

TRANSSEXUALISM



Transsexualism refers to the condition of an individual with an apparently normal somatic sexual differentiation expressing the conviction that he or she is actually a member of the opposite sex. The conviction is accompanied by a profound sense of loathing for the individual's primary and secondary sexual characteristics. Finally, the conviction is absolute, overwhelming, and unalterable.

The sense of belonging to a particular sex, biologically, psychologically and socially, is called gender identity. It is suggested that J. Money (1955) coined the term gender identity and defined it as: the sameness, unity and persistence of one's individuality as male, female, or ambivalent, in greater or lesser degree, especially as it is experienced in self-awareness and behavior; gender identity is the private experience of gender role, and gender role is the public expression of gender identity.

Gender role is further defined as: everything that a person says and does to indicate to others, or to the self, the degree of being male, female, or ambivalent. It includes but is not restricted to sexual arousal and response.

Gender identity and gender role should not be separated for they are actually two sides of the same coin. Consequently, transsexualism can be defined as an incongruence between the biological sexual differentiation and the gender identity. For clinical and diagnostic purposes the criteria of the Diagnostic and Statistical Manual (DSM) of Mental Disorders of the American Psychiatric Association (3rd edition) are often used. The manual suggests that transsexualism is measured by:

- A. A sense of discomfort and inappropriateness about one's anatomic sex.
- B. A desire to be rid of one's own genitals and to live as a member of the other sex.
- C. A continuous conviction of inappropriateness (not limited to periods of stress) for at least two years.
- D. An absence of physical intersex or genetic abnormality.
- E. The absence of a coexistent mental disorder, such as schizophrenia.

The above criteria give rise to some comments. First, somatic intersex and all problems associated with (pseudo)hermaphroditism exclude transsexualism as a primary diagnosis. They should first be treated by procedures accepted as medically appropriate for such conditions (congenital adrenal hyperplasia or testicular feminization are such conditions).

Second, sexual orientation is not mentioned in the above criteria. However, since transsexualism is a gender identity problem, a person's sexual orientation is not relevant to this issue.

Third, in case of coexisting mental disorders appropriate psychiatric treatment is mandatory, but adequately treated psychiatric disorders in themselves are no reason to discourage future gender

reassignment. If a gender identity problem is not secondary to a mental disorder, then gender reassignment might even alleviate other psychiatric symptoms.


From the above definition it might appear that transsexualism is a discrete entity, which can be easily diagnosed and that gender dysphoric subjects constitute a homogeneous group. Gender identity disorders encompass, however, a whole spectrum of feelings of inappropriateness of the assigned sex and therefore a more global term as gender dysphoria is appropriate.

The gender identity problem may be mild; the person is aware that he is a male or that she is a female, but discomfort and a sense of inappropriateness about the assigned sex are experienced.

The American Psychiatric Association stresses that a transsexual have an intense and persistent desire to alter his or her genitals. The belief that one can only be transsexual if he or she has a desire to alter, malign, or remove his or her genitals simplifies the dynamics of transsexualism. It ignores those with the condition who prefer to live with the condition rather than commit to surgery. The reasons for such decisions are varied, and are not -- as some have suggested -- limited to financial resources. Religious and ethical beliefs, as well as a transsexuals relationships with family and friends are among the possibly more focused reasons for a transsexual preference to be non-operative.

Transsexualism can be classified as the extreme degree of gender dysphoria. Transsexuals are not only uncomfortable with their assigned sex but have the sense of belonging to the opposite sex. Disorders of gender identity are rare; they should not be confused with the far more common phenomena of feeling inadequate to fulfill the expectations associated with one's gender role.

An example of the latter would be a person who perceives himself or herself as being sexually unattractive or unsuccessful by societal standards yet experiences himself or herself unambiguously as a man or a woman in accordance with his or her assigned sex. The classification of gender dysphoria syndromes is rather unsatisfactory. DSM III-R (1987) has classified gender identity disorders as those occurring in childhood (302-60), transsexualism (302-50) and gender identity disorder of adolescence or adulthood non-transsexual type (GIDAANT 302-85).

TABLE Classification of gender crosscoding by total (all components), partial unlimited (most components, but no surgery) and partial limited (only sexual orientation), and the continuous or episodic character of the phenomena (according to money).		
	Continuous or Constant	Episodic or Alternating
Total	Transsexualism	Transvestophilia (cross dressing for erotic arousal)
Partial Unlimited Dressing not	Gynemimesis and Andromimesis (desire to live as a member of the opposite sex but no wish for genital surgery)	Transvestism (cross for erotic arousal)
Partial Limited	Male hemophilia/Female hemophilia	Bisexualism

Both DSM III-R and Money reintroduce sexual orientation in the classification of gender dysphoria. This ignores the fact that gender identity and sexual orientation are two distinct phenomena in one person.

It is not the sexual orientation that troubles transsexuals, but the identity problem. All human variants of sexual orientation are observed in transsexual subjects. Sexual orientation is not one of the criteria for diagnosis and/or treatment of transsexualism. Neither the DSM III-R classification nor Money's classification is based on underlying causes since they are as yet unknown.

Money acknowledges the necessity of revising his classification as soon as more data have been accumulated. It is evident from the aforementioned definitions and classifications that transsexualism and transvestism/transvestophilia are different phenomena. Cross dressing is a component of both, but it is only a sign or symptom and therefore, does not constitute a diagnosis.

Historically, there were also men who dressed and behaved as women. Among the most famous were the Roman emperor Calligula; King James I of England; and Edward Hyde, Lord Cornbury, Governor of New York and New Jersey. However, in these cases their behavior was episodic.

Today we would probably label them as transvestites. A similar, but very particular case, is the life story of the Chevalier D'Eon, a nobleman who served the French King Louis XV as a diplomat in Russia. The year before his appointment he spent several months in disguise, presenting himself at the Russian court as his own (non-existent) sister Lea. He became quite popular as a woman and no one ever doubted his self-assigned sex. Later, he served in England where the rumor was spread that he was in fact a woman. He refused to settle the question by submitting to a medical examination. On the royal order of Louis XVI he was obliged to dress as a woman and live a female role until his death in 1810. The autopsy bore out that he had the body of a normal male, to the great surprise of the public and the people who knew him closely.

The modern documented history of transsexualism and medical gender reassignment ("changing the body to fit the mind") started in Germany with the first recorded adult sex change operation on a Danish artist, Einar Wegener, who in 1930 became Lily Elbe. Not until 1953, with the story of the surgical gender reassignment of the American ex-GI George Jorgensen, who became Christine Jorgensen, did transsexualism receive worldwide publicity. Since Jorgensen's 'sex-change', thousands of individuals have undergone gender reassignment surgery. Very slowly, medical interest in transsexualism has evolved.

In a recent study the prevalence of transsexualism for three different periods was calculated to compare and analyze whether a trend could be discerned over the last 10 years. Prevalence of male-to-female transsexualism was 1:45,000 in 1980, 1:26,000 in 1983, and 1:18,000 in 1986. Prevalence rates for female-to-male transsexuals showed a similar increase from 1:200,000 in 1980, to 1:100,000 in 1983 and to 1:54,000 in 1986. The ratio of male-to-female to female-to-male transsexualism decreased from 4:1 to 3:1. It is evident from these figures that prevalences show a substantial upward trend. The interpretation of this trend can only be speculative.

The distribution over the different age groups remains almost constant. Therefore one might assume that the increased prevalences are the result of a higher percentage of transsexuals seeking hormonal treatment over the last 7 years. Meanwhile the social climate has become increasingly more benevolent and there are no financial barriers for those desiring treatment. A true increase would probably have shown a shift towards younger age groups.

In an attempt to draw conclusions, Money categorized outcome as satisfactory, unsatisfactory, uncertain and unknown. He also included the number of reported suicides. Male-to-female female-to-male (n=283)(n=83) satisfactory 202 (71.4%) 67 (80.7%) unsatisfactory 23 (8.1%) 5 (6.0%) uncertain 48 (17%) 11 (13.3%) unknown 4 (1.4%) suicide 6 (2.1%).

The conclusion of this review, a tenfold higher probability of a favorable result than an unfavorable one, has been much criticized on methodological grounds. Lothstein (1982) discussed the lack of control groups, the differences in received care, the lack of relevant data and of valid criteria for good results in the published reports. He collected data on the results of treatment in 785 transsexual subjects. Most studies showed that transsexuals themselves were satisfied with the sex reassignment treatment. However, unfavorable results were also presented.

These include disappointment regarding surgical results; some subjects who still felt inappropriate in their new gender role (some of them reverted to their biological sex), and individuals who did not experience a post-operative improvement in their well-being. Based on the reviewed results, he questioned the often cited psychological improvement in 70%-80% of the gender reassigned transsexuals.



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