisfactory surgical outcome.

Examples showing the degree to which Male to Female SRS has developed at this point in time will be shown along with comparison photographs of poorly crafted Genitalia where important structures were not present.

E.B.H. van Onselen The Netherlands

New refinements and modifications of vaginoplasty in male-to-female transsexuals: the last experiences in Amsterdam

Primary genital reassignment surgery was performed in more than a 100 male-to-female transsexuals in the VU Medical Centre during the last three years.

Our basic technique of the neovaginoplasty is by inversion of penile and scrotal skin combined with a sensate pedicled neoclitoroplasty. Although the basic surgical technique of the vaginoplasty in male-to-female transsexuals in our hospital remained the same, we would like to report the last refinements and modifications in our pre-, intra, and postoperative measures.

We will present our series of male-to-female transsexuals who underwent primary genital reassignment surgery during the last three years.

P J Thomas United Kingdom

Co-authors: J Bellringer & M Royle (United Kingdom)

Functional outcome of Neo-clitoris in male to female gender re-assignment surgery

Introduction

Preservation of tissue from the glans penis with its neuro vascular supply from the dorsal aspect of the penis has allowed creation of a neo-clitoris following male to female gender re-assignment surgery. Reports of the outcome of the procedure are limited.

Methods and Patients

A cohort of patients undergoing male to female gender re-assignment between January and December 2001 were offered and accepted creation of a neo-clitoris using a standard technique during gender re-assignment with the peno-scotal inlay vaginoplasty. The functional results of the surgery related to the neo-clitoris were assessed using a postal questionnaire.

Results

80 patients were sent a questionnaire and replies have been received from 44 (55%)

31/44 (70%) were pleased or extremely pleased with the results of the clitoral surgery.
13/44 (30%) were dissatisfied because of reduced sensation or oversensitivity.

26 described that they were able to achieve an orgasm.

Changes in sensation over time following surgery were experienced by a small number.
Few patients reported changes in size of the clitoris over time.

Conclusions

Creation of a neo-clitoris at the time of surgery produces satisfactory results with the majority of patients expressing high satisfaction rates.

Some patients have unpleasant sensation and should be warned of this pre-operatively.

M.L.J. Djordjevic Serbia

Co-authors: S.V. Perovic, D. Stanojevic and M. Milenkovic (Serbia)

Complex Repair in Failed Male Transsexual Surgery

Introduction: We present redo surgery in 28 years old patient previously underwent male to female surgery. She complained of voiding disturbances, painful erection of corporeal bodies remnants and impossible sexual intercourse. Distorted external genitalia with absent labia minora and majora, clitoris and vagina except it's introitus were noted. A bulging originating from corporeal bodies remnants and bulbar urethra was seen. Urethral meatus was abnormally highly located and passable for only 10 Fr catheter. Our repair includes: repair of urethral stenosis and removal of corporeal bodies remnants as well as creation of female urethra, rectosigmoid vagina and vulva.

Method: Former penile urethra including its bulbar part and stenotic meatus is completely mobilized. Prostaglandin E1 is injected into the remnants of corpora cavernosa to induce their erection, demonstrate their true size as well as facilitate their dissection. Both cavernous bodies remnant are released from adhesions and ligamentous attachments to the bone and removed. These remnants were making painful erection and were closing vaginal introitus during sexual arousal. Remaining erectile tissue is destroyed using large cavernosal dilators and cautery in order to completely prevent erection. Tunica albuginea is sewn with 2-0 absorbable sutures.

Abdomen is approached through Pfannensteil incision and rectosigmoid segment is harvested for creation a new vagina. Stapled sigmorectostomy is used to re-establish bowel continuity. Isolated bowel segment is only 8 cm in length. This size prevents possible complications concerning utilization of bowel as a vaginal substitute. The neovagina is pulled down through the very wide perineal channel previously created by blunt dissection between rectum, bladder and posterior urethra. Anastomosis between neovagina and skin of vaginal introitus is made deeply in the perineum avoiding vaginal prolapse.

Mobilized urethra is incised dorsally including it's bulbar part. This way, urethral flap is created and sutured to the vaginal introitus and to the surrounding skin. Normal epithelial transition between urethral opening and vaginal introitus is established. Drain is placed in the perivaginal space. Condom filled with soft material is placed into new vagina.

Conclusion: Complex repair of failed male transsexual surgery which includes removal of corporeal bodies remnants, urethroplasty, rectosigmoid vaginoplasty and vulvoplasty requires great experience in male and female genitourinary reconstructive surgery for a successful outcome.

Elizabeth Anne Riley Australia

Counseling Clients With Gender Dysphoria: An Ethical Approach

Using clinical examples, Elizabeth emphasizes the discrepancies between much-loved traditional approaches to counselling and how they are sometimes not appropriate within the transgender community. In particular how this innovative approach evolved over time as her taught beliefs were shed. Elizabeth illustrates how the dilemmas a counsellor face feeds the process of reorientation toward a more appropriate system in support of the client. Elizabeth identifies what she regards as the extra responsibilities and duties a counsellor has in supporting this unique population.

Sex-reassignment Surgery: Historical Review

“On the shoulders of giants, we dwarfs can see a further horizon.”

This can only be true provided we know the giants, and all knowledge that they gathered for (and before) us. Knowledge of the relevant literature ought to be the base of any attempt to perform a surgical procedure. Such knowledge may prevent us from making mistakes that have already been made by others before us.

Moreover, it protects us from the embarrassment of re-inventing the wheel. For, if you search deep enough, far enough, and long enough, you may find that someone has done it before you (Pennisi, PRS 1983). Such a search may bring us to the true originator of ideas and techniques. The latter is not merely a matter of establishing the true ‘priority’ of the originator but, more important, allows us to track possible other innovative ideas of that particular giant.

The history of sex reassignment surgery, both male-to-female and female-to-male, has been extensively reviewed and illustrated and should no longer hold any surprises for any surgeon with genuine interest in this part of our work. If it does, he should question his self-complacency.

Stan Monstrey Belgium

Phalloplasty: Is It a Worthwhile Operation?

The surgeon's ideal goals in performing a phalloplasty in female to male transsexuals have repeatedly been described and include all of the following:

1. a one stage surgical procedure
2. with minimal morbidity
3. providing an aesthetically pleasing phallus
4. with erogenous and tactile sensation
5. with a full bifide scrotum
6. permitting the patient to void standing up
7. allowing sexual intercourse

It is universally agreed that these ideal goals have not been met yet but in this presentation a review will be given on the more than 10 year experience with over 120 phalloplasty procedures for female to male transsexuals.

For each of these ideal goals a critical analysis will be performed on where we stand right now with emphasis on improvements that have been made but also on shortcomings that still need to be addressed.

It is concluded that, despite some residual disadvantages, a free flap phalloplasty has become an almost routine intervention in many centers nowadays with an acceptable complication rate.

Surgery should continue to expand the boundaries of technical expertise in order to further improve the functional and the aesthetic outcome.

Preecha Tiewtranon Thailand

Vaginoplasty in Male Transexual (Bangkok Experience)

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Vaginoplasty is now accepted as standard treatment for Male-to-Female- Gender-Dysphorea patients who failed medical and psychological management to transform their mind to their sex.

The standard technique of these procedure can be divided as 6 steps.

1. Creation the neovaginal cavity with appropriate depth and width, also the good lining to prevent contraction and stenosis.
2. Orchidectomy and Penectomy.
3. Urethral reconstruction.
4. Reconstruction of labia major
5. Labia minor reconstruction
6. Clitoral reconstruction

We would like to share our experience in Vaginoplasty which we have performed more than 2,500 cases since 1980 in all these steps as well as the complications that may occur.

Felix de Jong The Netherlands

Surgical Raise of Vocal Pitch in Male to Female Transsexuals

Vocal pitch is determined by the mass, length, and tension of the vocal folds and aerodynamic processes like subglottal pressure. These parameters may be influenced by surgical procedures or voice therapy. At present, crico-thyroid (C-T) approximation, as described by Isshiki (Isshiki, 1983), is the most successful and common surgical procedure in order to increase vocal pitch. The technique of C-T approximation is based upon laryngeal biomechanics, in this case the function of the crico-thyroid muscle (Fink, 1978; Vilkmán, 1987). A horizontal skin incision is made and the platysma muscle and superficial cervical fascia are cut. The strap muscles are pulled laterally, rather than being cut. The inferior rim of the thyroid cartilage is made free. Four double armed mattress sutures are stitched through the cricoid and thyroid cartilage. As all thyroplastic surgery, C-T approximation is carried out under local anaesthesia in order to make proper correction and fine-tuning of the voice possible. A small over-correction of about 2 semitones should be made because the sutures tend to slacken postoperatively.

Complications are rare but may consist of haematoma, infection, tearing and fracture of the cartilage, under and over correction, and entering of the airway. C-T approximation was evaluated in 30 consecutive male to female transsexuals (de Jong, 1997). Before C-T approximation was performed, all patients underwent voice treatment. It should be noted that not only the pitch of the voice gives the impression that the voice belongs to a male or female person. Intonation, articulation, and resonance contribute also to the "gender type" of the voice. Furthermore, non-verbal factors like gesticulations and the general appearance contribute to the impression to which gender the person belongs. Therefore, voice treatment in gender dysphonia should imply more than working on pitch.

Laryngostroboscopy, phonetography, magnetic tape recording and extensive examination were used in pre- and postoperative evaluation of the voice. Four patients did not appear for adequate follow-up. Subjective satisfaction was achieved in 22 cases, whereas 4 patients were dissatisfied with the result. In 4 patients the rate of subjective satisfaction could not be obtained. The mean preoperative habitual speech frequency of 122 Hz raised significantly to 181 Hz by the procedure ($p \leq 0.05$). The intensity range at the mean phonation frequency of speech was unaltered after the operation ($p \leq 0.05$). The postoperative voice showed a significant decrease of the melodic range, with an increase of the minimum frequency and a decrease of the maximum frequency ($p \leq 0.05$). The maximum voice intensity was not decreased by the procedure ($p \leq 0.05$). Dysphonia did not occur in any patient. The results of this study indicate that C-T approximation is an appropriate thyroplastic procedure to raise the pitch of the conversation voice, without the risk of dysphonia. Postoperative speech and voice therapy is advisable in order to improve pitch variation and extension of the melodic range.

Terry Reed United Kingdom

Definition and Synopsis of the Etiology of Adult Gender Identity Disorder and Transsexualism

1. Gender Identity Disorder is defined as an incongruence between the physical phenotype and the gender identity^[1], that is, the self identification as male or female. The experience of this incongruence is termed Gender Dysphoria. The most extreme form, in which individuals need to adapt their phenotype with hormones and surgery to make it congruent with their gender identity, is called transsexualism^[2]. Those individuals experiencing this condition are referred to as trans people, that is, trans men (female to male) and trans women (male to female).

2. Transsexualism can be considered to be a neuro-developmental condition of the brain. Several sexually dimorphic nuclei have been found in the hypothalamic area of the brain (Allen & Gorski, 1990; Swaab *et al.*, 2001). Of particular interest is the sexually dimorphic limbic nucleus called the central subdivision of the bed nucleus of the stria terminalis (BSTc) which appears to become fully volumetrically sexually differentiated in the human brain by early adulthood. This nucleus has also been found to be sexually dimorphic in other mammalian and avian species (Miller & Vician, 1989; Grossmann & Jurkevich, 2002). In human males the volume of this nucleus is almost twice as large as in females and its number of neurons is almost double ($P < 0.006$) (Zhou *et al.*, 1995; Kruijver *et al.*, 2000; Chung *et al.*, 2002).

3. The Kruijver *et al.* study, cited above, indicates that in the case of transsexualism this nucleus has a sex-reversed structure. This means that in the case of trans women ($n=7$), the size of this nucleus and its neuron count was found to be in the same range as that of the female controls ($n=13$) and, therefore, women in the general population. In the only available brain of a trans man, the volume and structure of this nucleus was found to be in the range of the male controls ($n=21$) and, therefore, men in the general population. It is hypothesised that this male-like BSTc will be present in other trans men as well. These findings were independent of sexual orientation and of the use of exogenous sex hormones. In the 42 human brains collected for this study, the BSTc was found to have a structure concordant with the psychological identification as male or female. It is inferred that the BSTc is an important part of a sexually dimorphic neural circuit, and that it is involved in the development of gender identity (Kruijver *et al.*, 2000).

4. Sexual differentiation of the mammalian brain starts during fetal development and continues after birth (Kawata, 1995; Swaab *et al.*, 2001). It is hypothesised that in humans, in common with all other mammals studied, hormones significantly influence this dimorphic development although, at present, the exact mechanism is incompletely understood. It is also postulated that these hormonal effects occur at several critical periods of development of the sexual differentiation of the brain during which gender identity is established, initially during the fetal period, then around the time of birth; and also post-natally. Factors which may contribute to an altered hormone environment in the brain at the critical moments in its early development might include genetic influences

(Landen, 1999; Coolidge *et al.*, 2002) and/or medication, environmental influences (Diamond *et al.*, 1996; Whitten *et al.*, 2002), stress or trauma to the mother during pregnancy (Ward *et al.*, 2002; Swaab *et al.*, 2002).

5. Gender identity usually continues along lines which are consistent with the individual's phenotype, however, a very small number of children experience their gender identity as being incongruent with their phenotype. Adult outcomes in such cases are varied and cannot be predicted with certainty. It is only in a minority of these children that, regardless of phenotypical socialisation and nurture, this incongruence will persist into adulthood and manifest as transsexualism (Green, 1987; Ekins, 1997; Prosser, 1998; Di Ceglie, 2000; Ekins & King, 2001; Bates, 2002).

6. As stated, in trans people, a sex-reversed BSTc has been found. The findings of a specific sex-reversed brain organisation in trans people provides evidence consistent with the concept of a biological element in the etiology of transsexualism. The evidence for an innate biological predisposition is supported by other studies, one example of which, indicates a higher than average correlation with left-handedness (Green & Young, 2001). Where the predisposition for transsexualism exists, psycho-social and other factors may subsequently play a role in the outcome, however, there is no evidence that nurturing and socialisation in contradiction to the phenotype can cause transsexualism, nor that nurture which is entirely consistent with the phenotype can prevent it (Diamond, 1996). There is further clear evidence from the histories of conditions involving anomalies of genitalia, that gender identity may resolve independently of genital appearance, even when that appearance and the assigned identity are enhanced by medical and social interventions (Imperato-McGinley, 1979; Rosler & Kohn, 1983; Diamond, 1997; Diamond and Sigmundson, 1997; Kipnis & Diamond, 1998; Reiner, 1999; Reiner, 2000). It is not possible to identify one single cause for transsexualism: rather, its causality is highly complex and multifactorial. The condition requires a careful diagnostic process, based largely on self-assessment, facilitated by a specialist professional.

7. In conclusion, transsexualism is a neuro-developmental condition of the brain. (Zhou *et al.*, 1995; Kruijver *et al.*, 2000).^[3] The condition cannot be overcome by contrary socialisation, nor by psychological or psychiatric treatments alone (Green, 1999). Individuals may benefit from an approach that includes a programme of hormones and corrective surgery to achieve realignment of the phenotype with the gender identity, accompanied by well-integrated psychosocial interventions to support the individual and to assist in the adaptation to the appropriate social role. Treatments may vary, and should be commensurate with each individual's particular needs and circumstances.

[1] The term 'gender identity' is used, in the UK, to indicate the self-identification as male or female. However, terminology varies around the world, and the term 'sexual identity' is preferred by many in the US. (pace Professor Milton Diamond). See "Sex and Gender are different: Sexual Identity & Gender Identity are Different", (2000) Clinical Psychology & Psychiatry, Vol 7 (3):320-334.

[2] *The transsexual condition is also referred to in various ways (Diamond M, 2002 In Press) "What's In a Name? Some terms used in the discussion of Sex and Gender". Transgender Tapestry.*

[3] *The UK government recognises that transsexualism is not a mental illness. See Lord Chancellor's Department – government policy concerning transsexual people.*
www.lcd.gov.uk/constitution/transsex/policy.htm

Milton Diamond USA
Co-author: Skyler T. Hawk

Concordance for Gender Identity Among Monozygotic and Dizygotic Twin Pairs

The relative contributions of genetic and environmental factors to the development of gender identity are still being debated. We studied twins that are concordant and discordant for gender identity status in order to provide clarification of this issue. An extensive literature search yielded 14 studies of monozygotic twin pairs. These reports listed 9 male and 6 female sets who were discordant or concordant for transsexuality. In addition, Internet bulletin board and clinical contact requests for participants in a survey of twins in which one or both transitioned located 16 new pairs of twins: 6 monozygotic male pairs, 2 monozygotic female pairs, 4 dizygotic male pairs, 3 dizygotic female pairs, and 1 male/female pair. From the literature, 9 of 15 (60%) monozygotic pairs were found to be concordant for transsexual gender identity; 7 of 9 (78%) male pairs and 2 of 6 (33%) female pairs. In contrast, from our survey, only 2 male monozygotic pairs out of 8 male and female pairs (25%) were identified as concordant for gender identity. No dizygotic twin pairs were found to be concordant, nor were female twin pairs of any type identified as concordant. Combining data from the present survey with that of past research, 11 of 23 monozygotic twin pairs (48%) were found to be concordant for trans identity. These findings seem to support data from Coolidge, Thede, & Young (2002) that suggest a significant genetic contribution to the development of gender identity disorder.

Richard Ekins Northern Ireland

Internet Pornography, Virtual Identity and the 'Male Femaling' Gaze

The use of erotica by transgendered persons is a neglected area of research. This paper presents a qualitative examination of how three different transgendered informants interpret and derive pleasure from an Internet erotic site, Girl-a-matic.

The Girl-a-matic site creates a 'virtual identity' by featuring narratives of demasculinisation and feminisation of biologic males who retain their male genitalia, albeit in 'restrained' and non-functional form, accompanied by photographs of waif-like female models who are fantasised as representing these demasculinised/feminised males.

The male transvestite privileges the site's erotic gender display and disavows the 'ungendering' inherent in the restraint or negation of the fantasy characters' genitalia. By contrast, the male-to-female transsexual emphasizes and eroticises genital ungendering, primarily in the service of erotic transgender migration. The male sissy maid privileges the site's theme of genital ungendering in the service of a developing sissy asexuality.

These phenomena are considered in terms of two seminal works on the critical analysis of the media (Mulvey (1975) and Hall (1980)), as set within the models proposed by Ekins (1997) and Ekins and King (2001) for the sociological examination of contemporary transgender diversity.

Walter Bockting USA

Co-authors: Autumn Benner & Eli Coleman (USA)

Gay and Bisexual Identity Among Female-to-Male Transsexuals in North America: Emergence of a Transgender Sexuality

Background: Ten years ago, we reported on homosexual and bisexual identity among a small sample of Dutch female-to-male transsexuals. Since then, we have identified a larger number of gay or bisexual female-to-male transsexuals in North America, and examined their development of identity and sexuality.

Methods: Twenty-four female-to-male transsexuals who were 18 years or older, post-sex reassignment surgery, and attracted to men were recruited via an FTM community conference and listserv. They completed a paper-and-pencil questionnaire with open-ended questions, an assessment of sexual identity, and standardized measures of self esteem, sexual functioning, and psychological adjustment. A content analysis was performed on the qualitative data; quantitative data was analyzed using SPSS.

Results: Of our sample, 58% identified as gay, 33% as bisexual, and 8% as queer. All felt comfortable with their gender identity and sexual orientation. Disclosure of their transsexuality varied across settings: most were “out” among close friends and family but not within the gay community. However, disclosure as well as acceptance of their homosexuality among family and friends was limited. What emerged from examining participants’ sexual histories is that for some, sexual attractions and experiences served to affirm gender identity, whereas for others, self-acceptance of transgender identity facilitated actualization of attractions toward men.

Conclusion: The development of a gay and bisexual identity among female-to-male transsexuals in a number of ways mirrors the developmental process of nontransgender homosexual men and women. However, at the same time, participants described experiences unique to being both transgender and gay or bisexual. These unique experiences signal the emergence of a transgender sexuality.

Richard Docter USA

Co-author: James S. Fleming (USA)

Assessment of Transgender Identity and Role

Five self-descriptive scales were developed based on a series of factor analytic studies in biological males involving over one thousand transvestites and transsexuals. The present report is based upon 455 transvestites and 61 male-to-female transsexuals. A 70 item questionnaire was used. Most subjects were recruited from transgender support groups and they were significantly better of socioeconomically than a representative sample of the general population. The five scales were believed to measure: I. transgender identity, II. transgender role, III. sexual arousal, IV. androallure, , and V. pleasure. The number of items for each scale were: 26, 18, 11, 9 and 9. The term *androallure* refers to sexual, affectionate, or social encounters between a transgendered person and another male. The Means for transvestites and transsexuals differed significantly for each of the five scales. For the Identity scale, the overlap between transvestites and transsexuals was 6% for Role 19%, for Sexual Arousal 18% and for both Androllure and Pleasure it was 46%. These five scales are believed to assess core dimensions of transgendered ideation and behavior. The intercorrelations for the obliquely rotated factors ranged from $-.37$ to $.27$. The Means for age and the distribution of this variable were approximately the same for both groups. Despite the major differences between transsexuals and transvestites, their transgender cognition, identity, and behavior appear to be built upon differing combinations of the same set of variables. Transsexuals did not show any age effects for any of the five scales; transvestites did differ in age for Androallure and Pleasure. For transsexuals, 25% reported a female as their usual sex partner; for transvestites 6% reported males as their usual sex partner. One-third of both groups said their usual sex practice was without a partner; five percent of all subjects said they preferred this. The scales are believed to have practical application in clinical and research work.

Lee Emory USA

Co-authors: Collier M. Cole, Eric Avery, Olivia Meyer, Walter Meyer

Client's View of Gender Identity Life and Treatment Status and Outcome

Ninety-eight adults seen for transgendered issues at the Rosenberg Clinic or University of Texas Medical Branch (UTMB) in Galveston, TX completed a 63 item questionnaire concerning their current life and treatment status and outcome. Seventy individuals, age 47 ± 12 years (range 16 - 78), ethnicity 86% White, 1% Black, 9% Hispanic and 3% Native American, identified themselves as transitioning from anatomic male to female (MTF). They initially realized they were different at 7 ± 4 years; identified a gender issue at 15 ± 12 years; and began transitioning at 35 ± 11 years of age. They had 8 ± 7 years of treatment and received hormones for an average of 6 ± 5 years. The vast majority received no mental health treatment, but 38 % acknowledged prior problems with drugs or alcohol; 4% had a current drug problem. Twenty-five had undergone full sexual change surgery, and 17 had received some type of breast augmentation. The vast majority was at least moderately satisfied with their ultimate breast size. Fifty-four percent were sexually interested in females rather than males.

Twenty-eight adults, age 40 ± 9 years, ethnicity 86% White, 7% Hispanic 4% Asian and 4% Native American, identified themselves as transitioning anatomic female to male (FTM). They initially realized they were different at 7 ± 4 years, identified a gender issue at 12 ± 6 years old, and began transitioning at 29 ± 9 years of age. They had 9 ± 8 years of treatment. All received some mental health therapy and 50% acknowledged past drug or alcohol abuse; 7% had current abuse. Seventy-five % received hormones, usually injectable androgen, for an average of 10 ± 9 years; 50% had hysterectomy and breast reduction. Ninety percent are sexually interested in females.

For the group of 98 adults, with transition there was little change in employment status with a slightly positive income change. Forty % MTF and 16% FTM perceived some type of discrimination because of their gender status. Most had individuals with whom they could talk about their situation, and in most cases some family members had accepted the change. Over 40% considered themselves religious. Over 75% had begun to deal with end of life issues: 92% desiring to be buried under their new name and gender. Only 44% said that they were familiar with the Benjamin Society's Standards of Care, and of those, over 90% of them agreed with the treatment standards, except the real life experience which had only 83% agreement. In summary, this survey of 98 adults dealing with gender issues sheds light on current life styles and treatment outcomes, adding further our understanding and recognition of variations of the transgender phenomena.

Petra De Sutter Belgium

Co-authors: K. Kira, A. Verschoor & A. Hotimsky

The Wish for Children and the Preservation of Fertility in Transsexual Women: A Survey

Introduction: Transsexual women, who undergo feminising hormone treatment and/or gender reassignment surgery, are confronted with the loss of their fertility. This loss often is considered a psychological prerequisite for a successful transition into the female role. However, modern reproductive techniques easily allow sperm freezing and intrauterine insemination or in vitro fertilisation to obtain a child with a female partner. This would allow a transsexual woman to have a genetically own child within a future lesbian relationship. The purpose of the present survey was to raise this topic with a representative sample of the community of transsexual women themselves, and to try to analyse their opinions on this subject.

Materials and Methods: A semi-structured questionnaire containing demographic and personal history questions, as well as questions on the subject of sperm freezing, was disseminated on the Internet through mailing lists and support sites in The Netherlands, Belgium, France, and the United Kingdom. The answers to the questionnaire were initially submitted to a cluster analysis in order to detect relationships among the answers to the different questions. Then, the relationships between specific questions were analysed using contingency tables when appropriate.

Results: Answers were received from 121 individuals from 11 countries (48 English, 46 French and 27 Dutch speaking respondents). Seventy percent of all respondents were between 30 and 50 years of age. Half of them indicated that having their own genetic child would be an important matter to them. More than 90% of the respondents stated that loss of fertility was not (or had not been) an important reason to delay their transition. To the question whether sperm freezing should be offered to all transsexual women before hormonal treatment, 77% answered affirmatively. If sperm freezing would have been a possibility for them, 51% would have seriously thought about it or actually done it (especially the younger lesbian and bisexual group), whereas 45% would have refused (mostly older asexual and heterosexual women). Arguments not to store sperm were that this did not allow to completely split with their past as a male, or the psychological burden of masturbating to produce a sample. Only ¼ of the respondents would consider themselves “father” to the child rather than “mother”, and half of these would consider this thought to be unbearable. For most people, however, this would not matter or they would really be a “mother” to their child. Only a few respondents raised the problem of a possible hereditary risk of transmitting their transsexualism to the child, or the fact that they would not be good parents because of psychosocial conditions.

Conclusion: The majority of the respondents to the survey indicated that transsexual woman should at least be made aware of the possibility to store sperm before starting hormonal treatment. Half of all respondents would prefer their own sperm to be used if the wish for a child occurred in a possible future lesbian relationship. The results of this survey demonstrate that there is a significant part of pre-transition transsexual women

who would benefit from the possibility of freezing sperm. It is a free personal choice whether to cryopreserve gametes or not, but transsexual women ought to be counselled by their health care providers on this important matter.

Randi Ettner USA

Family and Systems Aggression Towards Therapists Treating Patients with Gender Dysphoria

Individuals who change gender presentation often witness havoc in their social systems. Family units may be disrupted, and some are catapulted into crisis. While many negative emotions may arise as a result of the disclosure that a spouse, child, sibling, or other family member is transgendered, the most toxic affect for the family constellation is shame.

The shame affect has the ability—unlike any other affect—to act as an attenuator system. Thus, the amalgamation of painful affect will cause aggression against self or other. It is known that therapists who work with transgendered patients have been subjected to a variety of forms of aggression toward themselves, personally, and toward their professional careers. This general risk to therapists is acknowledged in the introduction to each of the versions of the HBIGDA Standards of Care.

The purpose of this study is to ascertain through survey techniques the prevalence of various forms of aggression (verbal, physical, administrative, legal) towards therapists by family members and systems (e.g. employers, institutions) on the basis of their work with transgendered patients. We will also test the hypothesis that if one is non-accepting towards a transgendered family member, this will engender significant shame in family members or systems, resulting in one or more forms of aggression towards the therapist. We hypothesize that this aggression may be acted out against the therapist who may be blamed, threatened, sued, or actually assaulted by a spouse or other shamed family member of the patient. Alternatively, systems (universities, employers, institutions, hospital administrators, etc) may act out against therapists through systems aggression (threatening employment, curtailing professional autonomy, creating a harassing work environment in an effort to rid the system of the “offending” therapist).

To document the prevalence of various forms of aggression towards therapists and to test the above hypothesis, 200 questionnaires were sent to members of the HBIGDA organization in 2002. A 75% response rate was attained. Results of this survey, including the demographic data for the responders, and therapeutic implications of the results will be presented.

Norman Spack USA

From Genital Ambiguity/Intersex Disorders in Infancy to Gender Identity Disorder in Adolescents and Adults—A Pediatric Endocrinologist’s Perspective

Until recently, pediatric endocrinologists have followed a paradigm for sex assignment in cases of genital ambiguity. That paradigm has been challenged by recent notorious case reports and opposition from organizations of intersex persons. Follow-up studies on selected populations have cast doubt on the permanence of initial gender assignment and on the adult sexual adequacy of patients who experienced genital surgery in infancy. Unfortunately, we do not have the long-term outcome studies needed to help clinicians provide optimal guidance to parents and patients confronting these issues. The recently implemented Health Information Portability and Accountability Act (HIPAA) will seriously limit the ability for such studies to be conducted in the USA.

The presenter will share his unique perspective as a pediatric endocrinologist who also provides hormonal replacement therapy for adolescent and adult patients with Gender Identity Disorders. His work with transsexuals suggests that no single model—neither genetic, gonadal, biochemical, phenotypic, or sex of rearing—can predict a patient’s gender identity. He recommends that pediatric endocrinologists and urologists incorporate the experiences and perspectives of transsexuals in their training programs.

A. Becerra Spain

Co-authors: J.L. Llopis, M.J. Lucio E. Sarmentero, L.Enríquez, J.E. Campillo, & Gender Dysphoria Work Group of Spanish Society of Endocrinology and Nutrition (Spain)

Gender Dysphoria in Spain: Ten Years Experience in 278 Cases

In recent decades, the demand for sex reassignment in transsexual people has increased as have the number and variety of possible psychologic, hormonal and surgical treatments. In Spain this care is not accepted in public hospitals and so endocrinologists and other health professionals have not sufficient experience about this condition, and the transsexuals have to make use of self-therapy and private hospitals. We analyse the experience of a multidisciplinary team: For 10 years (1994-2003) we have cared to 278 people with gender dysphoria (GD), 152 male-to-female transsexuals (M-to-F) and 126 female-to-male transsexuals (F-to-M), aged 18-58 years, and a mean of 33 years; with different study levels (23% primary, 41% mean and 36% advanced). All was evaluated by psychiatrist for diagnosis and psychological help in view of the physical changes produced. After clinical and biochemical evaluation, 4 was pushed back for the reassignment therapy due to organic disorders. The rest was selected to steroid hormone therapy, checking each 6 months. During the monitoring the side effects of therapy in M-to-F was: Hyperprolactinemia (65%), alterations of liver enzymes (8%), and no case with thrombophlebitis. And the side effects of therapy in F-to-M was: Alterations of liver enzymes (24%) and hyperprolactinemia (13%). After two years with the hormone treatment 58 was operated with sex reassignment surgery and without serious organic side effects, but with diverse rates of sexual dissatisfaction in 5 cases. In conclusion, the GD are more and more frequent, and thus, in order to avoid and prevent the side effects of self-therapy, it must be assumed by the Spanish health public service and it must be created specific multidisciplinary units.

A. Becerra Spain

Co-authors: J.L. Llopis, E. Sarmentero, R. Abenzoza, M.J. Lucio (Spain)

Changes on Fat Body Distribution After Cross-Gender Hormone Therapy in Transsexuals

Regional fat distribution and other anthropometric measurements differ between men and women, and it has been suggested that this is an important correlate of sex differences in cardiovascular risk. These parameters are regarded as secondary sex characteristics, and thus sex steroid hormones are important determinants. In order to study the influence of therapy with sex steroid hormones on fat body distribution in transsexuals we prospectively studied 31 male-to-female transsexuals [M-to-F] (age 29.9±7.9 years) treated with ethinyloestradiol (10 mg/mo.) and cyproterone acetate (100 mg/day), and 26 female-to-male transsexuals [F-to-M] (age 30.8±6.7 years) treated with testosterone cypionate (250 mg/15 days).

	M-to-F transsexuals (n=31)			F-to-M transsexuals (n=26)		
	Baseline	After 12 mo	P	Baseline	After 12 mo	P
BMI, kg/m²	23.6±1.7	25.9±2.3	0.001	25.8±2.7	27.5±1.9	0.005
STB, mm	6.2±1.7	8.9±1.9	0.028	8.8±6.3	6.6±2.0	0.022
STT, mm	10.1±4.2	15.1±5.3	0.019	15.7±12.1	11.8±9.3	0.029
STS, mm	12.2±5.1	17.5±6.8	0.025	14.4±8.9	12.4±5.8	0.033
%BF	15.3±6.7	19.1±7.9	0.002	28.6±15.2	23.9±7.2	0.011
WP, cm	76.6±3.2	83.5±4.2	0.025	80.0±2.1	78.2±5.3	0.044
HP, cm	92.3±6.9	98.2±3.9	0.007	98.8±8.7	94.2±6.5	0.015

Isabel Esteva Spain

Co-authors: T Bergero, F Giraldo, G Cano, J Lara, S Ruiz de Adana, G Rojo, E García Escobar, C Crespillo & R Nuñez. (Spain)

Evolution of the Gonadal Axis after Genital Plastic Surgery in Transsexual Patients

INTRODUCTION: Gonadal steroid therapy in transsexual persons should be suspended 10-15 days prior to genital plastic surgery to prevent perioperative thromboembolic complications and after surgery the dose of crossed hormones should be reduced. Medium- and long-term post-surgical data about the evolution of the gonadal axis in these persons is scarce.

METHODS and AIMS: A total of 335 persons with gender identity disorder have been attended by our unit since 1999, and more than 70 genital and non-genital operations have been undertaken. We present the post-surgery hormone therapy used and the evolution of the gonadal axis in the first 47 patients after their sex reassignment surgery; 39 male-to-female transsexuals (MF) and 8 female-to-male transsexuals (FM). Their ages ranged from 18-60 years (mean 26.5 years).

RESULTS:

1. Presurgical levels of gonadotropins were adequately suppressed.
2. Half of the MF and 6 of the 8 FM developed a pattern of primary hypogonadism more than 1 year after surgery, despite maintaining and even increasing doses of post-surgical replacement hormone therapy.
3. The mean post-surgical estrogen replacement doses in MF were as follows: equine estrogens: 1.8-2.4 mg/d, or estradiol valerate: 3-4 mg/d or transdermal estradiol: 100 mcg/3d. The mean doses of testosterone in FM were 250 mg/15 d IM or 5 mg/d patches.
4. The pattern of hypogonadism throughout follow-up (range 6-120 months) improved in 33% of the MF after 18-24 months, but it remained in all the FM.
5. 15% of the MF have stopped attending post-surgical follow-up and in another 20% there is a tendency to self-adjust hormone doses; this was not the case in any of the FM.
6. Reduced bone mineral density was observed in 40% during the pre-surgical phase (mainly in the MF).

CONCLUSIONS: Post-surgical hypogonadism is present in persons receiving sex reassignment surgery. It is necessary to individualize therapy, inform the patients of the consequences of stopping treatment and find preventive measures for complications arising during follow-up, especially post-surgical osteopenia.

MCM Bunck The Netherlands

Co-authors: AWFT Toorians & LJG Gooren (The Netherlands)

Risk Assessment of Breast Cancer in Male-to-Female Transsexuals

So far four cases of breast cancer in estrogen-treated male-to female transsexuals (M-F) have been reported in the literature. In our clinic hormone treatment of transsexuals started in 1975 and since then the population of M-Fs receiving estrogens has accrued to approximately 1500. Fortunately, no cases of breast cancer have been observed in our clinic. Breast cancer occurs in both women and men. Epidemiological findings show that the occurrence of breast cancer is related to age (in women the incidence levels off after age 60, while in men the incidence continues to increase) and to duration of estrogen exposure. Genetic factors (such as the BRCA2 mutation) may increase the risk considerably. In men conditions with low testosterone production are risk factors. Also diabetes and obesity, two conditions with lowered testosterone levels, have been identified as risks. So, there is reason for concern about breast cancer in M-Fs who have been long-term treated with estrogens. The existing strategies for early diagnosis of breast cancer (patient education with self-examination of breasts, periodical medical examination, and if necessary, sonography of the breast and needle aspirations) should be available for M-Fs.

MCM Bunck The Netherlands

Co-authors: AWFT Toorians & LJG Gooren (The Netherlands)

Type of Estrogens and Risk of Venous Thrombosis

Cross-sex hormonal treatment in male-to-female (M→F) transsexuals is accompanied by a significant number of events of venous thrombosis (VT). In our clinic, the incidence of VT is considerably higher in transsexuals treated with oral ethinylestradiol (oral-EE) than in transsexuals treated with transdermal 17- β -estradiol (td-E₂), both administered in combination with oral cyproterone acetate (CPA).

We have attempted to find a biological explanation for the different thrombotic risks and to differentiate whether the molecular structure of the estrogens: 17- β -estradiol (E₂) versus ethinylestradiol (EE), or the mode of administration i.e. oral, with a first pass effects of estrogens through the liver, or transdermal, contribute to the different thrombotic risks. We have compared the effect of treatment of M→F transsexuals with CPA-only and with CPA in combination with transdermal-E₂, oral-EE or oral-E₂ on a number of laboratory haemostatic variables which are clinically associated with an increased risk of VT: Treatment of M→F transsexuals with the combination oral-EE+CPA has a significantly more pronounced influence on haemostatic parameters than treatment with oral-E₂+CPA, td-E₂+CPA or CPA-only. This indicates that the prothrombotic effect of EE is due to its molecular structure rather than to a first pass liver effect. The pronounced effect of oral-EE+CPA on haemostatic parameters (decreased plasma levels of total and free protein S, increased prothrombin and particularly increased APC resistance) may explain why M→F transsexuals treated with oral-EE are exposed to a higher thrombotic risk than transsexuals treated with td-E₂ or oral-E₂. So, treatment with oral EE should no longer be advised.

In addition, we found an anti-thrombotic effect upon treatment of female-to-male (F→M) transsexuals with androgens.

Melanie Spritz USA

Effects of Cross Gender Hormonal Therapy on Prostates of 20 Male-to-Female Postoperative Patients

The author will present the results of cross gender hormonal therapy with on the prostates of postoperative MTF patients. Testing of the hypothesis in Urological literature that a reduced testosterone environment, in the face of an increased estrogen milieu will be tested at both the third and fifth year intervals. . Preliminary data using PSA, Testosterone – Total and Free levels, Estradiol and Estrone levels, Serum hormone binding globulin measurements through indirect measurement of the T3 radioactive uptake will be used.

Background: 20 patients were found in a retrospective study of their medical records done at years 3 and 5 of treatment. PSA levels were increased in 5/20 of the patients with demonstrable BPH in 4 of the patients, and one case of prostatic carcinoma. Since there is only one case of prostatic carcinoma in a postoperative MTF in the literature.

Measurement of prostate was done by PSA, PAP, DRE and intraoital physical measurement, along with levels of testosterone and estrogen in affected patients. Reasons for development of prostatic carcinoma will be explored

Discussion; A preliminary report of an ongoing retrospective study with cancer and its markers is presented. Preliminary evidence in the urological literature suggests that transsexual MTF's may be at increased risk for this disease due to lowered levels of testosterone and increased levels of estrogens. Literature explaining the risk to the patients will be handed out, and are eagerly waiting for patients to reach the decade long mark in this retrospective study.

MFC Kersten The Netherlands
Co-author: JW Mulder

How to Shape a Male Chest: Experiences and Literature Analysis on the Subcutaneous Mastectomy

The subcutaneous mastectomy is the surgical treatment of gynecomastia. Its goal is to create a male chest shape by removing excessive glandular tissue and skin. In the surgical treatment of female-to-male transsexuals, the subcutaneous mastectomy often is the first surgical procedure. At first, most of these patients are very pleased with the evident change of contour, but after some time they are often dissatisfied with the appearance of their chest. There are prominent scars and skin retractions, furthermore the shape of the chest does not always meet the specific male characteristics.

In order to improve our postoperative aesthetic results we made an inventory of recent literature on this subject. Our analysis reveals that there is no consensus on the surgical technique; instead we found four different techniques being used. These are the partial periareolar, circumareolar, transareolar incision with or without medial or lateral extension, and the inframammary, or infrapectoral incision with nipple transposition. Evaluation of the results only took place a short time postoperative; no evaluation was performed after a longer period postoperative. We also found that the postoperative results were solely judged subjectively; no objective evaluation took place. Objective criteria are known in literature as the anthropometric relations of the male chest, but tend to be ignored when performing this operation.

With our analysis and experience in mind we believe that the aesthetic postoperative results and patient satisfaction can be improved to a great extent with the following directives: Choose a surgical procedure by which the scars will be less prominent. We believe this can be achieved by placing the incisions on borders of anatomical structures, e.g. around the nipple and infrapectoral fold. Leave a sufficient layer of subcutaneous tissue behind to prevent skin retractions. And finally, consider the anthropometrical relations of the male chest with regard to this operation pre-, per- and postoperatively.

G. Selvaggi Belgium

Co-authors: S. Monstrey, P. Ceulemans, P. Hoebeke, K. Van Landuyt, P. Blondeel, M. Hamdi, G. De Cuyper & the Genderteam of UZ Gent (Belgium)

Subcutaneous Mastectomy in Female To Male (FTM) Transsexuals: A New Algorhytm.

In the FTM transsexuals, the first (and probably the most important) surgical procedure in their Gender Reassignment Surgery consists of the Subcutaneous Mastectomy (SCM). The goals of a SCM are: removal of the breast tissue, removal of the extra skin, create a normal male nipple-areola complex, eliminate the inframammary crease and leave a minimal amount of scar.

In the past 12 years we have performed 92 SCM in FTM transsexuals.

The technique used depended on: the breast volume, the excess of skin, the skin elasticity (very important), the size of the nipple and areola and its position.

To best meet the goals of creating a normal male thorax in these patients we have used the following algorhytm:

- 1° Semicircular technique (17.1% of patients): small breast volume and good skin elasticity;
- 2° Transareolar (4.9%): small breast volume and good skin elasticity, oversized nipple;
- 3° Concentric circular (39%): medium volume and elasticity with moderate excess of skin;
- 4° Extended concentric (19.5%): moderate to larger volume, with more excess of skin and/or poor elasticity;
- 5° Free nipple graft (19.5%): large volume and substantial excess of skin and/or no skin elasticity.

Complications can include: hematoma, nipple necrosis (partial or total), wound dehiscence, hypertrophic scar formation and residual contour deformity.

Our results clearly demonstrate that a good final outcome mainly depend on the right choice of the most appropriate technique for each patient; however, secondary corrections are often needed (42% of the cases): these should be considered as part of the SCM procedure and patients should be informed in advance.

Michael van Trotsenburg Austria

TLH and BSO (Total Laparoscopic Hysterectomy and Bilateral Salpingo-Oophorectomy) Should Become The Standard Technique For Female-To-Male Sex Reassignment Surgery

Introduction

Hysterectomy and salpingo-oophorectomy as well as bilateral mastectomy is a prerequisite for legalizing a woman's change to man. The laparoscopic approach to hysterectomy is a new mode of access to a traditional operation, not a new operation. As most FM's do not experience intercourse previously, and cross-sex hormonal treatment causes substantial atrophy of the vaginal lining the vaginal route should be abandoned.

Laparoscopic hysterectomy was first reported not earlier than 1989. After a number of complications in some of the initial series (learning curve) several randomized controlled recent studies, as well as own results, comparing laparoscopic and abdominal hysterectomy show clearly the advantages and safety of the laparoscopic access .

Since 1999 TLH is the method of choice for FM's requiring hysterectomy and BSO at our department. We present the results of 25 consecutive TLH for FM's SRS, and discuss the rationale for the laparoscopic approach.

Laparoscopic vs traditional (abdominal) access n=19 (11 vs 8)

(comparison of hysterectomies in non-transsexual patients 1999 – 2002)

duration	65 – 145' vs. 30 – 85' abdominally 120- 131' vs 65 – 77' vaginally
estimated blood loss (as estimated by the surgeon)	Ø 40 ml (25-200) vs Ø 130ml (80 – 600)
post-op pyrexia	↓↓
post-op pain	↓↓
hospitalization	3 - 6 vs. 7 – 10 days
post-op recovery (re-uptake of work)	14 – 21 vs 35 – 42 days

FM's characteristics

n=25

Weight	Ø 77.21 kg (range 59 – 95)
Age	Ø 27.1 a (range 19 – 36)
Parity	all nulliparous
Previous intercourse	2
Cross-sex hormone treatment	all > 1yr (withdrawn 2 - 4 weeks before surgery because of thromboembolic risk)

TLH results 1999 – 2002

n=25

Operative time (min)	Ø 95 (65 – 145)
Estimated blood loss (ml)	Ø 52 (25 – 200)
Hospital stay	Ø 5 (3 - 8)
Operative complications:	2 conversions to laparotomy :

- 1x endometriosis rAFS IV
 - 1x teratoma of the ovary too large for removal via vagina
- none

Postoperative complications

Rationale for laparoscopic approach in FM's

virgo / nulliparous

severe atrophy of vaginal epithelium, and/or shrinkage of the vagina due to cross-sex hormonal treatment.

avoiding vaginal manipulation and microtraumatization of the vaginal epithelium

avoiding large laparotomy skin incision,

Conclusions

- TLH was first reported 1989, but established very quickly as a safe procedure with faster recovery, lower blood loss, lower postoperative pain scores, better cosmesis, and shorter hospitalization stay compared to the abdominal route.
- FM's do not fit for vaginal access. Avoiding extensive vaginal manipulation and microtraumatization is likely to contribute to less morbidity in consecutive penoplasty
- Hysterectomies, either abdominally or vaginally, have a long history of almost 200 years. Indications for TLH as third technique are still under controversial debate, as notable reservations persist among gynaecologists regarding laparoscopic hysterectomy as access artistry. However, we conclude that female-to-male sex reassignment is a true indication for total laparoscopic hysterctomy (TLH) and BSO. The laparoscopic approach should be strongly recommended for FTM - SRS. Significant longer operative times do not outweigh the benefits of this procedure.

Christine McGinn USA

Rethinking Phalloplasty for the FTM: The Feasibility of “UTERO-CONVERSION”
Virtually all models of phalloplasty in the female to male (FTM) transsexual are based on techniques derived from the repair of traumatic amputation of the penis in genetic males or reconstruction following radical cancer surgery in genetic males. This paper re-thinks the problem by focusing on the FTM transsexual and the unique tissues he has to offer; specifically, the invivo use of the uterus, clitoris, vaginal wall and fallopian tubes to form the neophallus.

Sava V. Perovic Serbia

Co-authors: Miroslav L. Djordjevic, Dusan Stanojevic & Milan Milenkovic (Serbia)

Metoidioplasty: A Variant of Phalloplasty in Female Transsexuals

OBJECTIVE: Phallic reconstruction represents one of the most difficult problems in the female transsexuals. There are several techniques but none of them gives ideal results. Metoidioplasty presents a technique for creation of a neophallus from enlarged clitoris in female transsexuals without performing the complex, multistaged surgical construction of a large phallus.

PATIENTS AND METHODS: During the period from September 1995 to April 2003 technique was performed on 26 patients aged from 18 to 33 years. The technique is based on the repair of the most severe form of hypospadias and intersex repair. "Urethral plate" and urethra are completely dissected from clitoral corporeal bodies. Urethral plate is divided at the level of glandular corona and clitoris is straightened and lengthened. Longitudinal vascularized island flap is designed and harvested from the dorsal skin of the clitoris. Flap is transposed to the ventral side, tubularized and anastomosed with native urethra. New urethral meatus is brought to the top of the neophallus. Skin of the neophallus and scrotum is reconstructed using labia minora and majora flaps.

RESULTS: Follow up was from 6 months to 7 years (mean 4,4 years). The size of the neophallus ranged from 4 to 10 cm (mean 5,7cm). Satisfactory neophallus size was noted in 21 patients, while in remaining 5 patients additional phalloplasty was performed. Complications were: urethral stenosis in two and fistula in three patients.

CONCLUSIONS: Metoidioplasty presents an alternative to phalloplasty. It enables voiding in standing position. In patients who desire larger phallus various techniques of phalloplasty can be used.

Aleh V. Stasievich Belarus

Co-author: Vladimir N.Podgaiski (Belarus)

Thoracodorsal Flap for Phalloplastic

Experience of microsurgical autotransplantation of tissues has allowed to newly reconsidering both the problem of phalloplastic of men who lost penis as a result of injury or illness, and the problem of social adaptation of transsexuals in case of female-male transformation.

Since 1992 the Center of microsurgery has performed 21 total phallus plastic surgeries, among them 3 cases as a result of mechanical injury and burn, 1 person was operated for penis removal resulting from glans penis cancer, 16 phallus operations for transsexuals, 1 plastic surgery due to an anorchic reason.

Three methods of phallus plastic were used. On first stages (2 phallus operations) the base was the m.rectus abdominis that on a pedicle moved through the subcutaneous tunnel into the projection of neophallus, and then was covered by a free microsurgical radial flap. For other three patients phallus plastic was performed using the method of free transplantation of megacomplex brachium tissues with the inclusion of a spoke bone fragment and cutaneous brunches of n.radialis for further reinnervation.

Afterwards we began to apply the most popular method in plastic and reconstructive microsurgery, we used musculocutaneous flap on the basis of m.latissimus dorsi. The underlying reason for choosing this flap was the fact that besides the artery and the vein, the pedicle of the flap consists of thoracodorsal motor nerve. It innervates the m.latissimus dorsi and allows recovering the motor function of neophallus using the primary reinnervation of this function. The tension of the muscle base of neophallus affords an opportunity to imitate erection and to perform introjection. Besides, the flap allows forming the body of the penis of a sufficient size without any significant losses for the donor area, and performing immediate phalloplastic with the help of microsurgical outfit. The average size of the flap ranged from 15-18 cm to 12-15 depending on the constitution of the patient. The donor area was actually always covered primarily using rotational flaps.

Revascularisation of neophallus made of thoracodorsal flap was performed through anastomosis with femoral vessels using 8/0 thread, "end-to-side" type. For reinnervation the motor nerve of m.gracilis was used.

Out of 16 phalloplastics with the use of m.latissimus dorsi, there was only one case of necrosis of distal two thirds of neophallus as a result of brim tension and further pressure and necrosis. Later the patient went through the operation of a complex of brachium tissues.

The signs of the neophallus muscle reinnervation began to appear 3-4 months after the surgery, the motor activity increased, which indicated the recovery of the wholesome nueromotor structure of neophallus.

Thus the functional and aesthetic results of phalloplastic by the means of thoracodorsal flap allow to conclude that on a modern stage its use is most optimal not only in microsurgery of transsexualism in case of female-male transformation, but also for phalloplastic in case of penis loss.

Aldo Felici Italy

Co-authors: Giorgio Maggiulli, Giuliana Sciortino, Loredana Cavalieri & Marco Felici (Italy)

Technical Aspects of Phalloplasty with Suprapubic Flap: Personal Experience

The ideal phalloplasty would create a sensate neophallus with the proper dimensions and shape in one stage. With this neophallus the patient would be able to micturate while standing with good flow and no spraying. He would also have full erogenous sensibility and would be able to use the neophallus for sexual intercourse. Unfortunately, there is no single technique available today which can meet those requirements. Instead, we have found it necessary to follow multiple operative steps to achieve more modest results. These steps are outlined below:

Step	Timing	Procedure	Special Note
Step 1	Start	insert skin expanders + depilation of neourethral donor site	
Step 2	40 to 60 days later	hysterectomy + oophorectomy + phalloplasty + neourethroplasty	no urethral meatus anastomosis
Step 3	3 months later	neourethra to urethral meatus anastomosis	
Step 4	3 months later	Scrotoplasty + inflatable penile prosthesis insertion	

This multi-stage approach is modified from Pryor and uses flaps of pre-expanded suprapubic skin that are tubed. This allowed us to construct a urethra with a good calibre together with a neophallus of sufficient size to allow subsequent insertion of a penile prosthesis. Using a skin expander in the abdomen not only increased the area of skin available for neophallus construction but also prevented the frequent complication (e.g. delayed healing due to excessive tension and distal flap necrosis) through the 'delay phenomenon'. We report the results of our experience in using this approach in 50 consecutive cases.

C. Trombetta Italy

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One-Stage Sex Reassignment Surgery in Female-to-Male Transsexuals

Objectives: The ideal female-to-male sex reassignment surgery should be a one stage procedure, be cosmetically acceptable to both patient and partner, have a sufficient rigidity for vaginal penetration, have tactile sensitivity, have a minimal scarring in the donor area and construct a neourethra to permit voiding in standing position. Herein we present our recent experience with one stage sex reassignment surgery in female-to-male transsexuals where mastectomy and chest contouring are carried out with oophorectomy and hysterectomy at the same time as the pedicled pubic phalloplasty.

Methods: During the last two years 3 female-to-male transsexuals underwent one stage sex reassignment surgery in our Department. All patients had been cross-dressing, living as men and receiving testosterone for a long time. Before surgery each of them underwent a complete psychosexual evaluation. Hormonal therapy was discontinued one month before the intervention.

Two operative teams are necessary. While the first team performs subcutaneous adenomammectomy and mastopexy using the round-block technique, hysterophorectomy and phalloplasty are carried out by the second team. The phallus is fashioned from a flap of anterior abdominal wall skin, 10 cm in width and 11 cm in length measured from the base of the clitoris. Superficial inferior epigastric and external pudendal vessels are incorporated into the flap pedicle. Following mobilization of the flap any excess subcutaneous tissue is excised to give a better cosmetic fashion. Through the same incision hysterophorectomy can be easily performed. Hypogastric incision is laterally prolonged, and, after the umbelicus is incised and closed with separate stitches, abdominal skin and subcutaneous fat are widely dissected from the abdominal fascia. The donor area may be closed in a tension free manner. The flap is then tunnelled towards the abdomen through the base of the abdominal flap. The neourethra is not created because the patient does not wish to have the neourethra fashioned. The phallus is fashioned from the subcutaneous pubic flap. Total operative time is 6 hours.

Results: Patient has been discharged home on the 12 postoperative day. No postoperative complications occurred. Three years after the intervention cosmetic outcome is considered excellent by both surgeon and patients.

Discussion: Total one stage sex reassignment surgery for female-to-male transsexuals is feasible with acceptable cosmetical and functional results. Advantages consist of a significant reduction of postoperative morbidity, pain, scarring and convalescence. This report demonstrates the importance of a multidisciplinary approach to patients with gender dysphoria; at our University a team of psychologists, psychiatrists, endocrinologists, and plastic, urologic and gynecologic surgeons has been assembled to care for these patients.

Peter Ceulemans Belgium

Co-authors: M.Hamdi, K.Van Landuyt, Ph. Blondeel & S.Monstrey (Belgium)

A Novel Scrotal Plasty in Combination with the Radial Forearm Flap Phalloplasty

Introduction: Integration of transsexuals asks for genitals looking as natural as possible which includes the scrotum. As the labia majora are the embryologic counterpart of the scrotum, many techniques of scrotoplasties in female-to-male transsexuals uses this hair bearing skin. Older techniques consists of leaving the labia in situ with midline closure and prosthetic implant filling or bringing the scrotum in front of the legs using a V-Y plasty. These techniques are aesthetically unappealing and reminds of the female past.

Technical details: The novel scrotoplasty as we use it nowadays, combines a V-Y plasty with a 90 degree turning of the labial flaps. With this technique additional labial skin is transposed forward to enlarge an – anteriorly located – scrotum.

Results: In a study group of 81 female-to-male transsexuals, who underwent a one stage phalloplasty with urethroplasty, vaginectomy, hysterectomy and scrotoplasty, 30 patients had an in situ scrotoplasty, 30 patients had a V-Y plasty and 21 patients had the novel technique. The best aesthetic results where obtained in the last group with a substantially larger scrotum, being positioned well before the legs, having less complications of testis implantation and a better coverage of the urethra.

Conclusion: The excellent aesthetic results of the novel scrotoplasty in comparison with the former techniques and the functional benefit of lesser urological complications and easy testis implantation makes the novel scrotoplasty the technique of choice in female-to-male transsexuals. A further refinement of this technique in our department consists of the preservation of the clitoral hood for additional erogenous sensation.

Peter Ceulemans Belgium

Co-authors: M. Hamdi, K. Van Landuyt, Ph. Blondeel & S. Monstrey (Belgium)

A Secondary Scrotoplasty in Female-to-Male Transsexuals Using an Anterolateral Thigh Flap

Introduction: Older techniques of primary scrotoplasty in female-to-male transsexuals have often resulted in sub optimal results. Small sized scrotums with scarred labial skin are esthetically unappealing and difficult to adjust. The use of tissue expanders will only expand the unscarred inguinal skin resulting in an unnatural disfigured scrotal appearance. In these cases, only healthy tissue from a distant place can reconstruct a normal looking scrotum. We prefer the use of an anterolateral thigh flap because of the amount of tissue that can be transferred on a long and reliable pedicle and the possibility of primary closure of the donor site. The flap can be harvested as a thin sensate flap, sparing the underlying muscles, and be covered by the remaining labial skin.

Technical details: The flap is harvested as a fasciocutaneous island flap pedicled on a septocutaneous or musculocutaneous perforator of the descending branch of the lateral circumflex femoris artery system. The flap is transferred from under the quadriceps muscle to the inguinal region between the adductor muscles and the vastus medialis muscle. Finally the flap is tunneled to the scrotal defect and covered by the remaining scrotal skin. If transferred with the lateral femoral cutaneous nerve, the flap is sensate.

Result: The use of the anterolateral thigh fasciocutaneous flap will result in a large natural looking scrotum. Although the amount of labial skin is often scarce and the quality bad, it still remains possible to drape the frontal side of the flap giving the perfect color and texture of a scrotum. If the amount of labial skin is not enough to cover at least half of the scrotum, a sensate anterolateral thigh flap should be considered. Finally, the donor site can be closed primarily and morbidity is minimal.

Conclusion: The anterolateral thigh flap can provide a large cutaneous paddle with sensory innervation and is perfectly suitable for secondary scrotoplasties in female-to-male transsexuals.

Piet Hoebeke Belgium

Co-authors: Peter Ceulemans, Stan Monstrey & the gender team of Gent University (Belgium)

Dribbling Post Voiding in Phalloplasty: Can It Be Avoided?

Dribbling post voiding is a frequently observed problem after phalloplasty.

The neourethra is built of 2 parts: the perineal part, reconstructed from local perineal tissue (mostly mucosal tissue) and the distal part reconstructed from skin (in free flap phalloplasty). As there exists a major difference in compliance between these two tissues (high compliance in the perineum and low compliance in the phallic urethra), the perineal urethra dilates during voiding and urine gets trapped there. After voiding this urine starts to leak and gives the problems of post voiding dribbling.

Is it possible to avoid this problem?

Different measures can be taken to reduce the problem.

1. Instructions to the patients on how to empty the perineal urethra. Many patients have no insight into their new anatomy. The perineal urethra lies in the perineum behind the reconstructed scrotum. As surgeons we have to show the patients how to squeeze on this part of the urethra in order to empty it.
2. By creating a not too large urethra the problem can be reduced. We advise to create the perineal urethra tight around an 18 fr catheter. Furthermore the anastomosis between the perineal and the phallic urethra must be wide enough. When there is some stenosis at this level the urethra will further dilate in time and more urine will be trapped.
3. Reconstruction of the perineal muscles (bulbocavernous and ischiocavernous muscles) around the neourethra. This gives the possibility to the patient to empty his neourethra by contracting these superficial pelvic floor muscles (as is observed in biological males). This new technique has only been used in the last 5 patients. The results can only preliminary been evaluated in 3 patients and tend to be good.

In conclusion, some techniques are available in order to reduce the troublesome problem of postvoid dribbling. Reconstruction of the superficial pelvic floor muscles is a new and promising technique.

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Urinary changes after Gender Reassignment Surgery in Female to Male and Male to Female Transsexuals.

After Gender Reassignment Surgery (GRS), urinary changes are obviously present in all transsexual patients.

However, very few data is reported in literature about this specific subject.

We performed a long term follow up (1 – 12 years) of 55 transsexuals patients (31 MTF and 24 FTM) after GRS, providing them a questionnaire (for both MTF and FTM groups) and performing a urinary fluometry examination (for FTM group).

All the patients considered their miction changed just because of the different way to urinate after GRS (voiding while standing or while sitting).

In the *MTF group*, problematic changes were: occasional incontinence (urge, stress and mixed), simply loosing of drops of urine, slower voiding, more waiting time before starting to voiding and abnormal flow direction.

Rate of urinary infection, number of mictions per day and nicturia were also investigated.

In the *FTM group*, problematic changes were: loosing of drops of urine, pain, longer waiting time, higher number of mictions per day and abnormal low direction.

The most frequent and important urinary changes encountered in this group of patients at longterm follow up were not really pathological (e.g.loosing drops of urine in the FTM group), or are also regularly present in the normal female population (e.g. occasional incontinence and the higher rate of urinary infection as reported by the MTF group).

It is concluded that patients should be informed in advance that, after the completion of the GRS, urinary changes are quite always present and these may change the habits in their lives.

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New Law, New Ethics, New Practice?

After 33 years of campaigning by transsexual activists the UK government has drafted legislation to provide legal recognition, marriage and privacy rights to transsexual people. After only 3 years of campaigning Japan has also afforded legislation to provide some legal recognition. The 2 pieces of legislation are very different though, in that the UK's proposal could be said to be state of the art best practice, whereas the Japanese legislation is, I will argue, ill thought out and premised on concepts of transsexuality that are not only outdated, but which fail to recognise the reality of transsexual people's lives. I will evaluate what we have all learnt from the long campaign in the UK and why this difference has come about.

In both cases clinical practitioners will perform a gate-keeping role to the benefits of the legislation, a role that will undoubtedly face criticism from the transsexual community. In this paper I will further evaluate the role of the clinical practitioner in both examples and consider the ethical implications and possible dilemmas they might face as they take on a new role in the state, becoming the gender guardians of modern societies.

Alyson Dodi Meiselman USA

Reversal of Fortune (Or, Catching Up to the Past-The Transsexual Journey)

The case of Corbett (1970) set into motion a clouded legal mindset regarding transsexuals. After more than three decades later, two recent decisions, *In the Matter of R.W. Heilig* (Maryland, 2003), and, *In re Kevin* (Australia, 2003), effectively cleared that same mindset and set forth, with pellucidity, unfettered judicial logic, void of religious dogma and its associated bias.

This article will first present a brief synopsis of the major cases directly impacting transsexual individuals, including a brief tracing of some common law, Canon law, prior European civil law, and ancient biblical law. Next, we will discuss the social influences which lead to the English decision in Corbett, its American counter-part case of Ladrach, and those cases which "fed" on the pseudo-legal reasoning contained in cases since the 1970 decision. Finally, this article will present the reconstruction of legal analysis which lead to a group of cases bringing the law closer to a uniform, national and international, understanding of the complexity in legal decisions effecting transsexual persons.

Jillian Todd Weiss USA

The Creation of Institutional Inequality for Transsexuals and Transgenders via Medicalization and Legalization In Early 21st Century European Union and U.S. Transgender Policy

Medical intervention for transsexuals has as one of its main purposes the alleviation of suffering for people of variant gender, including advocacy in the public and private sectors for tolerance and understanding. Indeed, there is an increasing international drive towards creation of both public and private sector policies designed to prevent discrimination against transsexual people. These policies are broadly phrased and appear to be inclusive of people in various stages of medical intervention. Yet these policies are often interpreted so as to exclude protection for the most basic of necessities for transgender people who have not completed phalloplasty and vaginoplasty, such as bathrooms and dressing rooms. Such interpretations also deny legal protections such as identification and name changes to transgender people who have not obtained these surgical procedures. These problems more frequently and severely affect female to male transsexuals.

It is the thesis of this paper that transgender "equality" in early 21st century European Union and U.S. law is not "equality" as ordinarily understood in the context of such legal categories as race, religion and sexual orientation. Furthermore, the historical path of transsexuality (and later, transgender) separating sexual orientation and gender identity, tying gender identity to anatomical identity, and the achievement of greater tolerance through medicalization has created institutional inequality for transgender people, reinforcing old prejudices and newly legitimating and institutionalizing certain forms of discrimination. Lastly, this reinforcement of prejudices reinforces the perceived need for transsexuals to hide their stigma by erasing their identity, further inhibiting political legitimacy. This thesis will be demonstrated by means of ethnographic and legal data from the U.S. and European Union.

Richard Green United Kingdom

Legal and Illegal Discrimination Against Transsexuals

Legal discrimination against transsexuals occurs in vital life areas of healthcare, employment, civil sex reassignment, and family life. Illegal discrimination targets the transsexual with physical assault and death.

The United States and the United Kingdom are compared for whether or not legal discrimination is permitted. Legal discrimination impacts on the psyche. Specific laws will be discussed. Several nations are cited where physical violence and homicide against transsexuals impact on the body. Examples will be given.

The Harry Benjamin International Gender Dysphoria Association, with its 400 members from several countries, should be working vigorously to prevent both forms of discrimination.

Ken Zucker Canada

Measurement of Gender Role, Gender Identity, and Gender Dysphoria in People with Physical Intersex Conditions

Assessment of children, adolescents, and adults with physical intersex conditions often focuses on aspects of their psychosexual development, including gender identity, gender role, and sexual orientation. Such assessments are important with regard to the testing of theoretical models of intersexuality vis-a-vis psychosexual differentiation and with regard to clinical issues, including the person's relative content or discontent with sex- and gender-assignment decisions that have been made or need to be made.

In this presentation, I will review various measurement tools that have been developed, or are in the process of development, with regard to these parameters in childhood, adolescence, and adulthood. Consideration will be given to what is known about normative sex differences for these measurements, their use with clinical populations without known somatic intersexuality (e.g., gender dysphoria in both children and adults), and their use for various physical intersex conditions.

Gender dysphoria and gender change in 46, XX females with CAH

Congenital adrenal hyperplasia (CAH) is a monosomatic autosomal recessive disorder of steroidogenesis in which enzymatic defects result in impaired synthesis of cortisol by the adrenal cortex. 21-hydroxylase deficiency (21-OH) is the most common enzymatic defect causing CAH and occurs in classic form that can cause hypervirilization of the external genitalia in genetic females. The prevalence of 21-OH CAH is 1 in 15,000 live births worldwide. It is seen in equal frequencies in both genetic males and females. Patients remain dependent on hydrocortisone therapy.

46, XX CAH patients and born with ambiguous genitals are almost all assigned the female sex because they have female internal genitals, feminize normally in puberty and will be fertile in adulthood. Neonatal screening for 21-hydroxylase deficiency CAH can be routinely performed since 1997. This minimizes incorrect sex assignment and prevents postnatal virilization. In the past, CAH became apparent at birth or in the first year of life due to the ambiguity or progressive virilization of the genitals or due to illness as a consequence of salt loss. In cases of severe virilization (Prader stage 5) the diagnosis could be missed and the male sex could be assigned. The general policy has been to advise sex reassignment, based on the assumption that gender identity is not yet stable. In incidental cases -mostly in patients with the simple virilizing type and virilization of Prader stage 5- the diagnosis was detected at a much later age. For these patients there is no consensus about sex reassignment.

Studies on gender behavior in preschool and primary school CAH girls show that these girls are more masculine in their gender behavior compared to control girls. These girls often prefer boy's toys, boy's games and boys as playmates and are more likely to use aggression when provoked. The masculine behavior and preferences stretches out into adulthood. Correlations between masculine gender behavior, pre- and postnatal levels of androgens and degree of genital virilization have been found.

Studies on gender identity revealed that these girls have a female gender identity. Incidentally (a period of) gender dysphoria or gender confusion is observed. The literature only reports a few CAH females who changed gender in adulthood and lived as men. Factors which may contribute to gender confusion or gender change are: severe virilization, missed diagnoses at birth and sex reassignment; leaving the external genital ambiguous; parents having problems in raising a tomboy daughter; poor medication compliance leading to repeated excessive production of androgens and virilization of the external genitalia; a masculine self-image and body-image; a stigmatizing response of the social environment and erotic attraction to females.

Prenatal treatment for fetuses at risk for classic CAH ameliorates the genital virilization in all affected females and completely eliminates it in more than 85%. Neonatal screening also can prevent (severe) virilization. As degree of virilization of the body, masculine behavior and gender dysphoria appears to be correlated in CAH females, it can be hoped that early medical treatment and psychological counseling also may prevent gender problems.

Peggy Cohen-Kettenis The Netherlands

Gender Dysphoria and Gender change in 46,XY Persons with 5alpha-RD or 17beta-HSD

5 α -Reductase Deficiency (5 α -RD) and 17 β -Hydroxysteroid Dehydrogenase Deficiency (17 β -HSD) are enzyme deficiencies that may affect the biosynthesis of testosterone or the conversion of testosterone into dihydrotestosterone (DHT). In 46XY individuals, the development of the external genitals are affected, when DHT is lacking. Many children with these conditions are raised as girls.

Children with 5 α -RD and 17 β -HSD who are raised as boys have a male identity and behave like boys. When they are assigned and raised as a girl, the outcome is more varied. A gender identity change around or after a masculinizing puberty in affected children who were "unambiguously" raised as girls has been reported (Imperato-McGinley et al., 1979a, b; Rösler & Kohn, 1983). Such a change, however, does not happen in all affected individuals, even when they live in societies that highly value the male role. As many of the reports do not or only roughly describe their rearing, psychosexual development, and final outcome of these children, it remains unclear whether the gender identity change was induced by prenatal hormonal programming of the brain, cultural advantages associated with the male role, or a combination of the hormonal and environmental forces. Regarding the persons who were raised as girls, there are occasional referrals to marriage and sexual intercourse, heterosexual attraction, and relationships with men (e.g., Mendonca et al., 1996).

Tom Mazur USA

Complete Androgen Insensitivity Syndrome (CAIS), Partial Androgen Insensitivity Syndrome (PAIS), Micropenis: Gender Dysphoria and Gender Change

CAIS individuals are announced and reared as females at birth despite their testicular gonads and XY karyotype because of their normal appearing female external genitalia. They develop a female gender identity. There is only one case reported in the extant literature where a toddler with CAIS was reassigned from female to male based upon the recommendation of a physician. A male gender identity developed. In adulthood this person committed suicide.

There are documented cases of gender change in individuals with PAIS initially assigned male or female. However, they are in the minority. The majority of persons with the diagnosis of PAIS remain in their assigned gender.

Infants with a micropenis have been assigned male or female at birth. Currently there are no documented reports of gender self change from the initial sex assignment in either those assigned male or in those assigned female. However, there has been one recent report (Wisniewski, et al., 2001) in which one of twelve males with a micropenis classified as gender dysphoric (dissatisfied with his male gender) and four out of five micropenis persons assigned female questioned their sex of assignment. This study differs in this respect from earlier ones (Money, et al., 1984; Reilly & Woodhouse, 1989, Bin-Abbas et al., 1984) where there virtually were no reports of gender dysphoria.

While self gender change from the initial sex of assignment in cases of intersexuality is the exception (Zucker, 1999), it is important to know what factors would predict such a change. While answers are far from clear, most would agree that gender identity outcome cannot be predicted from any one single factor (Berenbaum, 2003). One study (Money, Devore, Norman, 1986) that included PAIS individuals suggested three factors in individuals requesting sex reassignment. These factors are: (1) a history of being teased ("stigmatization") both at home and in the child's community about their intersex condition, (2) late (at 3 years of age or later) of gonadectomy and (3) late (at 3 years of age or later) of feminizing surgery.

Present data suggests that all CAIS infants be assigned female and that micropenis individuals be assigned male. One exception, in the author's opinion, is the infant with a micropenis that has virtually no corpora or erectile tissue, only a urinary tube. In this case, sex of assignment as a female needs to be considered because of the possibility of a penis that has no erectile potential. Present evidence does not provide clear guidelines as to what sex to assign individuals with PAIS. In these cases, as in ALL cases of infants born with ambiguous sex organs, the best course of action is to fully inform the parents of all test results and to discuss what evidence there is on the pros and cons of sex assignment as male or female and the possible outcome of each given the syndrome in question (MacGillivray and Mazur, 2003).

Heino F.L. Meyer-Bahlburg USA

Gender Dysphoria and Gender Change in 46,XY Persons with Non-Hormonal Genital Abnormalities

Under the optimal gender policy of recent decades, 46,XY infants born with penile agenesis or cloacal exstrophy of the bladder, or 46,XY children who suffered a traumatic loss of the penis during infancy, were often assigned/reassigned to the female gender in order to diminish the emotional and social sequelae seen in individual cases. The underlying rationale was based on three observations: (1) Gender identity in children with intersexuality follows the gender of assignment in the majority of cases; (2) for most people, sexual functioning plays a major role in their overall quality of life; and (3) it is possible for the surgeon to create a neovagina sufficient for intercourse, but not a functioning (non-prosthetic) neopenis (although questions concerning the erotic functioning of the neovagina remain). Adherents of a true-brain-sex policy of gender assignment, which is largely based on the results of research concerning the role of sex hormones in the sexual differentiation of brain and behavior of lower mammals, have strongly argued against the assignment of 46,XY children with non-hormonal genital abnormalities to the female gender (e.g., Diamond & Sigmundson, 1997), and find support in scattered case reports of later patient-initiated gender reversal in such cases. All three categories of non-hormonal genital abnormalities in humans develop in the presence of or after what is assumed to be a normal-male sex-hormone milieu during the prenatal hormone-sensitive period of the sexual differentiation of genitalia and brain. Thus, the gender identity of such persons should be male when it emerges in preschool age, if indeed the prenatal hormonal milieu determined gender identity as is claimed.

In this paper, a review of available cases in each of the three categories will be presented. Only very few cases have been published, and some more have been presented at recent meetings. The tentative findings to date can be tentatively summarized as follows. (1) Gender role behavior in such 46,XY children raised female is markedly tomboyish/masculinized. (2) Where described, sexual orientation in older patients seems to be directed more towards women than in the general population of 46,XX women. (3) During childhood, core gender identity appears to be female in many such 46,XY individuals, but gender dysphoria and/or gender change to male has been described in some children, adolescents, and adults, while others maintain a female core gender identity into adulthood.

The available evidence is compatible with a marked influence of prenatal androgens on the development of gender-role behavior, but not with a direct determination of core gender identity by prenatal hormones. In regard to potential predictors of gender dysphoria and gender change in such children, the data do not permit any solid conclusions. Overall, the available data are also insufficient to answer the question whether the long-term outcome in male-assigned persons from these categories is clearly better, on average, than (early-implemented) female assignment.

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Internalized transphobia as a health hazard: development of the Transgender Identity Scale

Internalized transphobia can be defined as discomfort with one's own transgenderism stemming from internalizing society's normative gender expectations. Like internalized homophobia, internalized transphobia has been viewed clinically as a health hazard, a barrier to good self esteem, mental health, and HIV/STD protective behaviors. In order to examine the relationship between internalized transphobia and transgender health quantitatively, we developed a 52-item measure called the Transgender Identity Scale.

A pool of items was created by asking a small clinical sample ($N=12$) to complete an open-ended questionnaire asking participants about their thoughts and feelings when feeling down or ashamed versus really good or proud about being transgender. Content analysis of their responses resulted in 108 draft items. A panel of judges, all experts in transgender health, reviewed items for clarity and content, and agreed on 50 items for inclusion in the first version of the scale. Along with demographic questions and adapted items from two internalized homophobia scales (Mayfield, 2001; Szymanski & Chung, 2001), this first version was administered to a convenience sample ($N=430$) of transgender individuals recruited by transgender community representatives from 8 U.S. major metropolitan areas. Mean age of participants was 37 ($SD=12.0$, range 17-72); 72% was male-to-female and 18% was female-to-male; 57% was Caucasian, 18% African American, 9% Latina/Latino, and 8% was Asian/Pacific Islander.

Factor analysis (principal component, orthogonal, Varimax rotation) revealed 6 factors together explaining 47% of the variance. The first 4 factors were augmented with several adapted items from the Mayfield and Szymanski & Chung instruments, resulting in a 52-item measure with the following 4 subscales: (1) Pride (13 items, $\alpha=.89$), (2) Passing (14 items, $\alpha=.90$), (3) Alienation (15 items, $\alpha=.81$), and (4) Shame (10 items, $\alpha=.87$). Internal consistency of the total scale was .83.

Contrary to expectations, pride in transgender identity (comfort with being out) and investment in passing emerged as two separate factors instead of bipolar ends of one and the same dimension. This suggests that investment in passing may not necessarily be a sign of internalized transphobia. Each of these dimensions is expected to differentially impact HIV/STD risk and other transgender health indicators.

Joanne Keatley USA

Co-authors: Tooru Nemoto, Don Operario & Toho Soma (USA)

Mental Health Issues Among Transgenders: Implications for Clinical Care

Two studies examine the relationship between psychological vulnerability among transgender individuals and social stigma and discrimination against people with non-conventional gender identities, referred to as transphobia. Quantitative findings on psychological vulnerability, transphobia, and social support from a multiethnic (African American, Latina, and Asian and Pacific Islander) community sample of MTF (Male to Female) transgenders are discussed. Findings revealed heightened levels of depression throughout the sample, highest among Latinas, and alarming rates of suicidal ideation and suicide attempts throughout the sample, highest among African Americans. Findings also showed that experiences of transphobia and social support mediated the association between ethnicity and psychological outcomes. Suggestions for enhanced mental health services for transgenders are offered, with an example and preliminary findings from a community-based mental health intervention targeting MTF and FTM (Female to Male) transgenders in San Francisco.

Walter Bockting USA

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Gender identity and HIV risk: using the Internet to reach the transgender community for prevention research

Needs assessment studies have shown that among certain subgroups of the transgender population (particularly among transgender sex workers), HIV/STD prevalence and risks are high and have been associated with gender-related social stigma. However, little research has focused on the HIV/STD prevalence and risks of the transgender population at large. With funding from the National Institute on Drug Abuse, we set out to use the Internet to reach the U.S. transgender population for prevention research in order to assess how social stigma and internalized transphobia affect HIV risk.

Participants were recruited through banners on transgender community websites and postings on transgender listserves to complete an online survey and, if randomly selected, followed by an in-depth interview using a combination of asynchronous and synchronous online communication. Pilot testing consisted of two phases: (1) a national transgender advisory board ($N=10$) tested a prototype of the online instrument for usability, and (2) the feasibility of recruitment and data collection and the psychometric properties of the measures were tested online ($N=84$).

Usability testing called for improvements in 4 areas: (1) complexity of the enrollment process (consent, screening, registration), (2) clarity of directions within the study (item/scale instructions and overall user support), (3) simplification of language, and (4) length of survey. The online pilot test provided helpful lessons in sampling, data monitoring, and identification of invalid responses. Measures appeared to translate well from paper-and-pencil to online administration. The use of the Internet provided easy access to the transgender population, automated data collection was efficient, and while potential threats to data integrity exist, the availability of Internet-tracking data (e.g., timestamps, IP addresses) allowed for early identification and control of these threats.

Findings to date underscored the potential as well as the challenges of using the Internet to reach the transgender community for HIV/STD prevention research. Understanding the relationship between gender-related stigma and internalized transphobia and HIV/STD risk will benefit the development of targeted interventions, both off- and online.

Barbara Warren USA

Co-authors: Stephen Israel & Kate Bornstein (USA)

Taking The Last Drag

This 15 minute video production funded by the American Legacy Foundation, is a humorous and entertaining review of the top reasons that motivate lesbian, gay, bisexual and transgender smokers to quit smoking. It stars transgender performance artist, play write, activist extraordinaire and committed ex-smoker Kate Bornstein, who collaborated on the script with Dr. Barbara Warren of the NYC LGBT Community Center's LGBT SmokeFree Project. We anticipate that the video will be a useful tool for tobacco education, prevention and cessation and can used by professional and community groups seeking to motivate transgender smokers to quit!

HIBGDA Symposium: Satellite Meetings, September 12, 2003, Gent.

There are 2 roundtable meetings for HIBGDA members and members of Support Organizations. These are followed by a plenary session on the final day of the Symposium. In order to ensure these are fruitful and productive events, it has been decided to concentrate on specific matters which both HIBGDA and the Support Groups are directly involved.

We hope that both practitioners and providers of professional services will participate in these roundtables as well as members and representatives of support organizations.

Each 2 hour Roundtable sessions is to be structured to facilitate discussion around a key area in each:

- 1. Research, practice and funding;**
- 2. Primary Health Care Provision**

The purpose of these meetings is to:

- Educate potential allies in varied sectors about the intersex, transgender and transsexual health disparities and help identify ways in which they, through international, national or local initiatives can help address these disparities.
- Generate recommendations for advancing appropriate research on transgender and transsexual health issues.
- Develop ideas for building the capacity of health systems and practitioners to serve transgender and transsexual communities.
- Facilitate interest in supporting these efforts among private and government funders and other potential partners.

Each Roundtable will take the following format, and have the following rules:

15 minutes: Introduction to the subject by appointed speaker

20 minutes: Partner or group work to consider points that might be raised

1hr: Open to the floor as follows:

Each participant may speak for no longer than 3 minutes at a time, but may speak on more than one occasion.

The Chairs will enforce the time restrictions

The Chairs will endeavour to ensure everyone who wishes has an opportunity to speak.

The Chairs will invite those who have not spoken to speak before the end of the hour

20 minutes: Collective summary of main points for presentation at plenary meeting

We would like to express our special thanks to the following companies for their generous support to this XVIIIth Harry Benjamin International Symposium on Gender Dysphoria

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