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Gender Dysphoria Update

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Gender identity is almost inseparable from basic identity, and a simple exercise proves this: Think about someone you knew a long time ago. You may not remember the color of his hair, or the sound of his voice, or his opinion. You quite understandably may not remember her name, and you may have trouble remembering her face, but you will never forget whether that person was male or female. It is no wonder, then, that variations in gender identity and role are such a source of fascination and conflict.

Social Constructions of Sexuality and Gender Identity

Perceptions of transsexualism in the public consciousness have been heightened during the past few decades. Prominent cases such as that of Christine Jorgensen's 1953 "sex change" surgery remain salient to the public (some of our clinic clients state that hearing her story was one of the most significant events in their lives). Daytime talk shows (arguably one of the most significant new public education sources of the past two decades) demonstrate an almost inexhaustible appetite for portraying and discussing the sexually ambiguous. A spate of movies, articles in mainstream magazines, and the popularity of sexually ambiguous entertainers and fashion models confirm a societal fascination with the subject.

Transsexualism is by no means a new phenomenon, even if the opportu-

nity for surgical and hormonal intervention is. In fact, the concept of a male-female identity within the same individual is one of the persistent themes of human culture. Carl Jung's concept of the *anima* and the *animus* is just one of the most recent manifestations of an idea stretching back to the ancient Greeks and their notion of a half-male, half-female god (goddess?), Hermaphroditus.

Our understanding of transsexualism is complicated by a certain degree of confusion and ambivalence about sexuality. In broad terms, sexuality can be seen as having four essential components:

Genetic identity is the chromosomal gender of the individual.

Gender identity is the self-perception of one's core as being male, female, or in-between — "I am male/female."

Gender role is the whole list of expectations about behaviors, occupations, interests, values, emotional reactions, and cognitive approach that each culture customarily expects of individuals on the basis of what gender they seem to be.

Sexual orientation has to do with the gender of those toward whom one is romantically or sexually attracted.

Life might be simpler if people adopted one equation, such as, "I am genetically female; I feel female inside; I do female things; I am attracted to males." But, because all of these components of sexuality can be independent, the result is a 4x4 interaction that generates 16 distinct possibilities of sexual identity (Friend, 1987).

Gender role in North American society is in a state of incredible flux, and the resultant uncertainty has spawned an intense effort to get to the root of the differences between the sexes. Books such as Deborah Tannen's *You Just Don't Understand* (1990) contrast typical "male and female" styles of communications. Moir and Jessel's *Brain Sex* speculates on anatomical differences that lead to gender-specific styles. Both of these works, and others like them, have found eager audiences. Yet, there is a huge crossover in human behavior.

As women take up masculine sports like boxing and (albeit very slowly) take over leadership positions in major corporations and in national politics, and as increasing numbers of men gravitate toward the role of housekeeper and child-rearer, demanding a balance between career and relationships, it becomes clear that biology is only one factor determining a person's gender role. Despite this immense plasticity in human behavior, most people hunger for a world that provides them with a simple dichotomy. "Given that our social context is based on clear differences between the sexes, any person who challenges this dichotomy is seen as problematic" (Friend, 1987).

The Biology of Sexual Identity

The biological causes of gender dysphoria and transsexualism remain elusive. Adult endocrine levels are almost always normal in transsexuals,

although it is possible that some hormonal “wash” occurred at a critical time of embryonic development, which sensitized the brain cells in an as-yet immeasurable way. Recent research has concentrated on some extremely small preoptic nuclei in the hypothalamus (Gorski, 1995), but the results have been hard to replicate and harder to interpret. One interesting finding is that a high proportion of individuals who are male-to-female transsexuals (MTFs) are left-handed (Watson, 1991). The significance of this finding with regards to gender role, gender identity, sexual orientation, and brain hemispheric dominance, however, is not understood.

Sexual orientation is another source from which people habitually derive their identity. Superficially, it would seem simple enough: Because heterosexual mating leads to procreation, it is not a huge logical jump to contend that the purpose of mating is procreation — thus defining heterosexual unions as the norm. But, just as people do not eat simply to satisfy their hunger, or talk only convey information, people do not engage in sex just to reproduce.

People can be heterosexual, homosexual, bisexual, or asexual — and all this irrespective of what anatomical equipment they possess, what gender role they live, or what gender they feel like on the inside.

Society has a strong investment in seeing gender within rigid categories, rather than as a continuum, despite the phenomenon, stretching back to the beginning of time, of biological intersex conditions. While people may be males or females, they can also be true hermaphrodites (an ovary, a testis, and both genders’ genitalia), “merms” (male pseudohermaphrodites), or “ferms” (female pseudohermaphrodites). Based on this reality, geneticist Anne Fausto-Sterling (1993) argues that “sex is a vast, infinitely malleable continuum that defies the constraints of even five categories.” Yet this mundane reality is almost unspoken of in our culture (and surgically “corrected” right after birth if discovered).

At least two social consequences flow from this strategy that prevent gen-

eral awareness of intersex conditions. First, society develops an inaccurate, binary conception of gender. Second, the recognition of the coexistence of male and female in the same individual is split off from mainstream culture, and relegated to the realm of poetic symbolism or pornography.

Medical Definition of Gender Identity Disorder

It is little surprise, then, that a tumult is created when an individual, apparently unambiguously one gender, comes to the conclusion that he or she is “trapped in a body of the wrong sex.” In medical terms this distress is called “gender dysphoria,” or a “gender identity disorder,” which the Diagnostic and Statistical Manual of Mental Disorders, 4th. Ed. (American Psychiatric Association, 1994) describes as:

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantage of being the other sex).

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

C. The disturbance is not concurrent with a physical intersex condition.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The most intense of the gender identity disorders is known as transsexualism, and like gender role and sexual identity, represents a continuum of experience. Although they are genetically and hormonally unremarkable males or females, high-intensity transsexuals generally show a life-long identification with the opposite gender.

An anatomically female transsexual, for instance, typically shuns frilly girl accoutrements for boys’ wear; prefers GI Joe to Barbie; prefers playing baseball with the boys to baking with Mom; and will only play house if she can be the dad, or the husband or brother. Many

transsexuals actually assumed in childhood, that they are the opposite sex, and that puberty will magically lead to the secondary sexual characteristics they so admire in the preferred gender. For the anatomical females, the onset of menstruation and breast growth comes as a huge disappointment and cruel confirmation of the biological truth.

For males, the situation is similar but the markers are opposite. Young transsexual males shun rough-and-tumble play, dress up in their mother’s or sister’s clothes, and may obsessively fantasize that they are a princess or mermaid. They gravitate to girls’ games, such as skipping rope and playing house, insisting on taking a female role. Somehow, they decide that it is more proper to sit rather than stand to urinate. They prefer the company of females, and become distraught when beard growth and a deeper voice destroy the fragile image they hold of themselves as a girl.

Society usually applies some ready-made social identities to young transsexuals, but these labels rarely fit with comfort, and usually are at variance with the transsexual’s self-concept. Young transsexual females may enjoy being called “tomboy,” but males frequently are called “sissy” (or at best, “sensitive”). Both groups take it as a compliment when other people mistake them for the preferred gender.

In an interesting corollary, transsexuals who are attracted erotically to members of their own biological sex do not consider themselves homosexual; therefore, the term “gay” or “lesbian” can be perceived as an insult. Nor are transsexuals comfortable with being labeled as transvestites, as their motivation in dressing as the other gender is role-identity congruency, not eroticism.

Although there is some discussion as to whether transsexualism should be considered a disorder at all (rather than an alternate lifestyle, like homosexuality), there is little disagreement that the condition causes profound suffering. Transsexuals routinely experience violent assaults on the streets. Substance abuse is a frequent consequence of this condition. Interpersonal relationships often are problematic, and a romantic life may be almost impossible. Family

alienation is commonplace. Young males especially experience severe peer isolation and bullying as a result of their feminine ways and lack of appetite for customary male pursuits.

The severe social and psychological consequences of gender dysphoria have led to attempts to "treat" effeminate behavior in young boys, largely through behavior modification techniques. In these behavior change programs, adult family members reward typically "masculine" pursuits with praise and gifts, and criticize typically "feminine" behavior. However, effects have been very mixed, and no long-term studies exist to confirm the success of these programs, irrespective of their ethical basis. Regardless of how these feminine boys act initially, almost all will spontaneously grow up to be typically heterosexual adults (Blanchard & Steiner, 1990).

Incidence

Some cultures, notably some aboriginal and Eastern European societies, accommodate gender role and gender identity variations without considering them pathological; therefore, comparing incidence across cultures is not reliable. In those societies that developed a contemporary postindustrial world view, male-to-female (MTF) transsexuals were once thought to outnumber their female-to-male (FTM) counterparts by a vast margin. Clinicians now speculate that incidence may be equal, with case finding responsible for the statistical differences. Fewer anatomical females show up for treatment at gender clinics, but this may suggest that it is easier for women to be immersed in a masculine lifestyle and self-image than it is for anatomical males to live as women. Generally, FTMs seek counseling less often, and suffer fewer other psychiatric disorders than their male counterparts, so their condition likely is identified less frequently.

Course of Gender Dysphoria

It is common for transsexuals, especially males, to fight their discordant internal voice by diving headlong into

pursuits typical of their birth gender. Frequently, males will join the military or other high-risk profession, and one study (Hoenig, Kenna, & Youd, 1970) observed that transsexuals likely enlist at a higher than average rate than the general population. It is not uncommon for male-to-female transsexuals to marry, either through parental or self-imposed pressures. Males are more likely than females to have children, and may delay their reassignment to the female role until the children are grown.

One immensely problematic area for many transsexuals is employment. Despite higher than average educational levels, transsexuals have difficulty finding and holding jobs (Burnham & Diewold, 1993). Again, an MTF who retrains for a more typically "female" occupation usually experiences a significant drop in income in the new career, and the resulting dissatisfaction is a persistent factor in those expressing post-surgical regret (Blanchard & Steiner, 1990). FTMs seem to be in a better position, as they often move into more masculine occupations if they have not found them already. Many report that the testosterone injections give them more energy and increased assertiveness, which is beneficial for working in more responsible positions and asking for promotions and raises.

Social Experimentation

Significant social problems are encountered during actual gender transition, when masculine and feminine features may compete for attention, and patients, sometimes clumsily, experiment with a broader range of cross-gender role behaviors. Added to this is the psychic effect of cross-gender hormones. Patients sometimes exaggerate the preferred gender's behavior. For instance, MTFs may become quite moody or histrionic, and ultrafeminine in their dress and deportment.

FTMs may begin to date females aggressively for the first time, and sometimes have some rather politically incorrect opinions about how to conduct themselves in this regard. (The author asked an FTM patient what it meant to be "the man" in a heterosexual relation-

ship. The answer seemed self-evident to the patient, who replied, "You know, make all the decisions for them [his girlfriends]. When they do anything they have to ask me first. And pay for dinner all the time. I don't like *that* part but that's what you do.")

Traumatic Transition for Family

The transition period tends to be just as traumatic for family members, particularly parents and spouses. Parents develop expectations about having grandchildren that frequently are dashed by their adult child's declaration of transsexual status. Spouses often make incredible psychological and lifestyle accommodations to their mate's gender dysphoria (referring to their mate with a different name, accepting cross-dressing in sexual relations, etc.), but the gross changes brought about by hormones can be a signal of the end of their relationship.

Both parents and spouses of gender dysphoric patients may express hostility toward the medical profession for legitimizing their loved one's behavior, and for aiding and abetting the physical changes that may prove impossible for the family constellation to bear.

Hormonal Treatment

Once hormonal treatment begins, changes can occur within a few weeks. The most common first signs are amenorrhea and lowering of voice pitch in FTMs, and development of tender breasts in MTFs. Some changes, such as beard growth (or its cessation) can take more than half a decade to manifest fully (Gooren & Asscheman, 1992). Patients frequently are impatient to experience faster and more profound changes, and believe increased hormone doses are the answer. However, individuals differ in their target tissue sensitivity to hormones, and also are constrained by genetic inheritance.

Vancouver Hospital's Centre for Sexuality, Gender Identity, and Reproductive Health employs a relatively consistent drug protocol for treating transsexualism. MTFs usually are started on an androgen blocker, customarily

the diuretic spironolactone, 200 mg to 400 mg per day. Spironolactone (or, less commonly, cyproterone) can bring about some feminization: reduction in facial and body hair, redistribution of body weight (many MTFs *want* their thighs to fill out), and some breast growth, without the major side effects of estrogen (Prior, 1989).

Many patients report a calming effect and reduction of gender dysphoria just on spironolactone; this could be due to a combination of a flattening of libido as well as the psychologically soothing effect of tangibly beginning the process of gender transition. Antiandrogens also reduce morning and spontaneous erections, which patients welcome, because the erections remind them of their maleness.

For those appropriate for continuing feminization, the Centre prescribes conjugated estrogens such as Premarin 0.625 mg daily, with a 3- to 6-day break each month. In some patients at high risk for coagulopathies and migraines, estrogen patches have been prescribed successfully.

In addition, clients routinely receive the progestin medroxyprogesterone acetate (Provera), 10 mg to 50 mg, daily. Apart from its effect as an antiandrogen, medroxyprogesterone has been shown to promote bone formation, and may counter the bone loss that might occur with the blockade of male hormones (Prior et al., 1994). It also seems to aid in nipple maturation. Postsurgical regimes are similar, but there is sometimes less need for an androgen blocker in the absence of testicular testosterone (the adrenals continue to produce some testosterone).

The standard treatment for the FTM group is testosterone cypionate, 150 mg to 300 mg IM, every 2 to 4 weeks. This generally produces all of the masculinization required, and the effects are profound. Over the course of a few months and years, patients experience to various degrees a permanent deepening of the voice and thickening of the jaw, plus hormonally sustained increases in muscle mass, and growth of body and facial hair. Male pattern baldness is common. Most report an increase in libido as a result of the higher serum testosterone (which sometimes places quite a strain on their love relation-

ships). Within one to two years, most FTMs pass unobtrusively as males in everyday society.

The Surgical "Sex Change"

Sexual reassignment surgery (SRS) has had a variable reputation in North American medical circles. Facilities performing this surgery increased in the 1960s and 1970s until the publication of Meyer & Reter's report in 1979, which concluded that SRS "confers no objective advantage in terms of social rehabilitation." Although this paper was vigorously criticized, Johns Hopkins Hospital in Baltimore phased out their transsexual surgery service shortly after, and the whole specialty was viewed with great reservation for some time, especially by the public. A flurry of studies were subsequently published on postsurgical outcomes that reaffirmed the value of surgery in carefully selected cases; surveys continue to confirm the improved social adjustment of transsexuals after surgery (Mate-Cole, Freshci, & Robin, 1990).

Sex Reassignment Surgery (MTF)

Despite the popular misconception that genital "sex change" surgery is available almost on demand, most clinics involved in approving individuals for surgery in North America and Europe adhere to the Harry Benjamin International Gender Dysphoria Association's "Standards of Care," first published in 1979 and last revised in

1990. These standards stipulate that two clinicians, at least one of whom is educated to the doctoral level and the other at least to a master's level, and both with experience and specialized ongoing training in assessment and treatment of a broad range of sexual disorders, must recom-

ment hormonal treatment and surgery. The endorsement for SRS must follow at least two years of documented gender dysphoria, and at least one year during which the patient lives immersed in the role of the preferred gender. The Standards of Care also specify the use of certain laboratory tests prior to surgery and provision of access to after-care as well.

For MTFs, there are two slightly different surgical options, although both involve bilateral orchidectomy. The first method, known as the penile inversion technique, consists of resecting the penis to create a hollow tube separate from the urethra; creating a perineal cavity; inserting the inside-out penile skin into the cavity to create a neovagina; and using the scrotal skin to create the labial folds. The second method requires the use of part of the rectosigmoid colon to create a neovagina. The later method has the advantage of creating a vaginal surface with secreting mucosa, but the surgery involves entry into the abdomen, so is significantly more radical. Both methods usually produce an excellent cosmetic result (some SRS surgeons claim to be able to fool a gynecologist, although the author could not locate such a gynecologist). Both methods, especially the former, usually require insertion of a temporary postsurgical stent, and then several months of twice-daily progressive dilatation at home by the patient.

A range of cosmetic surgical and nonsurgical techniques are sometimes employed. These include breast aug-

Even in large tertiary care hospitals, the admission of a transsexual patient often is a catalyst for a huge amount of discussion — most of it peripheral to the care of the patient. Transsexuals almost invariably generate an intense curiosity in staff that borders on the voyeuristic. Animated discussions ensue as staff struggle with the question of whether the patient is "really" male or "really" female. This morbid curiosity and resultant gossip frequently involves all members of the hospital staff: direct caregivers, support staff, building trades, security.

mentation, rhinoplasty, tracheal "shaving" (surgical cartilage reduction to reduce the size of the Adam's apple), and rarely, "laryngeal web" surgery to increase the habitual pitch of the voice. Frequently, hundreds of hours of uncomfortable and expensive electroly-

sis are used to remove facial hair. In some cases, electrolysis is used to remove body hair. In some cases, electrolysis is used to remove facial hair. In some cases, electrolysis is used to remove facial hair.

sis must be endured to remove unwanted facial and body hair permanently.

All of these surgical interventions can produce complications. Although the MTF's motivation for creation of a neovagina is almost always more role-related than erotic, most hope for a patent vagina. One of the most common problems is strictures of the vaginal orifice, or loss of length of the neovagina. This complication is not uncommonly due to lack of regular dilatation (pain while dilating can be sharp, and patients are understandably tentative in testing the new organ). Rectovaginal fistulae, devastating to the patient, are often extremely difficult to remedy. Problems with vaginal and urinary tract infections, and misdirection of the urinary stream due to granulation tissue, are an all-too-frequent reality for these patients as well.

Sex Reassignment Surgery (FTM)

Female-to-male surgery can be even more involved. Bilateral mastectomy and bilateral oophorectomy are standard surgical interventions, and many patients stop there. A few wish to go through with construction of a neophallus. This is a complicated procedure involving many stages (and there are several variations in surgical technique). Usually, construction of a neophallus involves the harvesting of a full-thickness skin graft, either from the upper forearm, thigh, or abdomen, or from the lower forearm after several months' insertion of a tissue expander. The urethra is lengthened, sometimes through the use of endothelial tissue from other parts of the body; the skin graft then is wrapped several times around this neourethra. The scrotum often is fashioned from labial tissue, and testicles simulated by synthetic implants.

Generally, the result is adequate cosmetically, and allows the patient to urinate standing up, a central desire for almost all FTMs. Since the neopenis does not contain erectile tissue, intercourse remains problematic: rigidity has been created by autologous transplants of cartilage, implants of bone or a permanent prosthesis, or use of removable

external devices. All of these methods have shown mixed results (Hage, Bloem, & Bouman, 1993). As in any grafting procedure, graft failure and necrosis are a definite possibility; even the tissue expander can cause complications. Phalloplasty still remains a complicated, expensive, and largely experimental procedure. Nonetheless, many patients maintain that braving the many complications was worthwhile, for the social confidence, for the ability to urinate while standing, and for the capacity to engage in intercourse.

Care of the Transsexual Patient

Several issues arise when treating transsexual patients. Some of these are specifically medical, some are administrative, and some are psychosocial. If clinicians take it as a commitment to provide holistic care, it is important to be sensitive to all of the impediments to that care, whether they arise from the medical condition, the prevailing social milieu, the temporary state of the patient, or the clinician's own assumptions about sexuality.

Transsexual patients are true medical patients receiving treatment for transsexualism, and as such may experience various complications of their treatment that can have an impact on concurrent care. "Baseline" laboratory results for hormonally treated transsexuals will likely be somewhat awry, with MTFs on hormones usually experiencing a slight drop in hemoglobin and a rise in glycosylated hemoglobin and prolactin. There is often an undesirable HDL/LDL ratio and a rise in total cholesterol in FTMs; lipid changes in MTFs generally are positive, but conjugated estrogens occasionally produce high total triglycerides. Also, care must be taken to consider whether female or male norms were employed by the laboratory, and if those norms are applicable to the patient at that particular time.

Accompanying Medical Conditions

MTFs are on significant doses of medications, sometimes augmented by unprescribed supplies. This puts them

at increased risk for breast cancer, coagulopathies such as deep vein thrombosis or pulmonary embolism, and osteoporosis. Thus, it may be desirable to hold the estrogens for 3 to 4 weeks prior to any serious surgery and take special precautions when this has not been done. Extra care should be taken when lifting, transferring, and ambulating transsexual patients, particularly the more aged, due to their potential for low bone density.

MTFs frequently take spironolactone, which is potassium sparing; these patients must be warned against unprescribed potassium supplementation. FTMs can experience obesity and severe acne, so these problems may need to be addressed. Male pattern baldness, although endured by this group with remarkable cheerfulness, is a frequent occurrence that may distress the patient. Also, as substance abuse is not an uncommon problem for either patient group, thorough substance-abuse history-taking and reasonable monitoring for withdrawal symptoms makes sense.

Staff-Transsexual Patient Interaction

Even in large tertiary care hospitals, the admission of a transsexual patient often is a catalyst for a huge amount of discussion — most of it peripheral to the care of the patient. Transsexuals almost invariably generate an intense curiosity in staff that borders on the voyeuristic. Animated discussions ensue as staff struggle with the question of whether the patient is "really" male or "really" female. This morbid curiosity and resultant gossip frequently involves all members of the hospital staff: direct caregivers, support staff, building trades, security.

Staff sometimes ask incredibly personal questions of these patients, often in a well-meaning but misguided attempt to educate themselves. The patient, sometimes with good cause, can experience these questions as a criticism, or as an attempt to repudiate their identity. Neither motivation is in the interest of the patient. All staff must be vigilant to prevent personal curiosity from overstepping clinical information gathering.

Moreover, many transsexual patients have no desire to act as a spokesperson or educational resource. They want to get fixed up and resume their lives, just like most other patients. A genuinely curious caregiver might do better to contact a specialized clinic with a gender program, and survey the literature on transsexualism rather than engage the patient at length on the subject.

One of the greatest sources of friction between caregivers and transsexual patients is the use of names and personal pronouns. Power struggles develop over whether staff should or will use the patient's chosen name and chosen pronoun of "he" or "she." This can be avoided by simply asking the patient what is preferred. Except in cases of psychosis, caregivers have a responsibility to acknowledge the self-chosen identity of their clients. Not to do so is, at the least, *very* bad manners.

Transsexual patients are involved in a developmental process in fully adapting to their new gender identity and as such experience the same travails and rough spots other people do when growing up. However, the urge to speed through gender transition often produces impatience that strains the emotional resources of the patient. As in the life of anyone experiencing adolescence, there will be times when boundaries are mutable and behavior is inconsistent. Add to this the effect of high-dose hormones, and it is obvious that to expect nothing but emotional equanimity from the patient is unrealistic.

Caregivers need to empathize with the growing pains of their patient. Consistent, nonjudgmental behavior on the part of the caregiver helps sustain a milieu that is comfortable for the transsexual patient and others temporarily sharing his or her environment.

Proactive Interventions

A number of proactive interventions are very desirable on the part of the caregiver. Counseling on a wide variety of subjects can be appreciated by the patient. Exercise and nutritional counseling is invaluable for both patient groups: for MTFs to counteract the

weight gain, hyperlipidemia, and osteoporosis associated with their treatment; for FTMs to develop muscle mass and thus better fit into their gender role, and to respond positively to the extra energy often experienced from the testosterone.

Supporting the patients through a stop-smoking program may be a health-saving intervention, in light of the well-established link between smoking, high doses of estrogen, and disease. Though sexual activity often is nil for transsexuals, safe sex information is still a must. Monitoring and appropriate specialist referral for concurrent psychological problems such as anxiety disorders and depression (especially postsurgical depression) is an important aspect of patient care.

Encouraging contact with an experienced social worker to help brave the administrative obstacles to official name change and gender change, and to provide some counseling on family and spousal issues, is another effective intervention. Employment counseling, either to help maintain the patient in their current situation during transition or to prepare them for entry into a more gender-congruent career likely will be beneficial. Putting the patient in touch with reputable self-help and peer counseling groups may be appreciated. Providing a referral to an alcohol or drug-abuse treatment agency could turn out to be one of the most important interventions of all.

Conclusions

Patients with gender identity disorder, especially in its extreme form of transsexualism, are faced with a variety of impediments to living in a healthy, integrated manner. Some of these arise from the disorder itself. Many arise from our society's simplistic and conflicted attitudes toward gender role, gender identity, and sexual orientation. Working with these patients poses a challenge for health care providers from any discipline. This challenge can be overcome with knowledge and a sophisticated, mature approach to care that provides practical information, avoids power struggles, and emphasizes letting the patient take the lead in care decisions.

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Gender Dysphoria

Keypoints

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- 1 Concepts of sexuality and gender identity are undergoing re-examination in society. Recent media attention has intensified interest in the area, although reliable information is sometimes lacking.
- 2 Gender dysphoria and its extreme form, transsexualism, frequently brings sufferers into contact with psychiatric, social, and mental health professionals, and surgical caregivers.
- 3 Treatment of these patients often represents a challenge on many levels. Some guidelines for this care are outlined.

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