Transgender Emergence: Understanding Diverse Gender Identities and Expressions

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Learning Objectives:
1. To increase social workers’ understanding of gender identity and transgenderism.
2. To increase comfort in working with transgender, transsexual, intersex, and other gender-variant people.
3. To develop and enhance specialized skills for provision of services to transgender people and their family members.

I. Transgender: An Overview

Transgenderism, a subject that was virtually unheard of a decade ago, has become a focus of increased media attention, and an area of interest for social workers as well as the lay public. Helping professionals of all types (physicians, psychologists, social workers, and educators) are now grappling with understanding gender-variant behavior and cross- gender expression. Students and experienced social workers alike are researching specialized education regarding sex and gender issues in order to be better prepared to provide quality and effective treatment to those requesting their services. In response to these concerns, the issue of FOCUS Continuing Education will offer an in-depth examination of transgender issues.

Professional Responsibility

The National Association of Social Workers has adopted a clear and direct policy position on Transgender/Gender Identity issues that emphatically states “…people of diverse gender expression and identity … should be afforded the same respect and rights as those whose gender identity and expression conform to societal expectations” (Social Work Speaks, 2000, p. 302). This is a progressive and vital step for our profession especially since the policy specifically “…encourages the development of supportive practice environments for those struggling with transgender issues (both clients and colleagues) [emphasis mine],” recognizing that social workers are not just impacted professionally, but also personally.

Policy statements are foundational for organizational development and instrumental in determining professional training goals and priorities, but they are often more visionary than to be realized. Social workers in the field may ideally make a commitment to transgender and transsexual people respect “right and rights,” but may not have the necessary knowledge base or feel they have the clinical acumen to implement respectful treatment strategies. Many social workers are beginning to recognize the basic lack of civil rights with which transgender people live, and that effective psychological treatment often requires advocacy and community organization skills in addition to clinical expertise.

As transgender people emerge from a veil of shame and societal stigma, social workers are encountering gender-variant people in diverse settings – schools, hospitals, mental health clinics, and work-related environments – highlighting the need for transgender education to become a standard part of the generalist education all social workers receive a decade ago, when social work students were asked to define the word transgender, they had rarely heard of the word. Currently, students routinely bring case material from their field placements into the classroom describing clinical contact with gender-variant children and youth in the school system, and adult transsexuals transitioning their sex and coping with related job loss, marital problems, and financial stresses. Occasionally students will also seek advice on upheavals in their own work environment as a social work colleague begins the often awkward transition across the gender binary. Social work programs, educational institutions, and training curricula are beginning to address the vision outlined in the NASW policy statement in order to better prepare social workers for a wide range of professional situations where expertise in gender variance will be required; this continuing education program is part of this evolution.

Transgender Emergence

The subject of transgenderism is one that produces an array of reactions; many people find themselves confused and uncomfortable dealing with the idea of transsexualism and “sex change” surgery. There is sometimes an emotional mix of an almost morbid curiosity on one hand, and profound revulsion on the other. Sometimes when issues of transgenderism are described in the media, the reporter will use the umbrella term transgenderism to describe their lived experience. Sometimes the term transgenderist has only recently emerged from the intense scrutiny of the psychological community within the past few decades, although lesbian, gay, and bisexual people continue to struggle for full equal rights.

Social justice strategies, based on knowledge and experience with other successful civil rights struggles, have become the focus for many transgender activists who are challenging the view that they are mentally ill simply because their gender is not normative. Transgender and intersex people are struggling to define themselves and the parameters of their own lives outside of an illness model. Gender-variability and cross-gender experience are not new psychological or medical “conditions,” nor is it a recent social or legal dilemma. Gender-variant people, those known today as transgender, transsexual and intersex, have always existed throughout human history and transculturally across all nations and ethnic groups. Long before the advent of modern synthetic hormones and surgical reassigment, individuals lived cross-gendered from the biological sex in which they were born and outside of the social restrictions of their assigned sex. Cross-gendered societies across the ages addressed the expression of sex in diverse ways, from complete acceptance and integration to ostracism, maltreatment, and violence.

Within contemporary western culture, changes within the social climate – politically and technologically – have created an environment within first world countries in which contemporary transgender identities can now be forged. Although diverse sexual and gender identity expression and behavior has always existed, the emergence of a community of people who express gender identities outside of the social norms is a nascent sociological phenomenon within contemporary western culture. In the last two decades social and political organizations have developed – many established on the Internet – that foster social identities for gender-variant people, creating a distinct category of people deserving civil rights and social justice. This movement, politically organized and self-determined, defies previous views of transgender expression as a mental health problem, and views diverse gender expressions – like same-sex sexuality – as a normative, potentially healthy human potentiality. Instead, it reframes the dysfunctionality often seen in trans gender individuals as the residuals and sequelae of oppression, not the manifestations of a mental disorder.

The psychological and social work professions are in the process of revisiting previous conceptions of gender-variance as psychopathological issues. Viewing transgenderism outside of a pathologizing model initiates a new cultural conversation that examines the essential nature of biology and gender, and the social construction of sexuality and culture. The mental health problems that have been associated with transgenderism may not be etiologically related to the sexual orientation of the individual; but caused by the social and political ramifications of being a member of a despised group. Instead of examining transgender people through a lens of disorder and dysfunction, clinicians need to ask what it means to be a healthy functioning gender-variant person in a society with strict gendered spheres, where transgression of traditional roles can have serious social consequences.

This perspective shapes fundamental assumptions about sex and gender, and shifts the paradigm from two sexes that are opposite and different from one another to a conception of sex and gender identities as potentially fluid. Feminism describes the meeting ground where the social construction of gender intersects with the individual’s personal psychological experience of gender, and where biology is not the only determining factor of identity. Within this newly emerging paradigm, transsexuality, transgenderism, and intersexuality are portrayed as normative human variations.

In many ways the transgender liberation movement is shaking the foundations of the mental health system in much the same ways that the civil rights movement, the feminist movement, and the gay liberation movement have done. Transgenderism, like the ongoing struggle for racial justice, women’s rights, and same-sex marriage, is challenging the held social constructs about human embodiment within social and cultural contexts. If gender variance is a mental health condition, then it, by definition, requires therapeutic intervention; pathology, however, has never been a useful model for a burgeoning liberation movement. Awareness of this dialectic tension - between the psychopathologizing medical model and a transgender specific identity that is emerging from oppression - is essential to understanding the nature and meaning of transgender identity in the early days of the twenty-first century.

In response to this dialogue, many professionals are also rethinking older treatment models that were based in mental health diagnoses, and developing more humanistic, narrative, post-modern, and advocacy-based perspectives. However, the first task for all clinicians working with gender-variant people is to recognize that we enter into this field of work with entrenched beliefs about gender that will likely be challenged. It is rare helping professional that can change their treatment approaches to gender-variant people, without first examining their own epistemology of gender.

The Scope of Gender-Variance

Previously ignored, vilified, and underserved, in the 1990s gender-variant people developed a broader, more inclusive community and began using the term transgender as an umbrella term to describe their identity. The term transgender is now used to include crossdressing, male-to-female transsexuals (MTFs), and female-to-male transsexuals.

The history of gender-variance and the mental health community is a history of diagnostic labeling and pathologizing mental disorders within a medical model that assumes that cross-gender expression is against nature, is abnormal, and should be treated. Western civilization has pathologized gender-variant people to the realm of the psycho-medical establishment for treatment, analysis, and “cure.” This complex field of sexology has generally pathologized all human sexual and gender variations outside of hetero-normative male/female sexual expression. Same-sex intimacy has only recently emerged from the intense scrutiny of the psychological community within the past few decades, although lesbian, gay, and bisexual people continue to struggle for full equal rights.
Transgender Emergence: A Developmental Model

Transgender emergence involves a complex interaction of developmental and interpersonal transactions. The process of developing a gender identity is a normative process that everyone experiences, but for gender variant people the process is complicated by cultural expectations that are at dissonance with their core sense of self. The emergence process describes an adaptive stage model for transgender men and women who are coming to terms with their own gender variance and moving from an experience of denial and self-hatred to one of self-respect and gender congruence. These stages are not necessarily linear and are impacted by other identity issues. These stages are not meant to "label" people or define transgender maturity. It describes what clinicians may witness when clients seek help for "gender dysphoria." Many transgender people negotiate these stages without professional assistance.

Awareness: In this first stage of awareness, gender variant people are often in great distress; the therapeutic task is the normalization of the experiences involved in emerging transgender.

Seeking Information/Reaching Out: In the second stage, gender variant people seek to gain education and support about transgenderism; the therapeutic task is to facilitate linkages and encourage outreach.

Disclosure to significant others: The third stage involves the disclosure of transgenderism to significant others – spouses, partners, family members and friends; the therapeutic task involves supporting the transgender person’s integration in the family system.

Exploration – Identity and Self-Labeling: The fourth stage involves the exploration of various (transgender) identities, and the therapeutic task is to support the articulation and comfort with one’s gendered identity.

Exploration – Transition Issues/possible body modification: The fifth stage involves exploring options for transition regarding identity, presentation, and body modification; the therapeutic task is the resolution of the decisions, and advocacy towards their manifestation.

Integration – Acceptance and post-transition issues: In the sixth stage the gender variant person is able to integrate and synthesize (transgender) identity; the therapeutic task is support in adaptation to transition related issues.

(FTMs). Additionally, the term also includes people who identify as androgynous, third-sex, and of mixed-gender. Some would broaden transgender identity to also embrace all people who exhibit cross-gender behavior such as gay or lesbian males and heterosexual males who are “demasculinized” or transgender women and heterosexual females who are masculine, drag queens, and those who have intersex conditions. This does not mean, however, that all people who exhibit cross-gender expression would identify as transgender; people may describe themselves or want to be categorized beneath the trans-gender umbrella. For example, a subset of transsexual women (i.e., male-to-female) resists the term transgender, believing that transgender identities are likely different from other cross-gender behavior and they do not want to be classified within this larger group.

Historically, transsexuals and crossdressers (previously referred to as transvestites) represented two distinct diagnostic categories. The first group of transsexuals were defined in the literature as heterosexual males who cross-dressed for erotic purposes, commonly beginning in adolescence. They were said to present convincingly as men in social situations, were not particularly feminine in appearance, and tended to work in traditional male-dominated careers. Most importantly, they rarely expressed a desire. According to this model the defining trait of cross-dressing was believed to be a hallmark of transvestism, and in those born males, had been used to rule-out "true" transsexualism.

Transsexuals, at the other end of the continuum, were identified in the literature as people with a typical gender-identity development starting in early childhood (i.e., "sissy boys"), life-long gender dysphoria, hatred of their genitalia, and a persistent desire for sex reassignment surgery. Transsexuals observed that their psychological body did not represent their true sex. Crossdressing was not experienced as erotic, but rather as clothing that felt natural for them to wear. They often appeared to be homosexual in social orientation (i.e., they were not attracted to men); however, since they experienced themselves as women, labeling their sexual desire for men as homosexual, confusing them as biologically-operative, they often identified as heterosexual women.

This diagnostic blueprint distinguishing crossdressers and transsexuals is based in a medical model first identified by Harry Benjamin, a pioneer in treating people with gender dysphoria at a time when medical providers routinely referred them to psychiatrists. The model that Benjamin outlined in the 1960s classified and treated transsexualism as a syndrome of gender dysphoria based in genital dis-satisfaction. According to this model the defining trait of transsexualism has been the transsexual’s desire, insistence, and even obsession with body modification; the most salient diagnostic criterion was hatred for one’s genitalia and desire for sexual reassignment. This classification paradigm has been referred to as the "wrong body thesis" and "anatopathological" was the primary symptom used to define transsexualism.

Distinguishing types and subtypes of gender-variant people has been the focus of researchers attempting to outline discrete syndromes. The underlying concern has been to insure that only "true" transsexuals receive medical and surgical treatments, therefore the eligibility standards have been rigidly enforced. Of course, there is a legitimate concern that people will have irreversible surgeries they will later regret; however, the evaluative process became prohibitively exclusive, belying an underlying attitude of social control and paternalism.

Classifying types of gender-variety etiologically and diagnostically is somewhat complicated and cumbersome and in some instances has created a flurry of political outcry from the transgender community. In this example we include a debate over the term autogynephilia, defined by Ray Blanchard as a type of transsexualism whereby the person fantasizes about possessing female anatomy, and is erotically excited by the thought or performance of activities that symbolize femininity. This idea of linking transsexual desire to sexual eroticism has caused both relief and rage at a time when medical providers routinely seek out services. The need for more inclusive research on both males and females and the development of newer treatment models has become the focus of the field of transgender studies in the past decade.

Setting aside the medical model, it appears that people struggling with gender issues represent a broad range of people, representing both male and female experiences, and numerous trajectories of expression. In addition to heterosexual male erotic crossdressers, and female transsexuals desiring SRS, there are various other ways that gender variability can be experienced and expressed. Some males with little or no desire to live as women or have sex reassignment surgery, have strong desires to wear women’s clothing and express a female persona at least some of the time, with little or no eroticism attached to being crossdressed. Some males used by being crossdressed, in an oversimplified dichotomy, clearly, the distinct classifications developed within the medical model have some severe limitations that impact current treatment strategies as well as the options for self-actualization available to gender variant people. It has become increasingly obvious to many clinicians, writers, and activists that many people do not easily fit into the categories that have been delineated, and yet are seeking clinical medical interventions in an attempt to gain alleviation or rehabilitation. The need for more inclusive research on both males and females and the development of newer treatment models has become the focus of the field of transgender studies in the past decade.

Additionally, some crossdressers do not identify as heterosexual – a diagnostic hallmark of transvestism – but instead consider themselves as gay men. Furthermore, a subset of gay male crossdressers, referred to as drag queens, dress as women in an extreme feminine manner for fun or “camp,” but not as a way to self-actualize. Drag performers work as female impersonator and dress as women as part of their job; they may or may not be transsexual or erotic crossdressers. Some gender-variant people believe their cross-gender identity to be an “essence” – who they are in the deepest part of their psyche and experience themselves as being in the
wrong body; others explain it as a “birth defect” that needs to be corrected. Clearly, cross- 
gender behavior is not easily defined without an in-depth assessment regarding the 
person’s motives and experiences, as well as their goals.

Gender-variant behavior in females has been assumed to be statistically rare; however the rel-
ative freedom that women have in our culture regarding dress and appearance can mitigate to 
some extent their gender dysphoria, and perhaps has led fewer females to seek treatment 
through medical and clinical avenues. Additionally, some expressions of female masculinity 
have been acceptable within lesbian subcultures; it is possible that many female-to-male 
transsexuals have lived as butch lesbians and not come under the scrutiny of researchers and 
clinicians. Historically, researchers assumed that FTMs were exclusively attracted to women, 
but more recent studies are revealing a diversity of sexual orientations and gender expressions 
for transgender females. Trying to categorize this diversity within a simple medical model 
does not justice to the diverse gender expressions possible.

One theme that is emerging with the growth of the transgender community is an alterna-
tive narrative about gender-variant identities, one that is outside of a gender binary model 
involving “opposite” sexes within a two-gender option. Some express feeling confined by 
the restriction imposed by either gender and choose to live in a mixed, dual, or bi-gender-
dered manner sometimes referred to as “gender blending” or “bigenderism.” This fluidity 
of gender presentation recognizes a broader spectrum of ways to explore and experience 
gender identity. Some variations of transgender experience include: moving from one side 
of the gender binary divide to the other on a permanent basis (i.e., many transsexuals); 
moving backwards and forwards over the gender border, only temporarily resting on one side 
or the other (i.e., many crossdressers); gender-blending (i.e., androgynous or bi-gender-
dered). Some enjoy the performity of gender and blend or mix their gender style as a way 
to express diverse aspects of themselves. These ideas were originally developed within the 
trans-liberation movement, and are increasingly becoming a part of clinical theories and 
treatment models.

The only way to determine the meaning of each person’s experience is through dialogue 
with them, rather than seeking to fit him or her into official classifications systems. In order 
to understand the diversity of gender expressions possible, it is important to have a 
broadening understanding of human sexual identity, and how the components of sexuality 
interact with one another.

II. Sex and Gender Identity

Understanding gender diversity and the relationship between gender identity and sexual 
orientation is undoubtedly complex. The term sexual identity is used here to describe a 
broad paradigm that includes many aspects of gender and sexuality. Sexual identity delin-
eates a biopsychosocial integration of four component parts including biological or natal 
sex, gender identity, gender role expression and sexual orientation. The four components 
are outlined below.

Biological Sex and Intersexuality

The first component of human identity is biological sex. Biological (or natal) sex is actu-
ally a complex relationship of genetic, hormonal, morphological, chromosomal, gonadal, 
biochemical, and anatomical determinates that impact the physiology of the body and the 
sexual differentiation of the brain. Sex is generally determined at birth (or during a sono-
gram) based on an examination of the visible genitalia. The presence or absence of the 
phallus is the first, the most salient, and often the only variable that determines whether 
one is a boy or a girl. In reality, physiology is only one determinant of natal sex, and it is 
possible for a child to visibly look like a boy, but have a genetic or chromosomal make-
up that belies that conclusion. A brief overview of fetal development will outline the process of sex determination. The biological differences between males and females develop at about 6 weeks into gestation, and before this stage male and female (XY and XX) appear the same, although genetic or 
chromosomal sexual differences are established at conception. The primitive duct systems 
are identical until the presence of male hormones triggers the development of male 
organs, the differentiation of the duct systems, and the formation of external genitalia. 
Without the presence of male hormones, the fetus develops female gonads, which has led 
scientists to label the female development process a “default” system. This means that if the 
XY fetus does not trigger the correct masculinizing process it will develop as a female. 
The gonads produce various hormones that further differentiate male from female, and 
eventually stimulate the development of internal and external genitalia.

Biological or natal sex, simply defined, is the bipolar categories of male and female. Due 
to the numerous biological variables intervening in the fetal developmental process it is 
possible for sexual differentiation to take place atypically. For instance, an irregularity in 
hormone production, such as an over or underexposure to particular hormones, or certain 
genetic conditions, can cause the internal or external genitalia to develop outside the 
expected parameters. If the external genitalia appear ambiguous, it may be difficult to 
easily assign natal sex; however, sometimes the physiological differences are internal and 
the intersex condition may go unnoticed until puberty, when fertility is compromised. 
When sex is not easily assigned, or a mixed reproductive system is evident, the person is 
referred to as intersex.

Most infants born with intersex conditions in first world countries have been surgically 
altered with “corrective” surgeries at birth to match the physicians’ sex assignment fit into 
the appropriate dimorphic sex category. These surgeries have been justified because of a 
concern that these children will develop confused gender identities due to their physical 
differences. It is, however, not clear that being surgically altered --- often leaving visible 
scars and an ongoing need for medical attention --- will eliminate the potential gender 
dilemmas intrinsic to being born with an intersex condition.

Medical science has assumed that gender identity emanates as the logical outcome of 
physiological sex, and that the creation of a morphologically correct body can determine 
the internal experience of gender. The relationship between natal sex, physiology, and 
the development of gender identity is far more complex, since some people without intersex 
conditions develop gender dysphoria, and many people with intersex conditions develop 
stable gender identities. Intersexuality stands as the most direct evidence that biological 
sex is not simply dimorphic and that calling a baby a “boy” or a “girl” is more of a social 
decision than a biological one.

There is a growing movement of people born with intersex conditions, who are protesting 
the standard medical treatments. One organization, The Intersex Society of North America 
(ISNA), under the leadership of Cheryl Chase, has developed an extensive grassroots 
network for intersex people. Additionally, ISNA continues to educate the medical profes-
sion about changing the protocols for the treatment of intersex infants. As issues facing 
intersex people are becoming part of the public discourse through interviews on television 
shows and newspaper articles, people who have been surgically altered at birth are seeking 
out professional assistance to make sense of what has happened to them---information that 
was often kept from them by family and the medical community.

Understanding human sexual and gender diversity requires a commitment to treating 
intersex people, from birth through adulthood, with dignity and respect, while they nego-
tiate challenges in sexual and reproductive development. Families who have a child born 
with an intersex condition are in need of qualified medical social workers to assist

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It is assumed that each of these components lines up and ensures the next:
- If a person is a male, he is a man.
- If a person is a female, she is a woman.
- If a person is of the male gender, he will be attracted to a feminine female woman.
- If a person is a female, she is a woman.
- If a person is a woman, she is feminine.
- If a person is of the feminine gender, she will be attracted to masculine male man.

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This bipsector system renders those who are intersex, gender variant androgynous, cross-gendered, and/or bisexual invisible.
families in education and ongoing family therapy, particularly regarding decisions about genital surgeries. Newer treatment models support a “wait-and-see” approach to early surgical procedures. Medical experts and families should work together to make an educated and informed decision about sex assignment, however, it is suggested that families should work together to make an educated and informed decision about sex assignment. Families should be involved in the decision-making process, and medical experts should provide guidance and support. People with intersex conditions may need different kinds of social work services at different stages of their life. Parents may need assistance accepting the challenges of having a child with ambiguous genitalia; children will likely need support during puberty and adolescence; and many adults may need support for dealing with the stress of being a “man” or a “woman.” Gender identity is experienced as a core identity, a fundamental sense of belonging to one sex or the other. The sense of being a “man” or being a ‘woman,’ is an essential attribute of self; many people would have trouble identifying their sense of “self” outside of the parameters of gender. People may feel conflicted by some of the societal assumptions about proper male or female behavior, or they may resist certain role restrictions. However, some people may identify as transgender, crossdressers, gender-blenders, or gender-benders. Additionally, men who are more feminine, and women who are more masculine, would be seen to exhibit a cross-gendered role expression. Hormonal treatment for FTMs can profoundly alter their physicality. Even females of men or women, recognizing their preferred gender identity, regardless of their natal sex. The four components of sexual identity have been generally thought to be completely independent. However, people with intersex conditions may need different kinds of social work services at different stages of their life. People may need assistance accepting the challenges of having a child with ambiguous genitalia; children will likely need support during puberty and adolescence; and many adults may need support for dealing with the stress of being a “man” or a “woman.” Gender identity is experienced as a core identity, a fundamental sense of belonging to one sex or the other. The sense of being a “man” or being a ‘woman,’ is an essential attribute of self; many people would have trouble identifying their sense of “self” outside of the parameters of gender.
people of all races, ethnicities, and class backgrounds, and seek out services at all stages of their lifecycles. It is important for helping professionals to recognize that gender-variant people can be school children as well as the elderly. They can be in heterosexual marriages and gay or lesbian partnerships. They can appear totally gender normative or be more obviously cross-gendered in appearance. Gender-variant people are found in wealthy communities, and established in professional jobs, and are also represented in high numbers among those who are homeless, engaging in prostitution for survival. Those with greater access to financial privilege often have greater access to health care, and services to assist in transition. Those who are poor, incarcerated, living with HIV, often procure treatments through any means possible, risking their lives and health.

Given the diversity of gender-variant people, it is obvious that they can also express a range of emotions about their gender issues, from revulsion to fierce pride. They may be angry towards clinicians, feeling hostile that they have to spend money on an assessment for a medical referral, or that they may feel deep shame, bordering on suicidality, when revealing their gender feelings to a provider.

Generally speaking, people contacting therapists seeking services for gender related issues fall into three broad categories. First, transgender people seek out services because they are in deep emotional pain and seek information and counseling. They also seek out professional assistance because obtaining hormones and surgery for sex reassignment, they must be evaluated by professional social workers or psychologists for eligibility and readiness. They are therefore seeking “the letter,” i.e., a referral letter for medical treatment. Secondly, gender-variant clients seek therapeutic assistance dealing with family related issues. This last category includes both the gender-variant person, as well as his or her loved ones who seek treatment because they are struggling with their significant others’ gender issues. Gender expression can profoundly impact the familial and social relationship of gender-variant people, and is often a major focal point of treatment issues.

Regardless of why gender-variant people are seeking therapy, treatment is most effective when gender-variance is assumed to be a normal expression of human diversity. Commonly clients are fearful of being judged, and have come into therapy already having diagnosed themselves with a psychological disorder, feeling that they must be psycho-socially normal in order to be whole. The treatment model below suggests that the assumptions men- tioned here postulates that transgender people need to emerge from this shame and self-hatred and that a significant amount of the problems gender-variant people experience is caused by societal oppression. Dysphoria and dysfunction are the sequelae to the experi- ence of being stigmatized both socially and medically, and the therapeutic relationship can serve as a reparative to the emotional isolation.

Diagnosis and Gatekeeping

The bulk of contemporary research on gender variant people has maintained a pathologizing medical model perspective, ignoring or minimizing the influence of family systems, social environment, or normative biopsychosocial development. Research within this medical model has shown transsexuals to have significant mental health issues, but there was little examination of the biopsychosocial issues they had to face living within a transphobic social system. Historically, people seeking medical treatment have had to fit into rigid and limited diagnostic classifications and boxes. Recent research shows that whether or not they have experienced gender dysphoria, guidelines, they are aware of their existence and will comply with them by lying about their history instead of telling their actual story and risking medical rejection.

Therapists who specialize in gender issues have been forced to become gatekeepers, whose job has been to assess the accuracy of the transsexual narrative, making sure the person’s story fits the approved narrative. Since referral for medical treatment has rested on this evaluative process, clients have been strongly motivated to tell a story that clinics have deemed the only acceptable narrative. This has unfortunately created a clinical environment, or normative biopsychosocial development. Research within this medical model has shown transsexuals to have significant mental health issues, but there was little examination of the biopsychosocial issues they had to face living within a transphobic social system. Historically, people seeking medical treatment have had to fit into rigid and limited diagnostic classifications and boxes. Recent research shows that whether or not they have experienced gender dysphoria, guidelines, they are aware of their existence and will comply with them by lying about their history instead of telling their actual story and risking medical rejection.

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The medical model of diagnosis and approval based on psychosocial assessment has come under critical examination in the past decade by clinicians as well as activists. Clinicians have begun questioning the accuracy of the classification systems and the necessity to approve or refuse those seeking medical treatments based on rigid diagnostic criteria. This may not represent the diversity of gender expression. Broader based models which see gender identity on a continuum and encourage educated consent and advocacy instead of expert approval are being promulgated. It is important to note that there is no research to date on the effectiveness of any treatment perspectives working with transgender people.

The medical model of gender identity as a disorder is currently being re-examined as dam- aging to transgender people’s self-esteem and has potentially negatively impacted their social cohesion and their collective sense of identity. It is no coincidence that new clinical models based in empowerment and self-identification is developing along side of the growth of transgender politics and community organizing. This is a familiar trajectory for those knowledgeable about the community-building in the early days of the transgender and gay liberation movement that culminated in the removal of homosexuality from the Diagnostic and Statistical Manual of Mental Disorders (DSM). Homosexuality, long considered a psychopathology, was removed from the DSM in 1973 because of the tremendous pressure of the burgeoning gay liberation movement. The recognition of a politically organized lesbian and gay civil rights movement was instrumental in the depathologizing of homosexuality. It is arguable whether the success of this movement for LBG civil rights would have been possible if homosexuality had remained a diagnosable mental illness. Would gay rights, employment and job protections, or gay marriage on the public agenda if same-sex sexuality was still considered a psychopathological per- version? Throwing off the yoke and stigma of "abnormality" allowed not only for the psychosocial growth of self-esteem on the part of gay, lesbian, and bisexual people, but also allowed for legal and political transformations that could not have been granted a "mentally ill" population.

Unfortunately, the struggle for civil liberties for lesbian, gay, and bisexual people was established by normalizing same-sex (i.e., natal) sexual desire and downplaying the re- llevance of gender identity and expression in identity development. Indeed, gender-variant behavior became separated from sexual orientation completely within the clinical dis- course and among political activists (despite its frequent expression within the LGBT com- munity and despite the role played by gender variant people in the early days of the gay liberation movement).
interesting enough, the development of a diagnosis Gender Identity Disorder coincided with the removal of homosexuality from the DSM. Furthermore, Gender Identity Disorder has been used to diagnose gender-variant individuals who present with specific behavioral and psychological characteristics. The DSM-IV-TR offers significant questions about the continuing psychiatric treatment of homosexuality. It also shows the continuing confusion and conflation within medical and psychiatric communities of gender identity and sexual orientation. It is important to note that an organized and vocal faction still exists within the psychological community who still consider gender-variant individuals as deviant with a mental illness for having distress about a sexual or gender expression. In a circular logic, people are diagnosed as mentally having a certain degree of distress regarding gender-variant medical treatment. Secondly, the diagnosis is based on gender and that only certain cross-gender expressions are assumed and that only certain cross-gender expressions are disordered, and only certain cross-gender expressions could be covered using other DSM diagnoses (i.e., Adjustment Disorder).

As it stands right now, in order to receive medical treatment, transgender and transsexual people must prove themselves disordered; in order to be granted civil rights, transgender and transsexual people must prove themselves mentally sane. Paradoxically those who can most benefit from the medical treatment that pathologizes them, have the most at stake in maintaining it. Approval for treatment should not depend on being mentally ill, but on being mentally sound enough to make empowered and healthy decisions regarding one’s body and life.

A Developmental Treatment Model
Clinicians working with gender-variant people need to create a safe space for clients to talk about their experiences, and to tell their stories. Transgender, transsexual, gender variant people are outlined by the HBIGDA, and include the need to meet the GID criteria. The DSM criterion is currently used in diagnosing two discrete groups of people. The first group - gender variant children and adolescents - are treated for their gender inappropriate behavior and cross-gendered identification. The second group - self-identified transgenders and transsexual people - depend on the diagnosis to assist them in receiving the medical surgical treatments. For adults who are gender-variant and seeking medical assistance, the diagnosis of GID has been used to diagnose gender-variant people reaching out for therapeutic help. It is, however, rare for persons to experience the transition to another gender, but are able to experience their gender differences in a natural outcome of living within a culture with an explicit recognition of gender and sex selves, the parts of them that feel the most genuine. Gender dysphoria describes the psychological discomfort expressed by individuals who are struggling with gender dysphoria, and if they can be differentiated from gender atypical children who are not in distress. The experience of gender dysphoria is a natural outcome of living within a culture with an explicit recognition of gender and sex selves, the parts of them that feel the most genuine. Gender dysphoria is a natural outcome of living within a culture with an explicit recognition of gender and sex selves, the parts of them that feel the most genuine. Gender dysphoria is an emerging paradigm, that outlines the developmental stages that transgender people experience, while they engage in conscious re-making regarding sex reassignment. It is a model based in client empowerment where the therapist is an advocate, an educator, and a mentor, but minimizes her role as a gatekeeper. This model supports clients’ unique gender narratives and minimizes placing the clinician in the role of gatekeeper for medical treatments.

Although it is important to recognize the seriousness and irreversibility of transsexual surgeries, as well as the importance of a mental health evaluation within the dialog to anxiety and depression. There are requests for reconfiguration of client autonomy and the limits of clinical control. It is questionable whether the diagnosis as it currently stands is adequate to identify young children who are struggling with gender dysphoria, and if they can be differentiated from gender atypical children who are not in distress. Finally, the diagnosis as it currently stands is a clinical replication of sexism. An examination of the diagnostic criteria indicates a reliance on socially determined assumptions about gender and behavior. Sexism is ubiquitous in this section of the DSM; there are no indications or guidelines on how to assess for the distinction between social nonconformity and intrapsychic illness. Despite all the above difficulties with the GID diagnosis, the diagnosis of Gender Identity Disorder is not gender variant and seeking medical treatments have relied on this diagnosis for their actualization. Unlike LGB people, gender-variant people depend on the medical field for their actualization.

Without a diagnosis, insurance coverage for expensive medical treatments will be even more difficult to attain. As a solution to this problem, it has been recommended that the DSM-IV-TR include 10 medico-social criteria of transsexualism and that psychological problems related to gender could still be covered using other DSM diagnoses (i.e., Adjustment Disorder). It is easy to understand how someone experiencing the kinds of distress that is often associated with the experience of functional or even emotionally disturbed in the eyes of most mental health specialists. Acceptable gender behavior is profoundly mandated - culturally, religiously, and even economically - and the realization of being relegated to the category of the stigmatized "other" can create extreme discomfort. It is to be assumed that most clients who reach out for therapeutic services are experiencing some distress. The experience of gender dysphoria is a natural outcome of living within a culture with an explicit gender system that associates certain appearances and behaviors with a specific gender label.

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However, it cannot be assumed that gender dysphoric individuals who seek out psychotherapeutic services are representative of all gender-variant people. It is possible that some transgender people do not experience any "dysphoria," or are able to experience their gender differences in an accepting and celebratory way. These people would be less likely to seek out professional counseling, except for a letter of recommendation for hormonal and/or surgical treatment. It is, however, real that the position that some gender-variant people experience in conflict with their assigned sex within a society with rigid gender normative rules, especially if they are unable to experience their gender differences in an accepting and celebratory way. These people would be less likely to seek out professional counseling, except for a letter of recommendation for hormonal and/or surgical treatment. It is, however, real that the experience of gender dysphoria is a natural outcome of living within a culture with an explicit gender system that associates certain appearances and behaviors with a specific gender label.
lies, live in families, and seek support and refuge in fami-
lies. The acceptance or rejection they experience from
their families is a core issue in their ability to integrate
their gender identity into their lives in productive and
meaningful ways. Just as family systems are developed
and maintained through interpersonal transactions, so
are gender-variant families. Individuals and family
members will assist in the development and maintenance of healthy stable
families, and consequently will yield greater success for
gender-variant members of those families, particularly
those engaged in sex reassignment.

Gender variant experience is not simply an internal psy-
chological process that needs to be navigated by transgen-
der and transgender people, but it is also a relational and systemic
dynamic that intimately involves family, friends, loved ones, and
all social relationships.

Gender dysphoria often begins in childhood, although not all children who express gender-variant behavior grow up to become transgender. Children and youth with gender dysphoria are a neglected population, whose issues are either minimized ("They will grow out of it") or pathologized, i.e., treated to have these behaviors elimi-
nated. Sorting out normative but variant gender expression in children, from early manifestations of divergent sexual or gender identities, requires knowledge of child develop-
manship and an understanding of gender identity trans-
sition. Families with gender-variant children often seek out services from professionals. There is currently an increase in youth seeking medical treatments for sex reassignment, raising ethical issues regarding the safety and identity of gender transition. Research from the Netherlands show excellent results for youth seeking medical treatments for sex reassignment.

Stage One

Negotiation: The next stage for families is negotiating acceptable boundaries and how they will process the gender issues and the resulting impact on their relation-
ships. When a partner discloses a desire for complete sex change and is acceptable to family members, it is necessary for the transgender person to have a conversation with their family regarding their identity, abilities, and resources before beginning the transition. Families often express gender dysphoria at remarkably young ages. The next stage for families is negotiating acceptable boundaries and how they will process the gender issues and the resulting impact on their relation-
ships. When a partner discloses a desire for complete sex change and is acceptable to family members, it is necessary for the transgender person to have an initial response that is intense and emotionally labile. Social workers and therapists must be educated about the gender dysphoria experiences and ex-
periences so that they can offer support to their clients and do not require their clients to educate them.

Transgender and transgender people face a large array of social, legal, and employment barriers. At the stage of Balance family members know the difference between secrecy and family lives. At the stage of Balance family members know the difference between secrecy and family lives. For many lesbian women having a partner begin to live as a family, even if they are not yet married; they often seek counseling having never come to terms with transgender identity and/or transsexu-
al identity. For many lesbian couples, their marriages must cope with not only the consequences of their relationships, but also their loved ones’ gender related issues. Family Emergence involves a complex interaction of both developmental and interpersonal transactions. It is an adaptive process, and unlike the developmental experience of gender-variant people which emerges from an intrinsic need for biopsychosocial authenticity, family members are often unwilling participants on this journey. The stages are outlined below:

Stage Two

Turfmoil: Although some spouses, partners, children, and parents accept gender variance, and even sex reassign-
ment, with grace, ease, and acceptance, it is more common for family members, especially parents, to have an initial response that is intense and emotionally labile. Social workers and therapists, who may not be knowledgeable about transgenderism, can increase the level of turmoil in a family by expressing a sense of hopelessness about the family’s ability to cope with their transgender child, and instilling a sense of guilt about treating gender issues in the same manner as other norma-
tive family lifecycle crises (death, disability, divorce, illness, etc.)

Stage Three

Negotiation: At this stage, family members are allowed to experience a range of emo-
tions in the process of limit setting and boundary marking. When a partner begins a sex transition, this may raise equally con-
fusing questions regarding sexual orientation and identity. For many lesbian women having a partner begin to live as a family, even if they are not yet married; they often seek counseling having never come to terms with transgender identity and/or transsexu-
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Stage One

Disclosure and Disclosure: The first stage for family members involves the Discovery and Disclosure of the gender transgression which is often met with shock and betrayal. Disclosure can include revealing a history of crossdressing behavior or the sharing with a loved one of increasing discomfort regarding cross-gender feelings that have been hidden or minimized. Discovery can take place accidentally, which may evoke feelings of betrayal, anger, fear, and potentially, shame. Research has shown that dis-
closure and discovery can raise questions about what other secrets their partner is hiding. Questions are raised about how well all family members have managed their own identity and feelings from what others might think, and how this will impact sexual intimacy. Children with a transgender parent might experience concerns about whether gender issues are inherent. Children who are gender-variant themselves often express gender dysphoria at remarkably young ages. Sadly, the discovery and disclosure of gender variance in families is rarely met with compassion and support, but more commonly, with emotionalism and turmoil.

Stage Four

Finding Balance: Balance does not mean that the gender issues are resolved, nor does it necessarily mean that the transgender person has realized their goals. It may only mean that the family members have managed these emotional upheavals in their family life-cycle with little actual “help” from helping professions.

Gender variant experience is not simply an internal psy-
chological, but at the intersection where individ-
ual sex changes in their loved ones. Families of infants born
in the development and maintenance of healthy stable
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family lives. At the stage of Balance family members know the difference between secrecy and family lives. For many lesbian women having a partner begin to live as a family, even if they are not yet married; they often seek counseling having never come to terms with transgender identity and/or transsexu-
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tive family lifecycle crises (death, disability, divorce, illness, etc.).
Guidelines for Therapists Working With Transgender Clients

Guidelines for therapists working with transgender clients include:

1. Therapists working with transgender clients must have a thorough understanding of gender identity issues, including information on the differences between gender and sexual identity, and the social construction of gender dimorphism.

2. Therapists must be knowledgeable about the current DSM diagnosis of Gender Identity Disorder (GID), and be familiar with the most recent Standards of Care developed by the Harry Benjamin International Gender Dysphoria Association.

3. Therapists must be aware of the issues being raised within the Transgender Liberation movement regarding the socio-political forces in the construction of gender identity and the limitations of a bipolar gender system, as well as the diversity of gender expressions.

4. Therapists must have a general knowledge of mental health issues, human development, and training in eclectic psychotherapeutic techniques. Therapists must be able to assess for mental illness, as well as addictions and trauma related symptomatology.

5. Therapists must be cognizant of the impact of stress on gender dysphoria and not pathologize the clients' stress related symptoms.

6. Therapists must have a humanistic perspective that supports the empowerment of client self-identification.

7. Therapists should be knowledgeable about issues related to gender identity, sexuality, sexual identity and gender role development, and be comfortable talking about these issues.

8. Therapists should be sensitive to the impact of family systems concerns including family of origin and current partners and children, and able to provide services or referrals for family members.

9. Therapists should have resources available for clients, including referrals to endocrinologists and/or psychiatrists, gender clinics, and support groups, as well as recommendations for bibliotherapy and Internet sites.

Definitions

Sexual Identity: An overall term that describes an individual's sense of their own sexuality, including the complex relationship of sex and gender as components of identity. Sexual identity includes a biopsychosocial integration of biological sex, gender identity, gender role expression and sexual orientation.

Sex: Sex is the physiological makeup of a human being, referred to as their biological or natal sex. Sex is usually thought of in a binary way, dividing the world into males and females. In reality, sex is a complex relationship of genetic, hormonal, morphological, biochemical and anatomical determinates that impact the physiology of the body and the sexual differentiation of the brain. Although everyone is assigned a sex at birth, approximately 2% of the population is intersex and do not easily fit into a dimorphic division of two sexes that are "opposite." Gender Identity: Gender is a social construct that divides people into "natural" categories of men and women that are assumed to derive from their physiological male and female bodies. Gender attributes vary from culture to culture, and are arbitrarily imposed, denying individuality. Most people's gender identity is congruent with their assigned sex but many people experience their gender identity to be discordant with their natal sex. A person's self concept of their gender (regardless of their biological sex) is called their gender identity. Gender Role: Gender role is the expression of masculinity and femininity and has often been referred to as "sex roles." Gender roles are usually a reflection of one's gender identity and are socially dictated and reinforced. Gender roles describe how gender is enacted or performed (consciously or unconsciously) and may or may not be related to gender identity or natal sex. Sexual Orientation: Sexual orientation is the self-perception of the direction of sexual desire. It describes sexual preference and emotional attraction. Some people experience their sexual orientation as an unchanging essential part of their nature, and others experience it in more fluid ways. Sexual orientation can be directed towards members of the same sex (homosexual) or the opposite sex (heterosexual), both sexes (bisexual) and neither (non-sexual). Sexual orientation is not merely "same-sex" attraction, but is experienced through the person's gender identity (regardless of their biology). A male-to-female transgender can be heterosexual, or bisexual. A female-to-male transgender can be heterosexual, a gay man, or bisexual.

Transgender: Transgender is an umbrella term including many categories of people who are gender variant. This term includes people who identify as transsexuals, crossdressers, masculine identified females (MIFs) or feminine identified males (FIMs), transmen, transgender women, and other different-gendered people.

Transsexuals: Transsexuals are people who believe that their physiological body does not represent their true sex. Most transsexual people desire sexual reassignment surgery (SRS) but transsexual people may be pre-operative, post-operative, or non-operative (i.e., choosing to not have surgical modification). Some transsexual people prefer to not have their birth sex known and to "pass" or go "stealth," and others are comfortable being known as transsexual and take pride in this identity. Most transsexual people prefer to be referred to simply as men or women, according to their gender identity and gender presentation, regardless of whether they have had sex reassignment surgeries. Crossdressers: Crossdressers are people who wear the clothing usually associated to the opposite sex. They have been referred to in the clinical literature as "transvestites" (TVs), but most prefer the term crossdresser. Some crossdress for erotic fulfillment, some for social fun (i.e., doing "drag") and still others just for comfort. Since women have more freedom to dress in American culture, crossdressers are, by clinical definition, males who dress in women's clothing, and most are heterosexually identified. Many crossdressers purge their female clothing periodically as a way to try to cure themselves of their behavior. The length of time a person crossdresses can vary from infrequent to full-time. Drag queens are males, often gay men, who dress as women, in an extreme feminine manner, often for entertainment. Some drag queens and drag kings might live full-time in these identities. Female impersonators are men who work in the entertainment industry and who dress as women as part of their job; they may be crossdressers or be transgendered but not necessarily; male impersonators are their female counterparts.

Intersex: Intersexuality refers to people who are not easily classified into the binary of male and female categories. They have physical sex characteristics, often including ambiguous genitalia, of both males and females, and are not easily differentiated into established sex divisions. Intersex people are assigned to either male or female categories at birth and may have been surgically altered at birth. Intersexuality and surgical alterations are often kept from the secret, sometimes even to those who have been altered whose medical records are kept from them. Intersex people can be heterosexual, gay, lesbian, bisexual, transgender, or transsexual from the perspective of the sex and gender identity that they have been assigned. Approximately 2% of the population may be broadly classified as intersex.

Female-to-male transsexuals (FtM or FTM): Female-to-male transsexuals, commonly referred to as "transmen," are natal females who live as men. This includes a broad range of experience including those who identify as "male" or "men" and those who identify as transgender, "transmen," "female men" or as FtM as their gender identity. FtMs are often contrasted with "biomen" or biologically born men. Some transsexuals are comfortable being included in the category of transgender and others are not.

Male-to-female transsexuals (MtF or MTF): Male-to-female transsexuals are natal males who live as women. This includes a broad range of experience including those who identify as "female" or "women" and those who identify as transsexual women. Some words used to refer to transsexual women are "Ergif" and "new women" which is contrasted with the term "biomen" for biologically born men. Some transsexual men are comfortable being included in the category of transgender and others are not.

Bigrender: Some gender variant people rejects the choices of male/female, man/woman and feel their gender encompasses "both" genders. Some feel that they are androgynous, simultaneously exhibiting masculine and feminine traits, and others feel they are neutral, or neither gender. This steps outside of a "changing sex" paradigm and allows for more flexibility of gender expression and identity. Biggerender people often identify as being of both genders. Transsexual people do not commonly consider themselves to be biggerender.

Transsex: Some American Indians cultures express both genders is refers to as "Two-Spirit," which includes culturally prescribed ambiguities of sexual and gender identity, often referred to as "gender queers," "gender benders," "gender-blenders," "third sex" and "gender perverts" as terms of pride.

Gender Community: This is a colloquial term for the transgender community or people who are dealing with issues of gender identity. It often includes the significant others of transgender people, referred to as SOFSAs (significant others, family, friends and allies).

Emergence: The process of become aware of, acknowledging, accepting, appreciating, and letting others know about one's (trans)gender identity. It is similar to the "coming out" experience for lesbian, gay men and bisexual people, but can also involve body modification and changes in pronoun use; it is, therefore, less easily hidden socially or vocationally. Emergence is normative within a culture that allows only diplogymorphic unique gender expressions; it describes an adaptive process that is necessary within a confining social system.

Transition: The process that transgender people move through in accepting their gender identity, particular the physical, legal and psychological experience of moving from one gender identity to another, or allowing others to see their authentic identity.

Pasing: To pass is to be able to successfully assume the gender role opposite sex when interacting with society and being able to function in public situations as a member of that gender. When someone does not pass well, or can be easily "read" as a member of his or her assigned sex, it can invite public ridicule and violence. Some transgender activists reject the idea of trying to pass, seeing it as playing into a dual-gender system, however for many transgender people passing well is as seen as affirming their re-integration into society.

SRS (Sexual Reassignment Surgery): SRS, also referred to as GRS (Gender Reassignment Surgery), is the surgical process involved in changing one's sex. This is most often referred to genital reconstruction, but also can include mastectomy and chest reconstruction for female-to-male transsexuals, and can also include a variety of cosmetic surgeries to enhance one's gender presentation. Genital surgeries for male-to-female people are currently more advanced than those available for female-to-male people.

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References
Dreger, A. D. (1999). (Ed.) Intersex in the Age of Ethics Hagerstown, Maryland University Publishing Group

Online Resources
7) Research has shown that gender-variant youth
8) Research has shown that newer treatment models are more effective than

3) Children born with intersex conditions:
   a) are actually intersexed.
   b) False
   c) have a high incidence of post-surgical regret.
   d) formed in early adolescence.

5) Gender Identity is:
   a) the same as gender role.
   b) assumed to develop consistent with natal sex.
   c) changeable with behavioral treatment.
   d) always consistent with gender identity and treatment.

4) Social workers:
   a) are confused about whether they are a boy or a girl.
   b) cannot convincingly pass.
   c) are commonly known as transmen.
   d) described as motivated by erotic desires.

6) Gender Identity Disorder:
   a) is only useful when working with people with psychiatric disorders.
   b) does not exist in people with intersex conditions.
   c) confuses sexual orientation with gender role expression.
   d) was removed from the DSM in 1993.

9) Transgender Emergence describes:
   a) a developmental model of transgender identity formation.
   b) a socio-political process establishing a transgender social justice movement.
   c) described as a non-clinical way of distinguishing transsexuals from crossdressers.
   d) used as a non-clinical way of distinguishing transsexuals from intersex people.

10) Transgender experience is:
    a) is always consistent with gender identity.
    b) does not exist in people with intersex conditions.
    c) a socio-political process establishing a transgender social justice movement.
    d) crossdressing and passing in public.

11) Female-to-Male transsexuals:
    a) are commonly known as transmen.
    b) never have interest in taking female hormones.
    c) are usually known as transmen.
    d) can successfully hide their crossdressing from their wives for decades.

12) Crossdressers:
    a) are commonly known as transmen.
    b) can successfully hide their crossdressing from their wives for decades.
    c) cannot convincingly pass.
    d) described as motivated by erotic desires.

13) Post–Test
    1. To increase social workers' understanding of gender identity and transgenderism.
    2. To increase comfort in working with transgender, transsexual, intersex, and other gender-variant people.
    3. To develop and enhance specialized skills for provision of services in transgender, gender-variant, and intersex people.
    4. To increase appropriate evaluation and treatment of sex and gender identity disorders.
    5. To increase social workers' understanding of gender identity and transgenderism.

14) A transsexual woman involved in a relationship with a natal male, would most likely identify the relationship as same-sex, i.e., "gay."

15) Transgender Emergence describes:
    a) a developmental model of transgender identity formation.
    b) a socio-political process establishing a transgender social justice movement.
    c) described as a non-clinical way of distinguishing transsexuals from crossdressers.
    d) used as a non-clinical way of distinguishing transsexuals from intersex people.

8) Focus CE Course Evaluation - February 2006

1. Did the course content increase your understanding of transgender, gender-variant, and intersex people?
   a) Yes
   b) No

2. Did the course content expand your knowledge and understanding of the topic?
   a) Yes
   b) No

3. Did the course content address issues of diversity and/or the social justice implications of the topic?
   a) Yes
   b) No

4. Was the course relevant to your professional work/interests?
   a) Yes
   b) No

5. Was the course challenging?
   a) Yes
   b) No

6. Was this course helpful in your professional work?
   a) Yes
   b) No

7. Would you recommend this course to your colleagues?
   a) Yes
   b) No

8. Did the course effectively convey important information and concepts?
   a) Yes
   b) No

9. Did the course address the issues of concern to you?
   a) Yes
   b) No

10. Please provide comments on current course and suggestions for future courses.
    ______________________________________________________________________
    ______________________________________________________________________
    ______________________________________________________________________
    ______________________________________________________________________
    ______________________________________________________________________
    ______________________________________________________________________
    ______________________________________________________________________
    ______________________________________________________________________
    ______________________________________________________________________

11) Transgender Emergence:
    a) findings from the DSM in 1993.
    b) including the relationship of sex and gender identity.
    c) has national policy directives in place regarding the treatment of gender-variant people.
    d) are at the vanguard of non-pathologizing treatment strategies working with gender-variant people.

12) Females of FTMs are usually relieved to no longer be viewed as lesbian.
    a) True
    b) False

13) There is general agreement that crossdressers are motivated by erotic desires.
    a) True
    b) False

14) Crossdressers have a high incidence of post-surgical regret.
    a) True
    b) False

15) Research has shown that gender-variant youth
    a) usually experienced isosexual desire.
    b) are likely to be therapists, counselors, or social workers.
    c) are more likely to be therapists, counselors, or social workers.
    d) never grow up to be gay.