

Trans. as I see it... A Crash Course on Trans Competency

By Julie Weber, MSW

When I grew up, trans meant transsexual. It was a rare someone, (seemingly one in 100 million), who was “born one ‘sex’ and switched completely to the other ‘sex’ as physically and visibly as possible. The word ‘sex’ back then was synonymous with gender.

In the Seventies, transsexuals were looked at strangely-- as freaks, with the suspicion that they were sexually obsessed and/or might contaminate others. Subsequently, after a male-to-female set of surgeries, for instance, transsexuals they were judged on how well they could ‘pass.’*

Not only were the words, sex and gender used interchangeably, when denominating gender, but people with alternative gender expressions (Drag Queen, cross dressers, transsexuals) were all assumed to be homosexual. In other words, gender difference and homosexual sexual orientations were synonymous.

Enter the nineties: Queer studies programs began emerging at cutting edge universities, and the simultaneous development and widespread pharmaceutical availability of the synthesized hormones estrogen and testosterone, and the androgen-blocking spironolactone, began facilitating more wide scale gender transition, making the development of secondary sexual characteristics (breasts, changes in skin, changes in hair growth, voice pitch, etc.) a tangible reality. Along with hormonal developments, the more difficult FTM (female to male) surgeries began emerging, and progressing, for changing female anatomy to male (phalloplasty, where a penis is constructed, and the now largely preferred, more standard, sensation enhancing metoidioplasty, where the enlarged ‘clitoris’ is freed from it’s hood), and the male to female surgeries improved and became more readily available.

Suddenly, for the first time in the history of our race, with the availability of both hormones and surgeries, people had the scientific means physically to cross the gender boundary. In the words of Max Valerio, “[Gender transition] is one of the most extravagant experiments of the Twentieth Century,” (The Testosterone Files). People who had previously had to settle for dressing in the clothes, roles and lifestyles of the opposite gender now have the wherewithal to change their bodies anatomically. This decision is frequently accompanied by relief, excitement, anticipation and at times, moments of confusion. It is not unusual to hear trans people who have undergone surgeries recount that the morning of waking up after their surgery with the anatomy of their identified gender was the happiest day of their lives.

Back to the early Nineties, one of the things that began happening in the Lesbian community around this time is that some of the butch dykes and ‘women,’ who were already on the more masculine edge of the gender spectrum, began to transition to male identities on testosterone and with surgeries, but the expense of the surgeries prohibited them at times from transitioning fully. The financial restrictions of growing up poor or working class stratified the gender revolution and prohibited the revolution from being available to all. Not surprisingly, for many people true gender freedom was enmeshed, and remains enmeshed, with class issues.

Among those who could and did intend to fully transition, some began their testosterone treatment and never progressed to the full dose. Some began, moved to the full dose and then backed off (to a median dose). Others had “top surgery” (a double mastectomy and breast reconstruction/contouring) but no “bottom surgery.” Yet others transitioned partially or fully and turned around and came part way back. A substantial number of FTM (male) identified people fully transitioned and stayed. Suddenly, where we thought we had two opposite genders (mistakenly, as we have always had people born intersex, with the anatomy of both genders), now, in the 21st Century, we have more or less fleshed out a full gender spectrum.

In virtually all cases in which people cross the gender boundary we are offered a unique lens to understand the psychological and social differences of men/women, and the effects of male and female hormones on perception, drive, feelings, intellect and action. Those who have landed somewhere in the

middle of the gender binary system have vivid and potent perceptions about the ways our traditional inclination to divide gender into distinct and separate categories is harmful, not only to transgender people, but also to heterosexual people with effeminate manners, girls who like trucks better than Barbies, boys who want to be dancers... to people who contradict the way we still classify gender by rote category.

Gender has emerged, in the 21st Century, as a complex kind of identity that we are still on the brink of exploring and understanding. Where it used to be thought to reside in the genitals, gender is now thought by scientists to reside in the brain. Arguments that gender is a social construct, while prevalent for a time (particularly during the nineties) in academia, seem to fall apart as more people bravely step forward and come out to share their truths and confessions about identifying in a way that contradicts the gender into which they were socialized. The experiences of people transitioning bio-chemically lend ground to a gender theory that acknowledges a hormonal basis for the feelings and tendencies we more typically classify as male and female.

Transgender is an umbrella term that spans the whole range of gender identities from the complete and traditional masculine stereotypes to feminine ones, with an entire scope of often 'unconventional' and relevant variations (including intersex variations) between. In addition to being a personal term for identification, the word transgender is also now used as a kind of political identification, meaning: transgender/beyond gender, i.e., I don't subscribe to the gender binary. Thus people who have no intention of starting hormones may identify as transgender as a way of supporting trans-liberation and/or as a means of acknowledging the natural gender variations and complexities in themselves.

The current political climate within the transgender community will undoubtedly change. We are arguably still in the early adolescence of understanding the complexities of gender and the ranges, forms and implications of gender identity. What has been in vogue: the rejection of the gender binary-- is now coming under question by those who do fully transition and actually prefer one side of the binary. In addition, recent years have seen the rise of a new group within the transgender community: transfemmes, i.e, queerly identified women who have stepped out of traditional female identity and have circled back around to a distinctly 'queer femininity' that works. Gender is reinventing itself daily.

Queer and Transgender are both umbrella terms for differently identified people-- in terms of gender and sexual orientation. Queer specifically might mean trans, gay, dyke, bi, polyamorous, kink friendly, etc. Trans might refer to bois, tomboys, cross dressers, leather daddies, gender queers, fags, sissys, tranny bois or traditional trans women, trans men... Queer is a larger umbrella that usually includes trans people. Trans is an expression of gender identity.

What's clear now, that we didn't understand several decades ago, is that gender and sexual orientation are two completely different issues. If someone is transgender and moves from one side of the binary where he/she was "placed" to the other side of the gender binary, it doesn't mean that that person is gay. Further, the hormones and the transition itself can sometimes change a person's previously identified sexual orientation (leaving one to wonder, was I straight all along/was I gay all along?).

I think (these are my thoughts) it's possible that in the next few decades, the term sexual orientation itself may become obsolete, due to categories of gender themselves coming under question. After all, if a person in the middle of the gender spectrum is attracted to overtly masculine or feminine identified people, what do we call that? It's somewhere between heterosexual and gay. See the problem? Sexual orientation is predicated on 2 distinct genders. Each landing point in the middle of gender complicates 'the orienting person's' definition. Sexual orientation may be/have been a mere stepping stone on this road of understanding the complexities of identity and attraction. While we want definition, our 'definitions' are crumbling before us. Science itself is breaking down forms: gender can be fluid, much more fluid at least than we had ever imagined. We are coming closer to Einstein's formula of relativity. Our language is changing, along with our understanding, as new psychological paradigms appear, based on qualitative research and attention to personal disclosure and narrative.

A Few Notes about Language and Terminology:

The term *'pass' is/should be falling by the wayside. The phrasing used to be "she 'passes' as female." How we look at it now instead-- is that the "'female' with the male birth anatomy" passed as a male for many years and now (after transitioning) has come home to the identity that fits, the person she really is.

Sex reassignment surgery is another phrase I expect will be phased out. Personally, I'd like to see everyone agree that sex is a physical act, not a set of genitals.

The terms FTM (Female to Male) and MTF (Male to Female) are still used at this point but are being replaced in some communities by 'male affirmed' or 'trans man,' and 'female affirmed,' or 'trans woman,' respectively.

Gender pronouns: at times, the traditional pronouns (he, she him, her) are being used interchangeably by gender variant people. Other times they are replaced by gender neutral terms that are emerging- hym, hir, s/he, ze... Many people who transition across to a full polar end of the gender spectrum, switch their preferred pronouns and the world follows suit. If you meet a transgender person and you are uncertain about pronoun identification, the proper etiquette is to ask: which pronouns do you prefer?

Diagnostic Issues:

The diagnosis Gender Identity Disorder (GID) is misleading and problematic, and yet we have not yet come up with a good solution to/revision of this term and category as a psychological diagnosis. The problem is that the word 'disorder' implies that there is something wrong with the individual. The reality is that the individual is intrinsically fine, but often traumatized socially and hence psychologically by the gender projections of others. In other words, the problem is sociological, i.e. caused by us, our society: we have been (often unknowingly) boxing people in and preventing freedom of gender expression. We need to accept that new gender definitions are emerging that often defy anatomical norms, and learn to embrace anatomical transition and intersex contradictions. When our society realizes gender and anatomy can be separate issues, and allows people to self-identify, and if desired transition respectfully, then we likely will not need a 'disorder' category.

In the medical field, instead of GID, the transsexual diagnosis is sometimes called Gender Dysphoria. Because it does not include the term disorder, the dysphoric diagnosis is arguably less problematic. Dysphoria, for trans people, is often two pronged. There is both a personal and an interpersonal level. The first is a the discord between the anatomy one may see in the mirror and the emotional gender one feels (a personal level of dysphoria). The second is the unanimously painful experience of being sociologically typecast by family, friends, co-workers, clinicians/society in way that differs from one's internal identity.

Right now abolishing the category of a Gender issues related diagnosis is problematic. Essentially, removing a gender category from Mental Health assessments would ameliorate the possibility for people to get the medical/mental health coverage that they usually need to help cover the costs of the often life-saving surgeries. Until we emerge with a more accurate, less punitive term to distinguish trans people's need to transition, we are stuck with the pejorative category we have. Please read between the lines and recognize that gender is a rapidly changing field and that we desperately need revisions to our terminology. Use the existing GID diagnosis to procure help for people, and avoid pathologizing clients.

Fortunately, physicians are waking up one by one, albeit slowly, to the fact that when infants are born intersex or with uncommon anatomical combinations, they need to preserve the child's gender neutrality. Like author and trans person Kate Bornstein says, in advocacy of all children: when asked what gender is your child, or 'what did you have, a boy or a girl;' tell them, "We don't know. We'll let you know when he or she tells us."

While the Harry Benjamin Standards of Care for transgender people have been loosened, therapists need to be cognizant of the fact that for now, we are often the gatekeepers to gender rectification. When clients present as transgender/transsexual, with clarity, after years of suffering, we need to be careful not to prolong the client's suffering due to our gender ignorance.

I'd like to add my view that it is a blessing, a privilege even, to be born with an anatomy that matches our internal gender identity. Transsexual people have not had that privilege. I'd like to encourage all of us to keep expanding our knowledge and generosity to include this trans people who are still largely disenfranchised by social and societal 'norms.'

Those of us uneducated about gender issues might contemplate that we are standing on a 'blind spot' we cannot see unless we begin to listen to the profound and often painful experiences of trans people whom we have marginalized or excluded, whether the ostracization has been intentional or accidental. It is our responsibility, particularly as mental health providers, to wake up to emerging evidence and changing realizations about gender and the problems our ignorance has caused. It's time to stop the cycle of harm and do our best to get over to the side of help.

Treatment Issues:

Among other things, therapists are often asked for a "carry letter" that explains to medical people, law enforcement, etc. that a person is under your care and is the process of gender transition (and should be referred to as she/he). This letter is also used to support the Change of Name process and is used to clarify issues like bathroom use, etc. as necessary. It is meant to be a simple, short documentation for guidance.

While the Harry Benjamin Standards (a 'bill of rights' and guideline of standards of care for trans people) no longer require letters of assessment from therapists for clients to begin hormone therapy (the letter is still necessary for surgeries in the US), these (longer) letters of assessment are nonetheless extremely helpful in medically expediting what can be an already difficult transition process. People at one time (fifteen years ago even) were required to live a whole year visibly representing the gender they were 'seeking.' This caused all kinds of problems, with safety (trans people being targeted for violence), employment, medical care, confusion for providers, friends, teachers, etc. In addition, it reinforced stereotypes by requiring a person to adopt the stereotypical attire of the 'opposite' polar gender. People who might not have wanted a 'full transition' were forced to feign the desire for surgeries they might not want or could not afford. People were denied 'gender reassignment' based on their ability both 'to pass' and their perceived ability to afford and follow through with the gamut of largely imperfect procedures. In addition to that, people who could not easily 'pass' were frequently denied access to both hormones and 'reassignment surgeries' with the justification that the therapist was saving the patient from gender confusion and social ridicule.

Therapists have long been the first step of gateway process that is followed in the second step by medical doctors and surgeons. We need to facilitate not hamper the life-saving transition process for people who often present with complex histories that can include self harm and repeated attempts at suicide. Childhoods of transgender people may well have been traumatic and may have involved physical or sexual abuse, along with dysphoric gender suffering, emotional trauma and isolation. Adolescence and the development of the secondary sexual characteristics seems to be universally problematic and painful for trans identified people. Isolation, acting out, rage, social anxiety, substance abuse, homelessness and promiscuity are common issues for gender variant people and are often mistaken attempts to cope with the social and societal dissonance.

While hormonal and anatomical transitioning will not 'fix' everything in client's life, therapists should help clients assess what symptoms might improve. Mood Disorders on the depressive scale are often one of the first things to respond to treatment. Other conditions such a bipolar disorder, schizophrenia, and true borderline conditions might show little change. In addition to the impact of co-morbid mental health

conditions, therapists can also help clients to be realistic about the psychological and emotional changes that come with hormone treatment.

When I am seeing a person for the first stages of 'gender reassignment,' I am primarily ruling out the possibility that the client has decided he/she/ze is transgender during and solely during a psychotic episode. In other words, I am looking to make sure the client is not deciding to transition while in a state of mania, heightened delusion, or based on an impulse, whether manic or otherwise mood-related. I am looking for a cohesiveness of desire for gender change/identity that spans most of a lifetime, though there may be blank areas in a person's memory.

Most transgender people have feelings of being different and of being socialized inappropriately as early as their earliest memories, though they certainly would not have (and may still not have) the language to articulate the dysphoria. It often takes clients many painful years to come to grips with their identities and to step forward, seeking help. We, who work in the field, have high hopes that the new hormone blocking medications will allow gender queer youth the emerging possibility of delaying the development of secondary sexual characteristics, as necessary, while the youths, with professional assistance, work to decide how to synchronize their body's anatomies with their internal gender identities in order to bring about a more cohesive sense of self. Some doctors are currently working with this temporary hormone blocking protocol with trans adolescents. Others will surely follow suit.

I believe the decision and the consequences of gender exploration and reassignment both ultimately lie in the informed client's hands. When I make a referral for hormones/surgery, I make certain the person is thoroughly educated about side effects, irreversible consequences, etc. From there, I empower and entrust the individual person's sense of self-agency and work to help them cope with and prepare for society's misunderstandings, in any way that they may not already be prepared. I am a co-assessor, an advocate, an educator, a student, a gateway, a resource, and a support for transgender people.

Thanks for your time and consideration.

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My suggested bibliography (for Trans Competence) can be found at http://http://www.amazon.com/Trans-Competence/lm/R2K0XRJUT0873/ref=cm_lm_byauthor_full

This list includes my top recommendations: Whipping Girl (Julia Serano), Hello Cruel World: 101 Alternatives to Suicide for Teens, Freaks and Other Outlaws (Kate Bornstein), and The Testosterone Files (Max Wolfe Valerio), Brain Gender (Hines) and The Transgender Child (Brill and Pepper).