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This paper presents the results of a survey conducted by AEGIS in 1993. It was presented at The International Congress on Cross Dressing, Sex, and Gender Issues, Van Nuys, California 23-26 February, 1995. It appears in B. Bullough, V. Bullough, & J. Elias (Eds.), Gender Blending. Amherst, NY: Prometheus Press, 1977.

Standards of Care: Survey Results

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Abstract

The Standards of Care of the Harry Benjamin International Gender Dysphoria Association, Inc. (HBIGDA) are a set of minimum guidelines consensually used by the community of mental and physical health care service providers to regulate hormonal and surgical treatment of transexual persons. First drafted in 1979, they are regularly revised, the most recent version being 1991. The Standards of Care are currently once again being revised.

The Standards of Care require ongoing involvement of mental health professionals in order for "approval letters" for hormonal therapy and surgical sex reassignment of transexual persons. Because they limit access to medical treatments, they have come under attack from some quarters of the transexual and transgender community, and alternative standards have been proposed.

We prepared and distributed a questionnaire which solicited the opinions of transgendered and transexual persons about the HBIGDA Standards of Care. In this paper, we present some results of that survey and discuss some of the issues involved in imposing such standards on transexual bodies

There is strong evidence that transgendered and transexual individuals have existed panculturally and throughout history [c.f. Ford & Beach, 1951; and Herdt (1994) for cross-cultural information; and Feinberg (1995), Money (1992), Roscoe (1994), and Taylor (1996) for historical evidence]. Ritual emasculation and castration have been practiced in the West (O'Hartigan, 1994), and in the East (Nanda, 1989) but only in the second half of the twentieth century has it been possible for large numbers of individuals to change their primary and secondary sex characteristics and come to function in society as members of the other sex. This process is called sex reassignment (Green & Money, 1969), and it has created a medicalized class of people known as transexuals. [1]

Sex reassignment has been considered by some to be palliative, as it does not do away with the "problem" (a term which unfortunately presupposes illness or pathology), but rather eases the pain and suffering of the individuals concerned by allowing them to live in the other gender role (Meyer, 1973). The procedure was once very controversial, and has been attacked by psychiatrists (cf Socarides, 1976) and feminist (Raymond, 1979, 1994) scholars, and defended as appropriate in some cases by other scholars (cf Money, 1971).

Interestingly, the one characteristic shared by almost all of the attackers is that their knowledge of and actual experience with transexual people is limited or even nonexistent. To give but one example, Janice Raymond interviewed only 15 transexual people before writing her anti-transexual manifesto, *The Transsexual Empire* (Raymond, 1979), in which she concluded that transexualism (and no doubt transexual people) should be

Authors' Note: In keeping with the emerging sentiment that those who are transexual have the ultimate right of self-definition, we have spelled the word transexual and its derivatives with one "s" rather than two.

"morally mandated" out of existence.

The obvious willingness of Raymond and others to use transsexual bodies for political purposes while purposefully remaining ignorant about transexual people as human beings have made their voices, once very influential, increasingly marginal. The sheer volume of people who have successfully undergone sex reassignment, the popularization of the subject in the popular press and on television talk shows, and the maturation of the scientific literature have made it clear that sex reassignment is the treatment of choice for many persons with chronic distress about their sex of assignment. Despite the often-lamented problem with keeping track of people following surgery, follow-up studies tend to show high rates of both positive subjective satisfaction and objective outcomes by those who have had the procedure (cf Blanchard & Sheridan, 1990). The only study which showed "no objective advantage" (Meyer & Reter, 1979) was so seriously flawed as to be discredited (Blanchard & Sheridan, 1990); recently, one of the conspirators has as much as admitted in print that it was a plot perpetrated for political rather than scientific motives (McHugh, 1992; Ogas, 1994).

As we approach the millennium, sex reassignment has become a realistic goal for those who are seriously unhappy about their sex of assignment and primary and secondary sex characteristics. That is not to say that it is the proper treatment for everyone with questions or doubts about their bodies or their social roles, but it is considered the treatment of choice in some cases. And so far as we know, this point has not been broached in the scientific literature, but we will put it to you here: Within very broad limits, it is the right of informed persons to do what they please with their own bodies. The ultimate decision to pursue sex reassignment should and does rest with the individual, and not with the mental health or medical professional. Only when the individual seeks medical treatment is it appropriate for the medical or psychological professional to serve as a gatekeeper.

Although sex reassignment is often considered experimental for purposes of denying insurance coverage and tax credits, the hormonal, surgical, and other medical techniques which facilitate an individual's changing of social role have a history dating back more than forty years (Hamburger, *et al.*, 1953), and can reasonably be said to have matured, in the same way that say, the management of diabetes has matured. The social techniques of sex reassignment have long lagged behind, outpaced by medical technology (see Rothblatt, 1994, for a discussion of this). However, the first author (Denny, 1995) and others have suggested that a Kuhnian paradigm shift has occurred, with the old model, in which persons with transgender or transexual feelings are viewed as unfortunate victims of a disorder, giving way to a model in which it is the society which is seen as pathological (Bornstein, 1993; Denny, 1997; Rothblatt, 1994).

Before about 1980, sex reassignment was available in only two ways: extralegally and extramedically, by purchasing services on the black market (often with disastrous results); or by going to a university-based gender program. The black market had no rules, and the gender programs, most of which were overly controlling and judgmental, required compliance with too many rules, and tended to turn away the majority of those who sought sex reassignment (Denny, 1992). [2] There were, to be fair, a few private practitioners who offered ethical services to transgendered and transexual persons (the late Harry Benjamin being a prime example), but they were few and far between, and difficult to locate by those not privy to the transexual grapevine (Stone, 1991).

To provide guidance to both practitioners and consumers alike, a group of concerned professionals came together in the late 1970s to form the Harry Benjamin International Gender Dysphoria Association, Inc. (HBIGDA). Named for Harry Benjamin, a pioneer in the field, the organization straightaway set about formulating minimal Standards of Care (Berger, 1990).

The *HBIGDA Standards of Care for Hormonal and Surgical Sex Reassignment of Gender Dysphoric Persons* were released in 1979. They consisted of a series of principles and standards which defined a professional ethic for treating persons with serious gender identity issues, suggesting constraints on both the caregiver and consumer. They were and are a road map, as it were, to sex reas-

signment. As such, they have served admirably. However, there is usually more than one path to a destination, and the route mapped by the HBIGDA Standards of Care may not be the only reasonable one. Certainly, ideas about what is "reasonable" standards vary widely. Recently, for instance, the International Conference on Transgender Law and Employment Policy (ICTLEP) formulated its own protocol (ICTLEP Health Care Standards, 1993).

The HBIGDA Standards of Care set minimum guidelines for access to medical procedures. They mandate ongoing involvement of mental health professionals (defined as "clinical behavioral scientists"), who provide authorization for medical procedures like hormonal therapy and sex reassignment surgery (SRS). They also require a minimum one-year period of real-life test, in which the individual must live and work (or go to school) 24 hours a day in the new gender role before he or she is eligible for irreversible genital sex reassignment surgery.

The HBIGDA Standards of Care have been used for more than fifteen years. They are widely accepted by helping professionals, and are discussed and disseminated by the transexual grapevine. They have been revised on a number of occasions, most recently in 1991 (and are currently being revised yet again. Dr. Friedemann Pfafflin discussed the proposed revisions and asked for input in the same session at the International Congress on Cross Dressing, Sex, and Gender Issues, at which this paper was originally presented (Pfafflin, 1995). However, the HBIGDA Standards have changed relatively little in fifteen years, and, while there has been much grumbling about them from transexual people over the years, they have recently begun to be seriously questioned by transexual scholars.

In 1993, alternative standards of care were proposed by ICTLEP, the International Conference on Transgender Law and Employment Policy (ICTLEP Health Care Standards, 1993). The ICTLEP Standards were written without input from mental health or medical professionals. These standards consider it unethical for a medical professional who provides hormonal therapy or SRS for transgendered and transexual persons to refuse a procedure to any individual who asks for it, subject only to informed consent and to the absence of counterindicating medical conditions. Quite frankly, in our opinion, they make very little sense as standards of care. However, as a transexual and transgender Bill of Rights, they make a great deal of sense, and they must be taken seriously as such. [3]

Early reports about the forthcoming revision of the Harry Benjamin Standards of Care suggest that they will be considerably more restrictive than previous versions, requiring a two-year real-life test before sex reassignment surgery and authorization from mental health professionals for procedures (for instance, breast augmentation) which have been hereto unregulated. This would give increasing power to caregivers, and at a time when transexual men and women are arguing for their right to control their own bodies.

It is at the points of conflict between the HBIGDA Standards of Care and the ICTLEP Standards that effort must be placed. What is the obligation of the caregiver to do no harm versus the right of the individual to self-determination? Why is access to hormones and genital surgery more tightly regulated than other medical treatments? Is it because of a legitimate concern about the well-being of transexual people (of course it is, in part), or because sex reassignment violates cultural norms (of course it does), or because tight regulation decreases the threat of provider liability (certainly it does), or because the pathology-based model on which they are based colonizes transexual people and trivializes our decision-making abilities? (it certainly does).

In our opinion, the HBIGDA (that is, the original) Standards of Care, although far from perfect, have served well, despite having been and continuing to be used as roadblocks by some caregivers. We are frankly concerned by the ICTLEP Standards, which were written because of a supposed widespread dissatisfaction with the Benjamin Standards, and by the forthcoming (apparently more restrictive) revision of the HBIGDA Standards. Certainly, the right of the individual to freedom of his or her body and the ethical duty of psychological and medical professionals to do no harm provide fertile ground for conflict. Certainly, the wisdom of having special standards for transgendered and transexual persons is questioned by some in

the transgender community, who find them patronizing and paternalistic. Certainly, much work needs to be done, and a reasonable starting place would seem to be to begin to examine the opinions about the HBIGDA Standards of Care by those who are most directly affected by them (i.e. transgendered and transexual persons). To our knowledge, no one has ever looked at the HBIGDA Standards to determine whether those who are most directly affected by them are even aware of them, much less how they feel about them.

Method

We formulated a questionnaire which attempted to determine whether transgendered and transexual consumers knew of the Benjamin Standards, whether they have followed the various standards, and how they felt about the Standard. The questionnaire asked for demographic information and treatment history, and solicited opinions about individual HBIGDA Standards and about whether the HBIGDA Standards of Care were seen as serving a useful purpose.

The questionnaire was included in a mailing of more than 500 copies of *Chrysalis* (a journal which deals with transgender and transexual issues), and sent to various helping professionals, support groups, and publications. Several newsletters and magazines reprinted the questionnaire, and it was distributed at various support group meetings and to the clients of the Program in Human Sexuality at the University of Minnesota. The questionnaire ended up posted on several electronic bulletin boards (BBSs), and on the Internet as well. Questionnaires were mailed to our post office box over a period of several months, and responses were entered into a MS-DOS database program called RapidFile.

Results

We are now ready to present our findings. Let me say that these results should not be considered final. There are a variety of additional analyses which could be done. However, we have learned from our survey most of what we wished to learn, and are unlikely to do further analysis unless called upon to do so.

We received a total of 340 completed questionnaires. One was discarded because it contained only demographic information. That left 339 questionnaires, of which 270 were from persons who reported having been designated as males at birth, and 69 by individuals designated as females at birth. This breaks down to 79.6% born male, and 20.4% born female. Because the terms male transexual and female transexual are confusing and are offensive to many transexual people, we prefer in the context of this paper to use the terms *born male* and *born female* to refer to the original sex assignment of the individual. This is in contradiction to the bulk of the literature, which uses terms which many transexual people find demeaning.

The age of respondents ranged from 18 to 88 years, with an overall mean of 42.7 years. Mean age of born males was 44.3 years, and mean age of born females was 36.7 years. The mean age of those who had had SRS was 41.4 years, and the mean of those who had not was 42.5 years (see Table 1, p 5).

What sort of people returned our survey? Well, mostly transexuals. Of the 270 born males, 163, or 60.4% were living full-time as women. 56 of 69, or 81.2% of born females were living full-time as men. That is 64.6% of the total sample. These people had made major strides along the road to sex reassignment (Table 1).

Sixty-one of 270, or 22.6% of born males, had sex reassignment surgery (SRS). Fifteen of 69, or 21.7% of born females, had had SRS. Seventy- six, or 22.4% of the total sample, had had SRS (Table 1). One hundred and thirty-seven born males and 47 born females indicated that they planned to have surgery. This is 50.7 and 68.1 percent of total born males, and born females, respectively, or just more than one half of the total sample.

When those who already had SRS are added to those who plan ned to have it, we see that nearly three-quarters of the born males and 90.0 percent of the born females either had or plan to have surgery (Table 1). This shows a great deal of commitment to the process of sex reassignment by the sample population. These are individuals who traditionally would have been classified by professionals as transexual, and would have classified themselves as such.

How Did Respondents Self-Identify?

Respondents were asked how they self-identified in terms of their gender identity issues. Item 4 of the questionnaire allowed them to check off boxes for transexual, crossdresser, transgenderist, or other. There was an additional space so that "other" could be explained. The breakdown is shown in Table 2 (p. 6).

One hundred and eighty-four, or 54.3% of respondents self-identified as transexual. Twenty-eight, or 8.3% identified as crossdressers, and 40, or 11.8% identified as transgenderists (someone who retains characteristics of both genders). The remaining 25.7% did not indicate any of the three pre-programmed choices, but checked "other," in many cases writing in their self-identification (Table 2).

In the nineties, self-identification is not limited to traditional categories like transexual and crossdressers. We thought we were clever for including a selection for the emerging category transgenderist, but respondents used more than forty different terms to describe themselves.

Knowledge of HBIGDA Standards of Care

Table 3 (p. 7) shows that 269 of the 339, or 79.4% of the respondents had heard of the HBIGDA Standards of Care. Of these, 125 or 46.5% had learned of them from professional sources (physicians, therapists, gender clinics, information services like the American Edu-

Table 1

Demographic Information

	n	*Percent*
Born M	270	79.6
Born F	69	20.4
Total (Born M + Born F)	339	100.0
Born M, living F	163	60.4
Born F, living M	56	81.2
Total crossliving	219	64.6
Born M, SRS	61	22.6
Born F, SRS	15	21.7
Total no. SRS	76	22.4
Born M, plan SRS	137	50.7
Born F, plan SRS	47	68.1
Total planning SRS	184	54.3
Born M, plan or had SRS	198	73.3
Born F, plan or had SRS	62	90.0
Total, plan or had SRS	261	77.0

Age in Years

	Range	*Mean*	*SRS*	*No SRS*
Born M	18-88	44.3	43.9	44.4
Born F	20-69	36.7	39.7	35.8
Total	18-88	42.7	41.4	42.5

Total n = 339 subjects

cational Gender Information Service and its predecessor, the late Erickson Foundation, and the professional literature) (Table 4, p. 7).

Seventy-five, or 27.8%, had learned of them from the transgender community (from other transgendered or transexual persons, at support groups, from computer BBSs or the internet, and through transgender publications). Of the remaining 69, twenty-three (8.6% of the total of 269) did not know or did not remember how they had heard of the Standards of Care, and 46 (17.1%) gave responses like "book," reading," or "library" which did not specify the nature of the material in which they found information.

Compliance with HBIGDA Standards

Ongoing therapy is a requirement of the HBIGDA Standards of Care. We wondered how many of our respondents had been in therapy at some point because of their gender issues. The answer was that 218 of 270 or 80.7% of born males, and 63 of 69 or 91.3% of born females had been in therapy because of their gender identity issues (Table 5, p. 7). The percentage was even higher for those who self-identified as transexual or transgendered. Of 242 respondents on hormones, only 18 (7.4%) reported not having contacted a therapist.

133, or 39.2% of total respondents, had at some time contacted a gender program or clinic in regards to their gender identity.

Disclosing the Existence of the HBIGDA Standards

The respondents reported that only about half (136 of 282, or 48.2%) of the therapists (psychologists, psychiatrists, counselors, social workers) they first contacted disclosed the existence of the HBIGDA Standards of Care (Table 6, p. 7). 65, or 23.0% of these respondents reported having told a therapist about the Standards. 125 (44.4%) of respondents reported knowing about the HBIGDA Standards upon entering therapy for the first time. 245 respondents (72.2% of the total sample) reported having consulted a physician for hormonal therapy. In 77 (31.4%) of these instances, the physician told the respondent about the HBIGDA Standards. In 52 (21.2%) instances, the respondent reported telling the physician about the Standards of Care.

257 (75.8%) respondents reported having at some time joined a transgender or transexual support group. In 153 cases (59.5%), the respondent reported having been told of the Standards of Care by someone in the support group. 182 of 339, or 67.7% of total respondents, had told another transgendered person about the Standards of Care.

These data suggest that knowledge of the Standards is communicated by transexual and transgendered persons to each other and to caregivers about as often (and perhaps even more frequently) than it is communicated to them by caregivers.

Table 2

Self-Identification of Respondents

184	ts (54.3%)
28	cd (8.3%)
40	tg (11.8%)
18	woman
8	female
6	male
5	ts/tg
4	ts/woman
3	man
2	cd/tg
2	tg/cd
2	ts (non-op)
2	ts/cd
2	new woman
1	androgyne
1	bigenderal (completely both)
1	bigendered
1	cd/sissy
1	cd/tg?
1	cd/ts
1	confirmed correct gender
1	ex-transsexual: woman
1	female-bodied man
1	female with transsexual past
1	human
1	human being
1	labels harmful
1	man wanting to live/love w breasts
1	Merissa
1	metamorph
1	normal
1	other
1	sex-reassigned
1	testicular feminization
1	tg/bisexual
1	tg/male
1	tg/man
1	ts/androgyne
1	ts/gay
1	ts (tg maybe)
1	ts/tg/cd/other
4	blank
1	don't know
1	uncertain

n = 339

Table 3

Had Respondents Heard of HBIGDA Standards of Care?

	n	*Percent*
Born M	212	78.5
Born F	55	79.7
Total, M+F	269	79.4

n = 339

Table 5

Respondents' Compliance with HBIGDA Standards of Care

How many respondents had therapy for gender issue?

	n	*Percent*
Born M, been in therapy	218	80.7
Born F, been in therapy	63	91.3
Total who had therapy	282	83.2

How many respondents had been to a gender program?

	133	39.2

n = 339

Table 6

Who Told Whom about HBIGDA Standards?

(n = 282) Respondents who reported having seen a therapist

	n	*Percent*
1st Therapist told Respondent	136	48.2
Respondent told Therapist	65	23.0

(n=245) Respondents who consulted a physician for hormones

Physician told Respondent	77	31.4
Respondent told Physician	52	21.2

(n=257) Respondents who attended a support group

Told by Someone in Group	153	59.5

(n=269) Respondents who had heard of HBIGDA Standards

Respondents told other transgendered person(s)	182	67.6

Table 4

How Did Respondents Learn About Standards?

n = 269 respondents who had heard of Standards of Care

Professional

54	Personal Contact
30	Clinics
29	Info Svc.
7	Literature
3	Conferences
2	Other

Total 125 (46.5%)

Transgender Community

27	Personal Contact
25	Support Groups
11	Literature
10	BBS
1	Conference
1	Other

Total 75 (27.8%)

Unspecified

10	Book
10	Magazine
7	Unspec. Reading
7	Library
6	Unspec. Friend
2	Personal Research
1	Television
1	Word of Mouth
1	College
1	Popular Literature

Total 46 (17.1%)

Blank / Don't Know

5	Blank
18	Don't Know

Total 23 (8.6%)

Opinions About the HBIGDA Standards

Did our respondents think the Harry Benjamin Standards serve a useful purpose? 298 or 339, or 88% of total respondents did think so. In fact, when we eliminated those who had no knowledge of the Standards of Care prior to our survey, 256 of 269, or 95.2% thought the HBIGDA Standards serve a useful purpose (Table 7, p. 8).

Standard 6 requires a 90-day evaluation period by a therapist before referral for hormonal therapy. 256 of 339, or 75.5% of total respondents, thought this was a good idea. 224 of 269, or 83.3% of those who had previous knowledge of the Standards of Care, thought it was a good idea.

Standard 9 requires a one-year period of full-time cross-living (a real-life test, or RLT) before the individual is eligible for genital sex reassignment surgery. 265 of 339, or 78.2% of total respondents, thought that this standard was a good idea. 224 of 269, or 83.3% of respondents who had previous knowledge of the Standards of Care thought the RLT was a good idea.

245 of 339, or 72.3% of total respondents thought that it was a good idea to require letters for hormonal therapy and SRS. 209 of 269, or 77.7 percent of respondents with previous knowledge thought that it was a good idea. However, in their comments, many respondents discussed the prohibitive expense involved with therapy, and especially with the necessity of having multiple therapists in order to obtain medical treatment.

We asked respondents whether they agreed with the standard which requires that one must plan on having SRS in order to initiate hormonal therapy. Only 116 of 339, or 34.2% of total respondents, and 97 of 269, or 36.1% of respondents with a previous knowledge of the Standards of Care, thought so.

We also asked respondents whether they thought breast reduction surgery/contouring of a male chest in born females should require approval letters from therapists. Only 103 of 339, or 45.0% of total respondents, and 87 of 269, or 32.3% of respondents with previous knowledge of the Standards of Care, thought so.

Discussion

While our survey does not indicate the widespread dissatisfaction with the HBIGDA Standards of Care that is claimed by ICTLEP, both the solicited and unsolicited comments on the questionnaires indicate that at least some respondents were vehemently opposed to any medical gatekeeping. However, the overwhelming majority of respondents believe that the Standards of Care serve a useful purpose. Perhaps the "widespread dissatisfaction" about the HBIGDA standards mentioned by ICTLEP is instead the loud voices of a few very dissatisfied persons.

It is clear from our results that most transgendered and transexual persons are in favor of some sort of regulation of hormonal therapy and SRS. It should be noted however, that most respondents, in their comments, noted that they felt there are problems with the restrictiveness of HBIGDA Standards, and that changes are indicated. Many respondents commented that the Standards lack flexibility and should acknowledge the differing needs of individuals seeking sex reassignment.

Our survey clearly reached the population most affected by the Standards of Care (those who identify as transexual), and clearly shows that there is widespread knowledge of and dissemination of the Standards within the transgender community. The data show that therapists and especially physicians have not been as active in informing their clients about the Standards as they might have been, and that transexual and transgendered persons have themselves been active in disseminating the Standards. No doubt some therapists deliberately withhold this information from their transgendered and transexual clients, but these data more likely result from the fact that many therapists and physicians do not themselves know about the Standards of Care. This is borne out by the fact that many of the respondents reported having told their therapists and physicians about the Standards—something that would not have been possible if their caregivers had already known about them.

It is also clear that the survey population was highly compliant in regard to the Standards of Care. The overwhelming majority of the respondents had been in therapy (some for many years), and of 242 respondents who had been on hormones, only 18 (7.4%) reported not having been in therapy.

We were especially intrigued by the variety of ways in which respondents self-identified. It is clear that many transgendered and transexual people are not willing to limit themselves to the "traditional" categories of transexual and crossdresser, or even transgenderist, going to the trouble to write in their self- identifications rather than checking the pre-programmed boxes. For this reason, it is important that any future revisions of the Standards uncouple hormonal therapy and SRS, making it clear that one need not desire or request surgery in order to be eligible for hormonal treatment. The relatively low number of respondents who believed that one should wish to be rid of one's genitals in order to have hormonal therapy suggests that many of the respondents already understand the distinction between transgenderism and transexualism. We believe that as this distinction becomes more clear, more members of both the transgender and professional community will come to realize that genital surgery is not the inevitable goal of sex reassignment.

A relatively low percentage of respondents agreed that breast reduction/contouring of a male chest in persons born with female bodies should be considered genital sex reassignment surgery. Comments indicated that some respondents strongly feel that this standard is the result of objectification of the female body, and should be removed or rewritten.

In the early 1980s, Jude Patton, a transexual man, was the "consumer" representative on the HBIGDA Board of Directors.

Table 7

Respondents' Opinions About HBIGDA Standards

Respondents with previous knowledge of SOC (n = 269)

Question	*Yes*	*Percent*	*Yes*	*Percent*
29	256	75.5	216	80.3
31	265	78.2	224	83.3
33	245	72.3	209	77.7
34	298	88.0	256	95.2
35	116	34.2	97	36.1
36	103	45.0	87	32.3

Key

29. The Standards of Care require a 90 day evaluation period by a therapist before referral for hormonal therapy. Do you think this standard is a good idea?

31. The Standards of Care require a one-year (minimum) period of full-time living in the new gender role before sex reassignment surgery. Do you think this standard is a good idea?

33. The Standards of Care require a letter from a therapist for authorization of hormonal therapy and two letters from therapists for sex reassignment surgery. Do you think this standard is a good idea?

34. Do you think the Standards of Care serve a useful purpose?

35. The Standards of Care require that the individual wish to be rid of the genitals in order to receive hormonal therapy. Do you agree with this standard?

36. Do you believe that breast reduction/contouring of a male chest in genetic females should be considered genital sex reassignment surgery (i.e. should require approval letters)?

n = 339

There are not, to our knowledge, currently any transgendered or transexual persons on the HBIGDA Board, or on the committee to revise the Standards of Care. Considering the large number of transgendered and transexual physicians, psychologists, and other professionals, many of whom are members of HBIGDA, this shows in our opinion a serious lack of judgement on the part of HBIGDA. One need only reframe this to imagine an analogous organization comprised of professional persons who intimately affect the lives of gay and lesbian people, or Black people, but without gay or lesbian or Black professionals intimately involved in the running of that organization, to realize that transgendered and transexual persons are still stigmatized by nontransgendered people, even by those who are trying hardest to help them.

Conclusion

The results of this survey indicate that our largely transexual sample believes the Benjamin Standards serve a useful purpose. This suggests that most transexual people understand that sex reassignment is serious business and support some limitations on access to medical treatment. The written comments of the respondents, however, indicate considerable desire for changes in the HBIGDA Standards in the direction of more personalization and less need to consult multiple therapists in order to obtain needed medical treatment. A majority of respondents indicated that a desire for genital sex reassignment surgery should not be a prerequisite for obtaining hormonal therapy. This belief was reflected in the terms used by many respondents to identify themselves; instead of "traditional" terms like transexual and crossdresser and even the relatively new term "transgenderist, motr than thirty other self-labels were used.

Future revisions of the Standards of Care should include input from transgendered and transexual persons and especially transexual and transgendered persons who are active in the physical and mental health care fields.

Notes

[1] Bullough & Bullough (1993) have noted that the term transexual was used by Hirschfeld (1910). However, the word did not come into common usage until after the publication in 1966 of Harry Benjamin's *The Transsexual Phenomenon.*

[2] The first author had a personal experience with one of these clinics. In 1979, she (then he) applied to the Gender Identity Clinic at Vanderbilt University, asking for sex reassignment. After evaluation, she was told by Dr. Embry McKee that since she had a history of being able to function in the male role (i.e., she had finished college and graduate school and had a respectable job) and since her primary erotic attraction had been toward females, the clinic would not help her to feminize herself; i.e., they would not offer hormonal therapy or surgery. Dr. McKee offered no alternatives, except for her to remain in the male mode or relocate to San Francisco, where there was another gender program, and where, he let it be known, she would likely be told the same thing.

[3] This is not to denigrate the spirit in which the ICTLEP Standards were formulated, or the excellent things which ICTLEP does. ICTLEP has done groundbreaking work in the areas of law and employment policy, and their concerns about gatekeeping and their belief in the autonomy of the individual are well-intentioned and valid.

[4] We have not done statistical analyses of these data, for several reasons. First, we feel that they are clear as presented, without statistical manipulation [as were Pavlov's (1926) data, which were also presented in tabular form]. Second, as applied behavioral analysts, we are aware that statistical analyses are often unwarranted, and needless complicate articles such as this, while adding very little to (and sometimes even obfuscating) the understanding of the phenomenon being studied. Is it really critical in this context to know whether the less-than-one-year age difference between respondents who had and had not had SRS are significant beyond the .05 level? We think not.

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Survey

Keypoints

Denny, D., & Roberts, J. (1997). Results of a questionnaire on the Standards of Care of the Harry Benjamin International Gender Dysphoria Association. In B. Bullough, V. Bullough, & J. Elias (Eds.), *Gender Blending.* Amherst, NY: Prometheus Press.

1 We measured the attitudes of transgendered and transexual people toward the Harry Benjamin Standards of Care, a set of guidelines for hormonal and surgical sex reassignment. Questionnaires were widely distributed in the transgender community.

2 Of 339 respondents, 261 (77.0%) had had or planned to have sex reassignment surgery; the sample then, was comprised largely of people who can be considered to be transexual.

3 Respondents identified themselves by a number of terms in addition to "traditional" terms like crossdresser, transexual, and even the relatively new term *transgenderist,* suggesting that many respondents view themselves in new and novel ways.

4 88% of total respondents indicated that they believed that the Harry Benjamin Standards of Care serve a useful purpose, and 78.2% indicated they believed there should be a required period of real-life test before sex reassignment surgery.

5 Results suggest that most transexual and transgendered people support reasonable limitations on surgical and hormonal treatment. However, many respondents indicated that they feel the Harry Benjamin Standards lack flexibility to meet individual needs.

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