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Are Gender Identity Disorders Mental Disorders? A Forensic Consideration

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Abstract: Historically the research, assessment and treatment of Gender Dysphoria (GD) and Gender Variance (GV) have tended to pathologize transvestites (also known as cross dressers) transsexuals (TS) and transgendered (TG) people, in addition to transqueers. Encouragingly, this transphobic psychological paradigm is shifting to a more transpositive one as a response to political pressure by TS/TG consumers and trans-identified mental health and sexual health providers and also as a result of more information about transpeople. To optimize this increasingly collaborative relationship between GD/GV clients and the mental health community, we must ensure that our clinical orientation is one that is truly responsive to the changing real-life needs of a highly diversified trans-population, including the rights to self-determination and comprehensive health care. The new gender created by the reassignment surgery has, in turn, led to many legal complications for postoperative transsexuals because in many developed and the developing countries, transsexuals are not given a legal identity, thereby adding to their agonies and miseries. This paper examines the gender identity disorders with a forensic viewpoint.

Key words: Transvestism, gender dysphoria, gender variance, transgendered transsexualism, autogynophilia

INTRODUCTION

In recent years, it has become orthodox within the transgender community to use the term transgender as a broad and inclusive term. The term transgender has been used to describe the community of all self identified cross gender people whether intersex, transsexual men and women, cross dressers, drag kings and drag queens, transgenderists androgynous, bi-gendered, third gendered or as yet unnamed gender gifted people. The term transgendering is to highlight (1) that transgendering is a generic social; (2) that manifestations of the dimensions and properties of this generic social process will depend on the very different relations that different modes of transgendering have to the male/female binary divide which, from the sociological point of view, constitutes the principal social structural determinant within which the various social processes of transgendering are played out; and (3) that the various and changing categorizations of transgender phenomena and transgender identities are emergent within ongoing social processes of transgendering.

Depending on their relationship to the binary male/female divide, transgendering processes are classifiable into four major modes or styles. These are termed, respectively, migrating, oscillating, negating and transcending (Ekins and King, 2001). Migrating involves moving from one side of the binary divide to the other on a permanent basis. Oscillating involves moving to and fro between male and female polarities, across and between the divide, as in the case with the part-time cross-dresser. Negating indicates those processes tending towards eliminating the binary divide a move to the ungendered: the gender-less. Finally, transcending presupposes going beyond the binary divide a move

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to the "gender-full, as is graphically illustrated in the following statement from an internet mailing list called "Sphere which states, we take our name from the idea that gender isn't a dichotomy (where there's either male or female) or a continuum (where there's a rainbow of stuff in between, all in a line and all related to male or female) but a sphere, where male and female are just two of an infinite number of possible points and you can be anywhere on, inside, or outside the gendered world.

The term autogynephilia (love of oneself as a woman) may well be unknown to many. It was originally introduced into the transgendering literature by Blanchard and Steiner (1985), which defined autogynephilia as a male's propensity to be sexually aroused by the thought of himself as a female.

Just as Hirschfeld (1910) had classified his transvestites according to their erotic interest, Blanchard did likewise with transsexuals. His empirical research convinced him that bisexual, asexual and heterosexual transsexuals were similar to each other and dissimilar to homosexual transsexuals, with regard to, *inter alia*, degree of recalled childhood femininity, extent of interpersonal heterosexual experience, a history of transvestic fetishism and a history of erotic arousal in association with the thought of being a woman. Such findings led him to the view that there are only two fundamentally different types of transsexualism in males: homosexual and nonhomosexual and, moreover, that the common characteristic of the nonhomosexual category is their tendency to be sexually aroused by the thought or image of themselves as women.

Early reports of transgender persons as miserable souls who plough their lonely and unhappy rum path through life (Hoenig, 1985) were followed by a number of studies in which these individuals were characterized as generally well adjusted (Bentler and Prince, 1970; Feinbloom, 1976; Bullough *et al.*, 1983). In recent years, a number of well-designed studies of this population have observed high levels of depressive symptomatology, affective disorder and suicidality (Cole, 1997). Clements-Nolle *et al.* (2001), in their community-based sample of transgender persons in San Francisco, found that 62% of the trans women were depressed. Several investigators have observed comparatively high levels of anxiety and suicidal ideation in this population (Pauly, 1993), while others have reported that a significant segment of this population suffers from some degree of emotional distress (Jones, 2002).

EPIDEMIOLOGICAL CONSIDERATIONS

When the gender identity disorders first came to professional attention, clinical perspectives were largely focused on how to identify candidates for sex reassignment surgery. As the field matured, professionals recognized that some persons with bonafide gender identity disorders neither desired nor were candidates for sex reassignment surgery. The earliest estimates of prevalence for transsexualism in adults were 1 in 37,000 males and 1 in 107,000 females. The most recent prevalence information from the Netherlands for the transsexual end of the gender identity disorder spectrum is 1 in 11,900 males and 1 in 30,400 females (Cast, 1999).

However, the following four observations, though not yet firmly supported by systematic study, increase the likelihood of an even higher prevalence: 1) unrecognized gender problems are occasionally diagnosed when patients are seen with anxiety, depression, bipolar disorder, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, other sexual disorders and intersexed conditions; 2) some nonpatient male transvestites, female impersonators, transgender people and male and female homosexuals may have a form of gender identity disorder; 3) the intensity of some persons gender identity disorders fluctuates below and above a clinical threshold; 4) gender variance among female-bodied individuals tends to be relatively invisible to the culture, particularly to mental health professionals and scientists.

Even if epidemiological studies established that a similar base rate of gender identity disorders existed all over the world, it is likely that cultural differences from one country to another would alter the behavioral expressions of these conditions. Moreover, access to treatment, cost of treatment, the

therapies offered and the social attitudes towards gender variant people and the professionals who deliver care differ broadly from place to place. While in most countries, crossing gender boundaries usually generates moral censure rather than compassion; there are striking examples in certain cultures of cross-gendered behaviors (e.g., in spiritual leaders) that are not stigmatized.

DEVELOPMENT OF NOMENCLATURE

The term transsexual emerged into professional and public usage in the 1950s as a means of designating a person who aspired to or actually lived in the anatomically contrary gender role, whether or not hormones had been administered or surgery had been performed. During the 1960s and 1970s, clinicians used the term true transsexual. The true transsexual was thought to be a person with a characteristic path of atypical gender identity development that predicted an improved life from a treatment sequence that culminated in genital surgery. True transsexuals were thought to have: 1) cross-gender identifications that were consistently expressed behaviorally in childhood, adolescence and adulthood; 2) minimal or no sexual arousal to cross-dressing and 3) no heterosexual interest, relative to their anatomic sex. Belief in the true transsexual concept for males dissipated when it was realized that such patients were rarely encountered and that some of the original true transsexuals had falsified their histories to make their stories match the earliest theories about the disorder. The concept of true transsexual females never created diagnostic uncertainties, largely because patient histories were relatively consistent and gender variant behaviors such as female cross-dressing remained unseen by clinicians. The term gender dysphoria syndrome was later adopted to designate the presence of a gender problem in either sex until psychiatry developed an official nomenclature.

The diagnosis of Transsexualism was introduced in the DSM-III (1980) for gender dysphoric individuals who demonstrated at least two years of continuous interest in transforming the sex of their bodies and their social gender status. Others with gender dysphoria could be diagnosed as Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type; or Gender Identity Disorder Not Otherwise Specified (GIDNOS). These diagnostic terms were usually ignored by the media, which used the term transsexual for any person who wanted to change his/her sex and gender.

In 1994, the DSM-IV committee replaced the diagnosis of transsexualism with Gender Identity Disorder (DSM-IV). Depending on their age, those with a strong and persistent cross-gender identification and a persistent discomfort with their sex or a sense of inappropriateness in the gender role of that sex were to be diagnosed as Gender Identity Disorder of Childhood (302.6), Adolescence, or Adulthood (302.85). For persons who did not meet these criteria, Gender Identity Disorder Not Otherwise Specified (GIDNOS)(302.6) was to be used. This category included a variety of individuals, including those who desired only castration or penectomy without a desire to develop breasts, those who wished hormone therapy and mastectomy without genital reconstruction, those with a congenital intersex condition, those with transient stress-related cross-dressing and those with considerable ambivalence about giving up their gender status. Patients diagnosed with GID and GIDNOS were to be subclassified according to the sexual orientation: attracted to males; attracted to females; attracted to both; or attracted to neither. This subclassification was intended to assist in determining, over time, whether individuals of one sexual orientation or another experienced better outcomes using particular therapeutic approaches; it was not intended to guide treatment decisions.

Between the publication of DSM-III and DSM-IV, the term transgender began to be used in various ways. Some employed it to refer to those with unusual gender identities in a value-free manner, that is, without a connotation of psychopathology. Some people informally used the term to refer to any person with any type of gender identity issues. Transgender is not a formal diagnosis, but many professionals and members of the public found it easier to use informally than GIDNOS, which is a formal diagnosis.

GENDER IDENTITY DISORDERS vis-à-vis MENTAL HEALTH

To qualify as a mental disorder, a behavioral pattern must result in a significant adaptive disadvantage to the person and cause personal mental suffering. The DSM-IV and ICD-10 (1992) have defined hundreds of mental disorders, which vary in onset, duration, pathogenesis, functional disability and treatability. The designation of gender identity disorders as mental disorders is not a license for stigmatization, or for the deprivation of gender patients civil rights. The use of a formal diagnosis is often important in offering relief, providing health insurance coverage and guiding research to provide more effective future treatments.

Mental Health Professionals (MHPs) who work with individuals with gender identity disorders may be regularly called upon to carry out many of these responsibilities: (1) To accurately diagnose the individual's gender disorder; (2) To accurately diagnose any co-morbid psychiatric conditions and see to their appropriate treatment; (3) To counsel the individual about the range of treatment options and their implications; (4) To engage in psychotherapy; (5) To ascertain eligibility and readiness for hormone and surgical therapy; (6) To make formal recommendations to medical and surgical colleagues; (7) To document their patient's relevant history in a letter of recommendation; (8) To be a colleague on a team of professionals with an interest in the gender identity disorders; (9) To educate family members, employers and institutions about gender identity disorders; (10) To be available for follow-up of previously seen gender patients.

The mental health professional, who specializes in gender identity disorders should possess: (a) A masters degree or its equivalent in a clinical behavioral science field. This or a more advanced degree should be granted by an institution accredited by a recognized national or regional accrediting board. The mental health professional should have documented credentials from a proper training facility and a licensing board; (b) Specialized training and competence in the assessment of the DSM-IV/ICD-10 Sexual Disorders (not simply gender identity disorders); (c) Documented supervised training and competence in psychotherapy; (d) Continuing education in the treatment of gender identity disorders, which may include attendance at professional meetings, workshops, or seminars or participating in research related to gender identity issues and (e) The professional who evaluates and offers therapy for a child or early adolescent with GID should have been trained in childhood and adolescent developmental psychopathology (Sharma and Harish, 2003).

Mental health professionals who recommend hormonal and surgical therapy share the legal and ethical responsibility for that decision with the physician who undertakes the treatment. The Mental Health Professionals Documentation Letters for Hormone Therapy or Surgery Should Succinctly Specify: (a) The patient's general identifying characteristics; (b) The initial and evolving gender, sexual and other psychiatric diagnoses; (c) The duration of their professional relationship including the type of psychotherapy or evaluation that the patient underwent; (d) The eligibility criteria that have been met and the mental health professional's rationale for hormone therapy or surgery; (e) The degree to which the patient has followed the Standards of Care to date and the likelihood of future compliance; (f) Whether the author of the report is part of a gender team; (g) That the sender welcomes a phone call to verify the fact that the mental health professional actually wrote the letter as described in this document.

CLINICAL THRESHOLD

A clinical threshold is passed when concerns, uncertainties and questions about gender identity persist during a person's development, become so intense as to seem to be the most important aspect of a person's life, or prevent the establishment of a relatively unconflicted gender identity. The person's struggles are then variously referred to as a gender identity problem, gender dysphoria, a gender problem, a gender concern, gender distress, gender conflict, or transsexualism. Such struggles are known

to occur from the preschool years to old age and have many alternate forms. These reflect various degrees of personal dissatisfaction with sexual identity, sex and gender demarcating body characteristics, gender roles, gender identity and the perceptions of others. When dissatisfied individuals meet specified criteria in one of two official nomenclatures the International Classification of Diseases-10 (ICD-10) or the Diagnostic and Statistical Manual of Mental Disorders--Fourth Edition (DSM-IV)--they are formally designated as suffering from a Gender Identity Disorder (GID). Some persons with GID exceed another threshold--they persistently possess a wish for surgical transformation of their bodies.

Two Primary Populations with GID exist: Biological Males and Biological Females. The sex of a patient always is a significant factor in the management of GID. Clinicians need to separately consider the biologic, social, psychological and economic dilemmas of each sex.

Harry Benjamin International Gender Dysphoria Association following ICD-10 (F64) lays the following standards of care for diagnosis and the psychiatric, psychological, medical and surgical management of gender identity disorders (HBIGDA, 2001).

Transsexualism (F64.0) has three criteria: (1) The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; (2) The transsexual identity has been present persistently for at least two years; (3) The disorder is not a symptom of another mental disorder or a chromosomal abnormality.

Dual-role Transvestism (F64.1) has three criteria: (1) The individual wears clothes of the opposite sex in order to experience temporary membership in the opposite sex; (2) There is no sexual motivation for the cross-dressing; (3) The individual has no desire for a permanent change to the opposite sex.

Gender Identity Disorder of Childhood (64.2) has separate criteria for girls and for boys.

For Girls

- The individual shows persistent and intense distress about being a girl and has a stated desire to be a boy (not merely a desire for any perceived cultural advantages to being a boy) or insists that she is a boy.
- Either of the following must be present: (a) Persistent marked aversion to normative feminine clothing and insistence on wearing stereotypical masculine clothing; (b) Persistent repudiation of female anatomical structures, as evidenced by at least one of the following: An assertion that she has, or will grow, a penis; Rejection of urination in a sitting position; Assertion that she does not want to grow breasts or menstruate.
- The girl has not yet reached puberty.
- The disorder must have been present for at least 6 months.

For Boys

- The individual shows persistent and intense distress about being a boy and has a desire to be a girl, or, more rarely, insists that he is a girl.
- Either of the following must be present: (a) Preoccupation with stereotypic female activities, as shown by a preference for either cross-dressing or simulating female attire, or by an intense desire to participate in the games and pastimes of girls and rejection of stereotypical male toys, games and activities; (b) Persistent repudiation of male anatomical structures, as evidenced by at least one of the following repeated assertions: That he will grow up to become a woman (not merely in the role); That his penis or testes are disgusting or will disappear; That it would be better not to have a penis or testes.
- The boy has not yet reached puberty.
- The disorder must have been present for at least 6 months.

Treatment Goal

The general goal of psychotherapeutic, endocrine, or surgical therapy for persons with gender identity disorders is lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment. The Standards of Care (SOC) are clinical guidelines intended to provide flexible directions for the treatment of persons with gender identity disorders that should be recognized as such, explained to the patient and documented both for legal protection and so that the short and long term results can be retrieved to help the field to evolve.

PSYCHOTHERAPY

Psychotherapy is a series of interactive communications between a therapist who is knowledgeable about how people suffer emotionally and how this may be alleviated and a patient who is experiencing distress. Typically, psychotherapy consists of regularly held sessions. The psychotherapy sessions initiate a developmental process. They enable the patient's history to be appreciated, current dilemmas to be understood and unrealistic ideas and maladaptive behaviors to be identified. Psychotherapy is not intended to cure the gender identity disorder. Its usual goal is a long-term stable life style with realistic chances for success in relationships, education, work and gender identity expression.

HORMONE THERAPY

Cross-sex hormonal treatments play an important role in the anatomical and psychological gender transition process for properly selected adults with gender identity disorders. Hormones are often medically necessary for successful living in the new gender. They improve the quality of life and limit psychiatric co-morbidity, which often accompanies lack of treatment. When physicians administer androgens to biologic females and estrogens, progesterone and testosterone-blocking agents to biologic males, patients feel and appear more like members of their preferred gender. However, the administration of hormones is not to be lightly undertaken because of their medical and social risks. Three criteria exist: (1) Age 18 years; (2) Demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks; (3) Either: (a) A documented real life experience of at least three months prior to the administration of hormones; or (b) A period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months) (HBIQDA, 2001).

The maximum physical effects of hormones may not be evident until two years of continuous treatment. Heredity limits the tissue response to hormones and this cannot be overcome by increasing dosage. The degree of effects actually attained varies from patient to patient.

Biologic males treated with estrogens can realistically expect treatment to result in: breast growth, some redistribution of body fat to approximate a female body habitus, decreased upper body strength, softening of skin, decrease in body hair, slowing or stopping the loss of scalp hair, decreased fertility and testicular size and less frequent, less firm erections. Most of these changes are reversible, although breast enlargement will not completely reverse after discontinuation of treatment.

Biologic females treated with testosterone can expect the following permanent changes: a deepening of the voice, clitoral enlargement, mild breast atrophy, increased facial and body hair and male pattern baldness. Reversible changes include increased upper body strength, weight gain, increased social and sexual interest and arousability and decreased hip fat.

However, hormones can provide health benefits as well as risks. Risk-benefit ratios should be considered collaboratively by the patient and prescribing physician. Furthermore, Hormonal treatment should be provided only to those who are legally able to provide informed consent. This includes persons who have been declared by a court to be emancipated minors and incarcerated persons who

are considered competent to participate in their medical decisions. For adolescents, informed consent needs to include the minor patients assent and the written informed consent of a parent or legal guardian.

SURGERY

In persons diagnosed with transsexualism or profound GID, sex reassignment surgery, along with hormone therapy and real life experience, is a treatment that has proven to be effective. Such a therapeutic regimen, when prescribed or recommended by qualified practitioners, is medically indicated and medically necessary. Sex reassignment is not experimental, investigational, elective, cosmetic, or optional in any meaningful sense.

Prior to performing any surgical procedures, the surgeon should have all medical conditions appropriately monitored and the effects of the hormonal treatment upon the liver and other organ systems investigated. Since pre-existing conditions may complicate genital reconstructive surgeries. The medical record should contain written informed consent for the particular surgery to be performed.

Genital surgery for biologic males may include orchiectomy, penectomy, clitoroplasty, labiaplasty or creation of a neovagina; for biologic females it may include hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, or creation of a neophallus.

Minimum eligibility criteria for various genital surgeries equally apply to biologic males and females seeking genital surgery. They are: (a) Legal age of majority in the patients nation; (b) Usually 12 months of continuous hormonal therapy for those without a medical contraindication; (c) 12 months of successful continuous full time real-life experience; (d) If required by the mental health professional, regular responsible participation in psychotherapy throughout the real life experience at a frequency determined jointly by the patient and the mental health professional; (e) Demonstrable knowledge of the cost, required lengths of hospitalizations, likely complications and post-surgical rehabilitation requirements of various surgical approaches;

The readiness criteria include: (a) Demonstrable progress in consolidating ones gender identity; and (b) Demonstrable progress in dealing with work, family and interpersonal issues resulting in a significantly better state of mental health; this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis, suicidality, for instance).

Genital surgical treatments are to be undertaken only after a comprehensive evaluation by a qualified mental health professional. Genital surgery may be performed once written documentation that a comprehensive evaluation has occurred and that the person has met the eligibility and readiness criteria. By following this procedure, the mental health professional, the surgeon and the patient share responsibility of the decision to make irreversible changes to the body.

ETHICAL QUESTIONS CONCERNING SEX REASSIGNMENT SURGERY

Many persons, including some medical professionals, object on ethical grounds to surgery for GID. In ordinary surgical practice, pathological tissues are removed in order to restore disturbed functions, or alterations are made to body features to improve the patients self image. Among those who object to sex reassignment surgery, these conditions are not thought to be present when surgery is performed for persons with gender identity disorders. It is important that professionals dealing with patients with gender identity disorders feel comfortable about altering anatomically normal structures. In order to understand how surgery can alleviate the psychological discomfort of patients diagnosed with gender identity disorders, professionals need to listen to these patients, discuss their life histories

and dilemmas. The resistance against performing surgery on the ethical basis of above all do no harm should be respected, discussed and met with the opportunity to learn from patients themselves about the psychological distress of having profound gender identity disorder.

FORENSIC CONSIDERATIONS OF SOCIAL BEHAVIOR

A variety of explanations have been suggested for the etiology of emotional difficulties in this population. One view sees the mental health problems of transgender persons and perhaps this condition itself, as bound up with early family difficulties and trauma. An absent or abusive father, or an overindulgent or abusive mother and other aspects of family conflict during early development, may impede identification with a same-gender parenting figure (Stoller, 1975). From a somewhat different perspective (Kohut, 1971) the mirroring of the self in relationship to significant others may be distorted among some transgender persons. This may be manifested as narcissistic pathology or some other form of personality disorder (Hartmann, 1997). Others have viewed transgender identification of children as a maladaptive defense mechanism in the context of a threatening environment (Ovesey and Person, 1976; Devor, 1994).

Another view traces emotional distress among transgender persons, more specifically, to a negative body image. A sense of awkwardness or discomfort about one's anatomical sex is often linked to negative affect associated with these ideas (Steiner *et al.*, 1985). Transgender persons have long been described as fundamentally disliking their biological sexual characteristics (Hoenig, 1985). According to Benjamin (1966), transgender persons exhibit intensely negative attitudes toward their genitalia, in particular. For trans women, the penis supposedly becomes an organ of hate and disgust (Benjamin, 1966). From this perspective, negative attitudes toward one's self (one dimension of depression) are epiphenomenal to underlying negative attitudes toward one's body.

Others have pointed to perceptions of stigma and experiences with discrimination associated with gender variant living in an often hostile environment (Cole, 2000). Because they transgress fundamental norms of the binary gender system, transgender persons are thought to be at the low end of the hierarchy of acceptability in American society (Herek, 1987). Recent studies indicate that these individuals experience stigma and discrimination in seeking housing, employment and social services and are not infrequently verbally and physically abused. There is some evidence that these perceptions and experiences take a toll on mental health functioning in this population (Jones, 2002). But in addition to the above factors, most investigators would probably agree that the mental state (and perhaps mental health) of transgender persons is affected by the extent to which transgender identity is incorporated in social relationships and supported (or not supported) by relationship partners.

The interpersonal relationships of transgender persons have been described in a number of qualitative and small-scale studies. Informing a long-term sexual partner (or spouse) about one's trans identity is often associated with interpersonal turmoil, especially if the relationship was formed on the basis of a non-transgender identity (Brown, 1998). Some relationships with existing sexual partners are re-negotiated in which a transgender identity is accepted and reciprocated (Higgins, 1999). Informing parents about transgender identity is described as critically important (Parker and Barr, 1984). The failure of parents to acknowledge the legitimacy of this identity is viewed as an obstacle to achieving a sense of self-acceptance among transgender persons (Bolin, 1988; Saporita and Brzek, 1983).

Identity-affirming relationships with parents, when they occur, are described as a type of symbolic rebirth. Among trans women, parents were the source of their birth and nurturance as males and symbolically can be the source of their rebirth and nurturance as females (Bolin, 1988). Some siblings, caught between their beliefs about proper gender roles and their personal loyalties to a brother

or sister, have been described as dismissive and hostile to transgender persons (Sapora and Brzek, 1983). When it occurs, acceptance by siblings is described as vitally important; it may represent a type of retroactive credibility for a trans identity (Bolin, 1988). Changing genders in the context of relationships with children may be charged with emotion and confusion. Despite these difficulties, relationships of transgender persons with their children have been formed in which finding novel ways of dealing with gender-variant living are a source of pride and distinction (Boszormenyi-Nagy and Spark, 1973).

In the process of transitioning, transgender persons typically sift through their friendship network, largely avoiding those individuals anticipated to be critical toward their newly celebrated core gender. Some friendships may be re-established, based on ones new gender and new friendships may be developed. Whether old or new, celebrations of identity with friends provide much-needed emotional support and generally legitimate a gender-variant lifestyle (Blumenstein, 1998).

Changing ones gender presentation in the workplace is a unique challenge. Turning over (changing genders) in the context of existing employment is not infrequently associated with strained relationships with co-workers and supervisors, which frequently results in loss of employment (Bolin, 1988). In sum, the social relationships of transgender persons appear to be a complex array of both negative and positive experiences, in the context of different relationships, which frequently change over time.

CONCEPTUAL FORMULATION FOR TRANSGENDER IDENTITY AND SOCIAL RELATIONSHIPS

The complex array of experiences in social relationships and their affects on mental health, can be conceptually understood in terms of four general processes:

- Identity awareness: Keeping the secret about ones transgender identity from others may, in itself, contribute to emotional distress (Cole, 2000). On the other hand, disclosing emotionally significant aspects of ones self-concept to others has long been suggested as contributing to mental health (Jourard, 1971).
- Identity performance: Even if a transgender identity is revealed to others, a failure to act upon it in the context of the relationship may negatively affect mental health. Behavioral expressions of transgender identity, such as cross dressing, may produce a sense of well-being (Steiner *et al.*, 1985). In a sample of 55 trans women, a scale of social reorientation, based on reported cross-dressing and role-playing in four role contexts, was strongly associated with fewer depressive symptoms.
- Identity congruence: Even if others are aware of transgender identity (identity awareness) and this identity is acted upon in the context of the relationship (identity performance), a failure of relationship partners to respond in terms of this identity may be disconcerting. A reciprocation of transgender identity (identity congruence) may contribute to mental health (Stets, 2001).
- Identity support: It may vary from ridicule and devaluation (identity rejection) to acceptance, positive reinforcement and behavioral reciprocation (identity support). The type of behavioral response (rejection versus support) is seen as critically significant for the well being of transgender persons (Boswell, 1998).

CONCLUSIONS

Here and there, so-called cases of surgical sex transmutation have been reported. However, in order to understand the many faceted questions involving sex transmutation, we need to understand sex in its genital meaning as well as in its physical and psychological manifestation as a passion. Furthermore,

we also need to look into social attitudes. There are different issues for people who are going to live full time in the opposite gender role versus people who are balancing two gender images. With the transsexual, once the gender shift occurs, most of the work is done and one can get on and live ones life. However, if one is a cross-dresser, its an ongoing issue. Ones whole life he is dealing with balancing the two and thats a big challenge. If your whole life is a secret, it affects who you are and your relationship with other people, particularly with people whom you love. Who do you tell, how do you tell, what is the effect of having a secret, of feeling not completely known, feeling of being rejected? Of course, there are issues of depression, isolation, loneliness, feeling different, issues of self-esteem and a lot of guilt over who you are. As such additional research is needed to further elucidate the social psychological processes involved in the association between identity affirmation and mental health among transgender persons.

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