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The Gender Variant Phenomenon--A Developmental Review

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NOTE: This is taken, in part, from a paper I wrote in 2001 entitled Implications of Being Gender Dysphoric: A Developmental Review. It was peer reviewed and published in Gender and Psychoanalysis, An Interdisciplinary Journal, Vol. 6 No. 2, Spring 2001, pp 121-141. I have updated it and post it here to make it available over the internet.

ABSTRACT

Living in conflict with one of the basic tenets of existence (Am I male or am I female?) is understandably anxiety provoking. This fact leads me to suggest that Gender Identity Disorder as this conflict is described in the DSM IV, is not an appropriate descriptor. I suggest here as I have elsewhere (Vitale, 1997, 2001) that instead the condition be termed Gender Expression Deprivation Anxiety Disorder (GEDAD). After explaining my thinking on gender expression deprivation anxiety, I will describe how this anxiety, if left untreated, is manifested in each of the five developmental stages of life: confusion and rebellion in childhood, false hopes and disappointment in adolescence, hesitant compliance in early adulthood, feelings of self induced entrapment in middle age, and if still untreated, depression and resignation in old age.

There is a growing body of evidence that Gender Identity Disorder (GID) as described in the Diagnostic and Statistical Manual IV (DSM IV) (1994) is at least in part, the result of insufficient or inappropriate androgenization of the brain at a critical stage of embryonic development.

As a result, the affected individual may be left with somewhere between a partial and a full sense of having a cross-sexed gender identity. Essentially creating a not-male, not-female but otherwise permanent gender variant condition. Even though there apparently are some individuals who fall very close to or dead-center on the gender identity spectrum, most gender variant people can easily identify with being closer to one end of the spectrum then the other.

Given the probable cause, it is reasonable to assume there are many permutations of the way gender variant individuals relate to their condition. However, people who present for treatment routinely fall into three distinct groups: Two groups of female-identified males(Group One and Group Three in this paper) and one group of male-identified females (Group Two).

Group One (G1) is best described as those natal males who have a high degree of cross-sexed gender identity. In these individuals, we can hypothesize that the prenatal androgenization process--if there was any at all--was minimal, leaving the default female identity intact. Furthermore, the expression of female identity of those individuals appears impossible or very difficult for them to conceal.

Group Two (G2) is composed of natal females who almost universally report a life- long history of rejecting female dress conventions along with, girls' toys and activities, and have a strong distaste for their female secondary sex characteristics. These individuals typically take full advantage of the social permissiveness allowed women in many societies to wear their hair short and dress in loose, gender-neutral clothing. These individuals rarely marry, preferring instead to partner with women who may or may not identify as lesbian. Group Two is the mirror image of Group One.

Group Three (G3) is composed of natal males who identify as female but who act and appear normally male. We can hypothesize that prenatal androgenization was sufficient to allow these individuals to appear and act normally as males but insufficient to establish a firm male gender identity. For these female-identified males, the result is a more complicated and insidious sex/gender discontinuity. Typically, from earliest childhood these individuals suffer increasingly painful and chronic gender

dysphoria. They tend to live secretive lives, often making increasingly stronger attempts to convince themselves and others that they are male.

As a psychotherapist I have found female identified males (G1) to be clinically similar to male-identified females (G2). That is, individuals in both groups have little or no compunction against openly presenting themselves as the other sex. Further, they make little or no effort to engage in what they feel for them would be wrong gendered social practices (i.e., the gender role assigned at birth as the basis of authority). Although I have seen some notable exceptions, especially in male-identified females, these individuals--at the time of presentation for treatment--are rarely married or have children, are rarely involved in the corporate or academic culture and are typically involved in the service industry at a blue- or pink-collar level. With little investment in trying to live as their assigned birth sex and with a lot of practice in living as closely as possible to their desired sex, these individuals report relatively low levels of anxiety about their dilemma. For those who decide transition is in their best interest, they accomplish the change with relatively little difficulty, particularly compared to G3, female-identified males.

The story is very different for Group Three. In the hope of ridding themselves of their dysphoria they tend to invest heavily in typical male activities. Being largely heterosexual, they marry and have children, hold advanced educational degrees and are involved at high levels of corporate and academic cultures. These are the invisible or cloistered gender dysphorics. They develop an aura of deep secrecy based on shame and risk of ridicule and their secret desire to be female is protected at all costs. The risk of being found out adds to the psychological and physiological pressures they experience. Transitioning from this deeply entrenched defensive position is very difficult. The irony here is that gender dysphoric symptoms appear to worsen in direct proportion to their self-enforced entrenchment in the male world. The further an individual gets from believing he can ever live as a female, the more acute and disruptive his dysphoria becomes.

Given gender identity permanency and its obvious importance in the ordering of one's life, it is reasonable to consider gender identity as essential existential

knowledge, knowledge that can not be unknown or separated out from the whole without radically redefining the whole.

For all three groups described here, I believe it is safe to say that gender dysphoria is the single most dominating influence during developmental stages in all three groups. In this paper, I will take examples from my case load to show how gender dysphoria effects these people at each of the classic five stages of life: childhood, adolescence, early adulthood, midlife and old age.

Living in conflict with one of the basic tenets of existence (Am I male or am I female?) is certainly anxiety provoking. This fact leads me to suggest that Gender Identity Disorder is not an appropriate descriptor. I suggest here as I have elsewhere (Vitale, 1997, 2001) that instead the condition be termed Gender Expression Deprivation Anxiety Disorder (GEDAD). After explaining my thinking on gender expression deprivation anxiety, I will describe how this anxiety, if left untreated, is manifested in each of the five developmental stages of life: confusion and rebellion in childhood, false hopes and disappointment in adolescence, hesitant compliance in early adulthood, feelings of self induced entrapment in middle age, and if still untreated, depression and resignation in old age.

Untreated GEDAD as it is manifested across the five stages of life:

The periodic need to cross-dress or otherwise express cross-gender behavior is a common element in gender dysphoria. Costume is obviously a form of gender expression. For people who are not gender dysphoric, cross dressing on a lark or for some other reason may be fun but in someone who is gender dysphoric, it is an essential aspect of their life. Some individuals with mild gender dysphoria come to terms with their cross-dressing/cross-gender behavioral needs and may even celebrate them with public presentations. Others have a far more negative view of their need to express cross-gender behavior and keep that part of their life private. Either way these individuals stay largely within the primary physiological bounds of their assigned gender. The problems they encounter are primarily social ones, the two most important being family pressures to conform, and the potential embarrassment of discovery.

For individuals with a mild to moderate form of dysphoria, life is tolerable and they rarely make any overt attempt to live outside prescribed social norms. For those with a more extreme dysphoria, mild palliatives such as periodic cross-dressing, although helpful, becomes insufficient. These individuals appear to need to inhabit and live out the cross-sexed identity.

TERMINOLOGY

In the DSM III-R (1987) people suffering from gender dysphoria were referred to as "Transsexuals." When the DSM was updated in 1994, the term "Transsexual" was replaced with "Gender Identity Disorder." This is not an improvement. The term Gender Identity Disorder implies that one's physiological sex is correct and that one's inner sense of gender is disordered or wrong. It is clear that this is not how gender dysphoric individuals perceive their condition. This is evident both in psychologists' inability to change a person's sense of gender with therapy and the ready preference of many of these individuals to undergo physical sex reassignment.

Despite the official diagnostic title of Gender Identity Disorder, what gender specialists really treat are disassociation (Seil, 1997), depression and anxiety (i.e., dysphoria). Of these three symptoms, resulting of the double burden of being hormonally and socially deprived of true gender fulfillment, I have found anxiety to be the most acute.

Gender fulfillment can occur on both psychological and physiological levels.

Psychological pressure comes from society's strong expectations that one conform to one's assigned gender role. This an obvious tenet. Physiological pressure is less obvious but most likely results from the inability of the individual's body to produce sufficient cross-sex hormones. This becomes evident in the fact that within days or weeks of receiving cross-sex hormones, dysphoric individuals exhibit markedly lower anxiety. This procedure is so reliable that it is the second step in a the triadic treatment plan described in the Harry Benjamin International Gender Dysphoria Association's (HBIGDA) Standards of Care. (W. Meyer, et al.,2001). Hormonal treatment is considered both a verifier of gender dysphoria and a treatment. Further, as treatment

continues, the resulting cross-sex feminization or masculinization typically reduces and eventually eliminates the anxiety entirely (W. Meyer, et al.,2001).

TREATMENT

Although there is still some disagreement as to how gender dysphoria begins and who should qualify for hormonal and surgical intervention, there is a remarkable amount of agreement in several important areas. Most psychologists now agree that gender dysphoria qualifies as a subject of clinical attention separate from other disorders. Further, most clinicians agree that the gender identity beliefs these people hold are profound, deep seated, and non-delusional. Even more significantly, outcome studies now clearly indicate that when three conditions are met: a proper differential diagnosis, a significantly long trial period of living in the gender of choice, and a satisfactory surgical result, there is only a small incidence of post-operative regret. Indeed, in a review of the outcome literature Pfafflin (1992) reports that less than 1% of the female-to-male transsexuals who had undergone sex reassignment had any regrets. For male-to-female transsexuals the number was slightly higher at less than 2%. Later studies supporting Pfafflin's report include Bodlund O. et al., (1996); Cohen-Kettenis P.T (1997); Exner, K. et al., (1995); Rakic, Z. et al., (1996), and Smith Y. L. et al., (2001). It should be noted that satisfaction is measured by self report of improvement in the individual's psychosocial well being.

Since everyone, even an intersexed child, is raised as either a boy or a girl even in the most non-sexist environment (Stein, 1984), a chain of physiological and societal events begins at birth that propel the individual into a predetermined set of behavioral expectations. In a bicameral sexed culture, deviating from those expectations almost invariably results in social conflict. The individual's quality of life, his or her relationship with family, friends, career, legal gender status and the nature of his or her being in the universe, are all at stake.

If we keep in mind that gender identity is in reality a continuum, and if what one looks like may not correspond to what one feels like, we can expect a corresponding mild-to-severe range in gender related anxiety.

What follows is a synopsis of what I have learned from

treating and conducting interviews with approximately 350 adults presenting with gender issues between 1978 and 2000. The age range is between 17 and 71. My comments on how GEDAD is experienced in childhood are taken from self-report of adults in individual and group sessions. To augment my limited clinical work with children I have also cited the work of Kenneth Zucker and Susan Bradley (1985).

In what follows I describe five distinct developmental stages, that make up the standard periods of developmental psychology: childhood, adolescence, young adult, middle age, and older adult.

Childhood---Confusion and rebellion

Adolescence--False hopes and disappointment

Early adulthood--Hesitant compliance

Middle age--Feelings of self induced entrapment

Older adult--Depression and resignation

CHILDHOOD

As early as age two and half, most children begin showing a preference for behaviors and activities consistent with their assigned sex. By age three, they actually refer to themselves as a boy or a girl. Interviews with three-year-olds reveal that they agree with statements such as girls like to play with dolls, ask for help and talk more than boys, while boys like to play with cars, build things, and hit other children.

Even the casual observer can see that children place a high priority on gender-appropriate behavior at an early age. Most individuals with gender expression deprivation anxiety report becoming aware that something was not right with their original gender assignment as early as age four. Males emphasize their experience that, unlike other problems a four-year-old boy may be able to discuss with friends or parents, wanting to be a girl was definitely to be avoided.

Even though my example below dates back forty years, I think it is still safe to say that a boy who wants to be a girl and is willing to admit it today can expect to be

"corrected," often in a very stern and firm way or his desires ignored as "something he will grow out of." For example, Arlene who is now in her fifties, reported a traumatic incident in school when, at the age of six, she (then he), was made to stand in front of his first-grade class wearing a large pink ribbon while his classmates were encouraged to laugh at him. He was being "corrected" for having been "caught" playing hopscotch with the girls during recess. Here is an example of a form of behavioral modification meant to insure immediate cessation of effeminate behavior in a male.

On the other hand a girl who wants to be a boy and is willing to admit it can expect far less retribution for her behavior. Girls who affect boyish behavior are generally perceived as cute and the behavior is usually tolerated by friends, family and school officials through childhood. Although they reported mild social pressure to "dress pretty" and be more gentle, none of the male-identified female clients I have worked with have shared experiencing behavioral modification efforts like the one endured by the hopscotch-playing boy.

Undoubtedly, there are cases where only guidance and time are needed to correct a gender identity misunderstanding in a child. In others, however, it appears that once gender identity is established, no amount of redirecting can change the child's gender identification. Some boys in particular openly endure the taunts of their peers and castigations of their parents in order to live according to their cross-gender understanding. The Child and Adolescent Gender Identity Clinic of Toronto treats many such children brought in by parents who are concerned over what they believe is unacceptable cross-gender behavior. Zucker and Bradly, reporting on the clinic's outcomes, report a high rate of helping these families. Interestingly, Ken Zucker and Susan Bradley (1995, p32), report a referral ratio of male children to female children entered for treatment since 1978 (n=249) to be 6.3 to 1. Since there is no evidence that cross-gender behavior occurs more often in boys than it does in girls, a possible interpretation of this statistic is that effeminacy in boys may be considered by parents to be more upsetting and in need of correction than tomboyish behavior in girls.

Given the nature of the disorder and the ability of some

children to conceal it, I believe that most children with gender dysphoria are never diagnosed as such. Those children cope by sticking rigorously to the role expected of them. Privately, however, they continue to go deeper and deeper into a highly guarded parallel world of cross-gender envy and fantasy. Given their propensity to be studious, detached and self absorbed, I have come to think of these children as living cloistered lives. These children grow up to form the core of Group Three.

Little is known about gender dysphoric boys who privately struggle to fit into their expected gender role. With no apparent problem, (many adult GID clients report being exceptionally well behaved as children) they simply go unobserved by clinicians studying GID. Yet from interviewing adults with gender dysphoria, I can report that the problem was as real for them then as it is now. Here are some of their childhood reflections.

The underlying feelings most often stated were of detachment and confusion, a sense of not really fitting in though family and teachers consistently rewarded them for their behavior. One of the most common areas of confusion was the sex assignment process itself. Although we as adults may think it simplistic, many children are completely perplexed as to why some children are assigned as boys and others as girls. Given a tendency toward privacy and modesty in our society, many children, especially those without siblings, often have no way of knowing that there is a physical difference between themselves and those differently assigned.

Andrea, a 35-year-old male-to-female, post-operative transsexual recalls that she was completely perplexed over her assignment as male until when she was seven her sister was born. While first watching her mother change her sister's diaper, she learned for the first time that her assignment as a boy was based on a real physical difference. Although it cleared up part of the confusion, she realized, even at that early age, that her identity concerns were far more complicated and serious then she had first imagined.

As Andrea above, it is common for clients to report thinking in childhood that gender assignment was based on parental preference and therefore open for redress. Girls are especially aggressive in their insistence that they are really boys. Indeed many are so insistent that they go

on to act for all intents and purposes as though they are boys, a pattern they carry into adulthood.

For cloistered gender dysphoric boys it was in the area of peers and activities, especially sports, that the problem was most noticeable. Unable or uninterested in competing in organized boys' activities and having been shuffled decidedly away from playing with the girls, many became reclusive. To add to their confusion, and counter to behavior typically reported in openly gender dysphoric boys, many cloistered boys actually preferred solo play with boys' toys and had little or no interest in girls' toys. For example I have heard more than one long-time post-op male-to-female transsexual speak fondly of having spent countless hours playing with an Erector Set or a Lionel model train set-up that their father had helped them build. Others described of designing and making detailed model airplanes, race cars and sailing ships. The more academic of this group report little or no interest in sports and rough and tumble play. To avoid castigation from their peers, they report spending a lot of time reading and studying. However, although these children appeared to be normal boys doing what most people would consider some normal boy activities, they may very well have been doing so while secretly wearing their mother's or sister's underwear, fantasizing about being a girl or both if they could manage it.

Like many children faced with difficulties they are powerless to change, such as family anger and divorce, gender dysphoric children often seek supernatural help with their special problem. This is usually in the form of praying to God and practicing special religious indulgences. This practice has an inherent opportunity for secondary gain. Almost universally they report that they believed that if God interceded for them by changing their sex, their parents and the world would have to exonerate them from what they typically perceive to be a negative and shameful desire.

ADOLESCENCE

If there was ever going to be a chance for these individuals to show that they are not really the gender everyone else believes they are, early adolescence is certainly it. Virtually every individual I have interviewed reported wanting desperately to have hidden internal sex organs of the desired gender finally come to life during

adolescence, giving them the desired secondary sex characteristics.

G1 boys, who have a strong feminine core identity, typically develop a sexual interest in other boys during adolescence and prefer girls as peer friends. Although they still desire to be girls, they appear to have significantly less anxiety over not being female then that reported by the boys in G3. I believe this is due to the relatively uninhibited open expression of their femininity. For example Monica was 19 years old when she reported to my office accompanied by her mother. She wore gender-neutral clothing but otherwise presented as female in voice inflection and mannerisms. The problem, of course, was that Monica was genetically male. Monica's mother related to me that Monica had been more like a girl then a boy all her life. Her and her husband loved her dearly but thought of her more as a daughter then a son. Over the course of treating Monica, it became clear that although she was distressed over her male physiology, she was otherwise emotionally stable and very aware of the seriousness of her situation. Once it became clear that she was her own person and ready to undergo transition, a course of hormone replacement therapy was introduced. With the exception of having to face some extreme religious issues brought up by her much older brother, she accomplished an almost effortless transition from male to female. The presence of family support and little or no investment by the family or Monica in her being male made this transition straight forward.

As sexual maturity advances, Group Three, cloistered gender dysphoric boys, often combine excessive masturbation (one individual reported masturbating up to 5 and even 6 times a day) with an increase in secret cross-dressing activity to release anxiety. In a post-op group I facilitated, Jenna (age 43) spoke fondly of the delight she experienced as a boy when she would find something of her mom's in the dirty clothes' hamper in the bathroom. Two others in the group laughingly agreed that they too took many a trip to the bathroom for the same reason. At the same time, in their public life, these boys report employing overtly stereotypical efforts to draw attention from their secret desires to be female by affecting appearances of being normally male. This includes dating girls, participating in individual sports activities such as swimming, running, golf, tennis, and for some, even body

building.

Cloistered (G3) gender dysphoric boys appear to others and even to themselves to be heterosexual. Although as a group they are not especially active daters, they clearly prefer to date girls when they do date. Significantly, unlike other boys, their dating motives are markedly different. For these boys, being on a date with a girl is a chance to spend time with a girl in a way not generally allowed under other circumstances. Dating serves two purposes for these boys. The first is social, as it gives them the all-important appearance of being normal. The second is therapeutic. Being close to a girl's softness, and even her female smell, has a mitigating effect on gender expression deprivation anxiety. The fantasy is not to make love to her but to actually be her.

The situation is less complex for girls. Having more social freedom in both their dress and behavior codes allows at least a modicum of dysphoric relief. Loose, gender-neutral clothing is typically worn to hide their feminizing bodies and there is little or no attempt to appear or act female. Many adult female-to-male transsexuals report having adopted a defiant attitude toward the world as a coping strategy. As with all teenagers, gender dysphoric girls must contend with emerging sexuality. These girls may go out of their way to dissuade boys from showing interest in them while being interested in other girls in a way that parallels that of heterosexual teenage boys.

EARLY ADULTHOOD

As more information about transition to one's felt gender identity becomes available to the general public, we are seeing genetic males with strong core female identities and genetic females with strong core male gender identities present in their early twenties with the clear objective to being sexually reassigned.

The cloistered, natal males, on the other hand typically start to realize the seriousness of their dilemma at this age. It is common to hear reports of these individuals increasing the intensity with which they try to rid themselves of the ever-increasing gender-related anxiety. Many individuals paradoxically adopt homophobic, transphobic, and overtly sexist attitudes in the hope that they will override their desires to be female.

The situation can become so convoluted that some gender dysphoric men come to therapy wanting, almost desperately, to be told that they are not transsexual. That would be understandable if they were simply confused and wanted to get to the bottom of their problem. Unfortunately, their stated preference here appears to be more a form of avoidance of the fear and complexities involved in transitioning than it is an honest desire to remain men. For example, there are natal males who desperately want to have breasts but say they would be terribly embarrassed to have them show in public. There are others who wince at the thought of having a female name like Janice or Mary or Linda. There are also gender dysphoric males who think that the social behaviors that most differentiate women from men -- are frivolous and unimportant. Going so far as to believe that women are "less than" men and being embarrassed about wanting to be like them. Interestingly, these people have no trouble at all with wearing feminine apparel -- as long as they can do it in complete privacy.

Perhaps the most insidious form of sexism can be seen in the gender dysphoric male who has attained a respected position in a male-dominated profession. These people routinely assert the common sexist attitude that although women are now allowed a certain professional tolerance, the real players are still men. As more people transition while continuing to work at the same position, these transsexual males see firsthand how public respect between men can quickly turn into private ridicule when a male colleague becomes a woman. Further more, some gender dysphoric individuals have confessed to participating in sexist jokes as a way to divert even the remotest suspicion from themselves. Given these seemingly unacceptable obstacles, many gender dysphoric males unconsciously accept certain male driven notions about women in an effort to purge the need to be female out of their mind.

When these individuals are questioned further, it is common to see that they have a deep-seated, love/hate relationship with their inward need to be female. While they apparently need do nothing to keep the love side of that dilemma alive, the hate side seems to need constant care and feeding. The danger is obvious: As they see it, if they don't continuously think negatively about women, they might have to face the reality of wanting to be one.

In essence, the sexism in this group serves as a cover, providing a convenient, and unfortunately a socially acceptable way to maintain denial.

Another common attempt to "make it"- as a man by gender dysphoric males in this age range is to marry and have children. Unlike their non-dysphoric male peers, these men's attraction toward the idea of family is not the standard one. Some individuals report telling their partners about their life long desires to be female before getting married, but the vast majority do not, perhaps from fear of ridicule or rejection, or because they maintain the fantasy that marriage will provide a cure. Many clients report that they were sure that being a husband would cement their maleness. This logic, unfortunately, gets extended to the idea of having children. Although gender dysphoric males are generally no better or worse as fathers then the next man, they soon come to realize that what they had hoped would be an answer has instead complicated their gender issues enormously.

In distinct contrast, genetic females who do not seek sex reassignment make little or no concerted effort to be rid of their gender dysphoria. Although they may be deeply disturbed by having acquired female secondary sex characteristics in puberty, many assume an androgynous appearance and affect outright male mannerisms. In larger cities, they may find refuge by taking active roles in the lesbian community and being involved in typically male occupations.

Meanwhile, gender dysphoric people must live in the real world, being subject to the same developmental pressures as their peers. Developmental psychologists refer to the ages between 28 and 33 as a time when individuals reassess their dreams and aspirations. Mistaken interests, family obligations and career demands start to become serious concerns. For women who are reaching the later part of their childbearing years, their children are now in school or yet to be born. New decisions have to be made relative to the bulk of life that still lies ahead. When someone contending with a gender identity issue reaches this pivotal period, the pressures are magnified far beyond what others experience.

Gender dysphoric individuals respond to this critical period in two characteristic ways. A growing number of

people (those who have access to information and other resources) now go directly to giving serious consideration to changing their sex. After an appropriate period of psychotherapy and evaluation by a gender specialist, these individuals almost routinely go on to be physically and legally reassigned to the sex that more closely fits their inner sense of self. Others, who may also be aware of sex reassignment options, may find the idea too impractical or too frightening, deciding instead to entrench themselves deeper into life as a member of their originally assigned sex.

MIDDLE AGE

For those who continue to struggle inwardly with their gender issues into mid-life, new issues come to the fore. As a time when most people realize that about half of life has been lived and feel the need to make an accounting of who they are and what they have done with their lives, this period can be especially anxiety provoking for the gender-dysphoric individual. Decades of trying to overcome an increasing gender expression deprivation anxiety begin to weigh heavily on the individual. Family and career are now as deeply rooted as they will ever be. The idea of starting over as a member of a different sex has become seemingly impossible. The fact that the need to change sex has increased rather than diminished, despite Herculean efforts, is now undeniable.

These individuals often show up in therapy offices with symptoms mimicking Depression or Generalized Anxiety Disorder. They complain of panic attacks, irritability, sleeping disorder, inability to concentrate, and recent weight loss. If they are married, there is often serious martial discord due to self-imposed disassociation from the family unit. Job performance may also be affected, it is not uncommon the hear reports of individuals experiencing negative performance revues or outright threats of being fired unless they seek help for whatever is bothering them. Pressed ever deeper into despair, suicidal thoughts begin to intrude into daily life. Even at this point the individual may be reluctant to discuss their gender issues lest the door be opened to a fear-laden real-world exploration of gender transition. They are consumed by feelings of being inexorably trapped.

John, a 50 year-old genetic male, medical research scientist, married (23 years), father of three children aged

20, 17 and 7, phoned me after experiencing a panic attack severe enough to require emergency attention from paramedics at the airport on his way to give a presentation at a conference. John gave me only his first name and informed me that I was the first to be told what he was about to tell me. He said he was "gender dysphoric" and that he was "desperate." Feelings that were once "controllable through sheer force of will," had increased to where he now was having protracted periods where he would close his office door, lie on the floor and weep quietly while curled up in the fetal position, holding his genitals in pain. Other than intrusive and repeated fantasies of being female, he had refused to allow himself any overt form of female gender expression. He reported feeling that if he was to cross-dress and be caught, he would dishonor his wife and family. Having attained international recognition for his work, he was also concerned about his professional reputation. The only other form of temporary relief came through masturbating, often up to five times a day.

Our work together over the last three years has been slow. However, with the help of extensive individual, group, and family psychotherapy, augmented by estrogen replacement therapy, with the full permission of his family, John has recently taken on a female name and is living full time in the female gender role. She is in the process of renewing and redefining her relationship with her family, and has successfully returned to work after an extended leave of absence.

OLDER ADULT

Some gender dysphoric individuals proceed into their senior years with their needs and desires to be female still unresolved. Even now the natal male's feelings about the matter may be as strong as ever. The relative freedom of gender expression that women enjoy throughout their lives continues, and there is even less pressure on G2 females to be attractive or feminine now than when they were younger. For natal males, the situation is reversed.

Little is known about these individuals. That they exist, however, is indisputable. Surgeons report performing sex re-assignment surgery on individuals as old as 71. I have personally worked with four natal males in their early to mid sixties. Colleagues in my peer-supervision group report working with others in their mid-sixties to early

seventies.

The issues these individuals face are now very different. Concerns about how to be a father to young children, maintain a career, and establish intimate relationships have lessened. New, less resolvable issues emerge. Along with low self esteem brought on from years of self denial, these individuals must now contend with a deteriorating male body.

Along with balding and paunchiness, there are more serious health issues to consider if an older person wishes to transition to the other gender role. Cardiac disorders, gastro intestinal disorders, diabetes and, often, liver dysfunction due to a life time of alcohol abuse are some of the most common. Here is a statement from Tom, a 63-year-old natal male who was notifying me that he was leaving a "starter" group I facilitate after attending for two months:

"*I have recently completed a year and a half of interferon and riboviron treatment for Hepetitus C. That means that anything like hormones could be detrimental to my liver health. No doctor would approve that. Short of that I don't believe that there is any in-between for me given my health, age, appearance, marriage and family. I believe now that I have to live my life as a gentle male and that is most comfortable for me. Not ideal but most comfortable*."

A mitigating factor for Tom and other seniors, ironically, is that the natural aging process decreases their serum testosterone level resulting in a corresponding increase in estrogen level. The feminizing effects, albeit mild, are welcomed whole-heartedly. As in hormone replacement therapy for younger men, the natural hormonal changes appear to ease some of the psychological aspects of the dysphoria in seniors. Yet when interviewed, those who chose to remain male speak of a clear longing for what might have been. Senior gender dysphoric males typically report they have been waiting, many since childhood in the hope that their desire to be female would simply "go away." Like those who are younger, they say in resignation that if they had known the dysphoria was going to remain such a strong force in their lives, they would have braved anything to face their dilemma decades sooner.

There is one other problem this population faces. In interviews, one gets the impression that the struggle to contain their gender expression deprivation anxiety--in and of itself--has become deeply ingrained in their psyche. It is as if the gender dysphoria has become a critical component of who they have become. Characteristically these people can be described as sad, depressed and deeply resentful. In treating these individuals, the best that can be done is to help them feel better about cross-dressing and encourage them to have contact with other crossdressers their age. Success of sorts can be as simple as helping someone find the courage to shave off a moustache behind which he has been hiding his gender issues for forty years.

Conclusion

Clinically, gender dysphoria shares symptoms often associated with Dissociative Disorder, Depression and Generalized Anxiety Disorder. Differential diagnosis may be complicated by the client's reluctance to disclose the source of the morbidity for fear of being overcome by real or imagined outcomes of the disclosure.

Gender identity issues can be a life-long condition for those who find it too difficult to deal with directly. Each life stage presents new dilemmas and decisions in relation to this core issue. In general it can be said that the more the individual struggles to rid themselves of gender dysphoria by increasing social and physical investments in their assigned sex, the greater the generalized anxiety and the harder it becomes to restart life sexually reassigned. For those individuals who, despite all obstacles, can transition to a new gender role, it has been shown that gender transition that includes psychotherapy, hormonal therapy and--in most cases--gender reassignment surgery, significantly reduce and eventually eliminates the anxiety entirely.

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