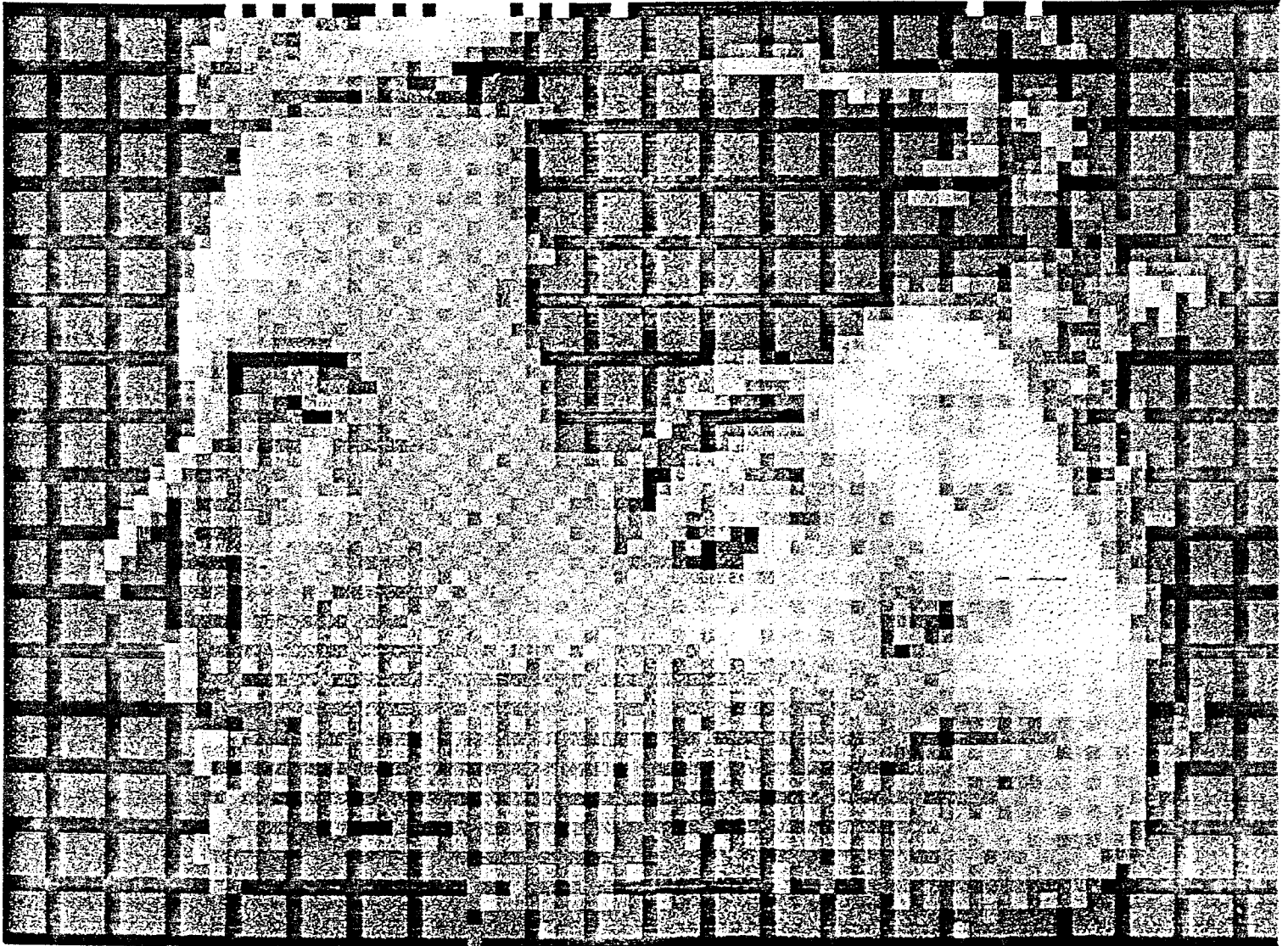


Out of darkness into the light

InSight

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trololysis, I found I could do away with heavy foundation. And I learned that I could do away with that biggest crutch of all—the wig. I didn't even realize that was possible until I saw others wearing their own hair. In a way the wig was the biggest step of all.

There is a flip side to this story. Some of my advances as a woman caused changes in my appearance as a man, when I was still living my life as a male. But like all transsexual people, I am used to compromise, and I found that eventually I grew comfortable with things about my body that would have previously made me very uncomfortable as a man. When I first shaved my legs at age 15 or so, I was absolutely terrified about being seen as a male with no hair on my legs; by the time I was 25, I didn't give it a thought. My clean shaven face, mildly tweezed brows, the holes in my ears, my feminine haircut, my nails—all of these would have made me very uncomfortable back in my hypermasculine days, but I grew accustomed to the changes; they all became part of my image as a man. The same changes that made me uncomfortable in my male role were of course a delight in the female role.

We all have crutches. Some of us could use our own hair, but we rely on our wigs. Some of us use padding we could do without. We need to recognize our crutches for what they are and come to grips with them. Maybe we can even throw some of them away.

Of course, false eyelashes and wigs and lots of other crutches were not invented with transsexual persons in mind. They were invented for genetic females, just as elevator shoes were invented for genetic males and not female-to-male transsexual persons. It is not totally inappropriate to use such aids on occasion. It is our unnatural reliance on them that we must face and defeat. So now that I no longer need them, maybe I'll wear a pair of false eyelashes some evening soon. ☺

Sexual and Genderal Characteristics: How Men and Women Differ

By Dallas

The statistically "average" genetic male differs from the statistically "average" genetic female in many ways, some of them striking, and some of them quite subtle. While the purpose of this article is not to provide a

complete lesson in the morphology or psychology of sex differences, I do want to point out some of the obvious differences for purposes of illustrating some of the physical and behavioral problems transsexual persons must overcome. Most of the traits I mention are discussed by Desmond Morris in his books *Manwatching* and *Bodywatching*.

The average person is well aware that there are anatomical and behavioral differences in men and women, but when pressed, may be unable to objectively describe any but the more obvious differences. It is the gestalt—the summation of characteristics—causes us to identify a person as a male or a female. It is perfectly possible, of course, for a female to have one or several of the traits usually associated with the male (for example, great height and a deep voice), without her sex or gender being questioned. Conversely, a male can be small-boned and without appreciable facial hair, and yet escape being mistaken for a female. It is only when a combination of characteristics begins to tip the scale that we see the person as a member of the opposite sex.

What are these differences? They are manifold. First, there are gross differences in morphology. Anatomists can tell the skeletons of males from those of females, and internal organs differ as well. Genetic males tend to be taller, with larger hands and feet, heavier bones, broader shoulders, and hips which are narrower than those of genetic females. Their brow bones are more pronounced, and they tend to be more prognathous (have heavier jawbones) than do females. The male pelvis makes for more efficient walking and running than does the female's, which is compromised by the conflicting requirements of locomotion and childbearing. The male is stronger, with more pronounced muscles. His legs and arms are proportionally longer, and his forearm is longer in relation to his upper arm than is the female's. His hands are bigger, with thicker fingers and stronger thumbs. His chest is bigger, to house bigger lungs. His neck is shorter and thicker. His brows are bushier; her eyes are proportionally larger. His nose is more prominent. And of course, his reproductive organs are on the outside of his body, whereas the female's are inside.

The female has larger, fleshier lips, and her buttocks protrude more than does the male's because of her pelvis anatomy. She has more fat on her body, and it is distributed differently. She is fleshier in the shoulders and knees, and in the breasts, buttocks, and thighs.

Fat in the male tends to show up as a "pot-belly." In the female, fat tends to show up on the thighs, buttocks, and upper arms.

The secondary sex characteristics of males and females arise at puberty, triggered by gonadotropic hormones (the sex hormones—estrogens and androgens). The male's voice deepens, and he may develop a visible Adam's apple. Facial hair, and genital and axillary (armpit) hair appear; thick body hair appears on the arms, legs, chest, and stomach, and sometimes the back and neck. If he carries a gene for pattern baldness, a man will begin to rapidly lose his hair, and even if he doesn't, androgens will often cause the hair to thin. His skin will become oilier.

The female's voice also deepens, and she develops genital and axillary hair and body hair, but generally not the extent of the male. Her genital patch will differ from that of the male, being triangular in shape, whereas his extends upwards toward the navel. Her breasts grow, and her hips widen.

Many of the physical differences in males and females occur at puberty as the result of mediation by gonadotropins. Administration of opposite-sex hormones after puberty can offset some of these differences—for instance, causing breast development and redistribution of body fat in genetic males, and causing deepening of the voice and beard growth in genetic females—but other changes, once triggered, are not subject to hormonal reversal. A six-foot-two male will not shrink to the five-foot-seven height that may have been his ceiling if he had received estrogens at puberty, and a five-foot-two inch female will not grow to the five-foot-ten height she may have achieved with androgens at puberty (although she may grow an inch or two). Neither will large hands and feet or broad shoulders go away, or will pattern baldness reverse itself—and the male's voice will not raise in pitch, or the female grow appreciably taller.

Behavioral differences are legion, and to a large degree unstudied. Males tend to be louder and more boisterous than females, and are often more object-oriented and less aware of or attach less importance to interpersonal relationships than do women. Their movements are more rapid, and less streamlined and smooth than those of women. Their speech differs from that of women. They are quicker to show anger and slower to express tenderness.

Many behavioral differences are subtle; when

passing a male in a crowd, women tend to turn away from him; the male usually turns toward her. Women clasp their hands more often. Men are more likely than women to fold their arms across their chests (and the way in which they fold their arms and cross their legs is topographically different than in men). Women's wrists are more likely to be dangled limply. Desmond Morris points out in *Manwatching* that males often mimic this behavior in an exaggerated manner when pretending to be effeminate.

Other gender signals are what Morris calls invented; that is, they arise for cultural reasons. They are not inherently masculine or feminine, but are interpreted as such because of the society in which they occur. Morris' examples of invented signals are "short hair versus long hair; skirts versus trousers; handbags versus pockets; make-up or no makeup; and pipes versus cigarettes." Invented gender signals can influence behavior—long hair can be tossed or stroked in ways that short hair cannot. Skirts demand a modest way of sitting, and this habit can persist even when an individual is wearing trousers. Invented signals cross the line from "sex" to "gender"; they are part of the learned display that makes us a man or a woman, and have little to do with being male or female.

Unfortunately, many gender-specific behaviors remain unidentified and unstudied. We respond to them, but cannot say exactly what they are—we just know that someone seems masculine or feminine to us.

Sex reassignment requires tipping the balance—altering the sexual characteristics so that one is perceived as and believed to be of the sex that corresponds with the gender of choice. Some characteristics (height, bone structure, pitch of the voice) are unfortunately set at puberty, and little can be done about them. Others (breast development, body hair, fat distribution, and, for the FTM, facial hair and vocal pitch) can be altered over time by administration of male or female gonadotropins. Other traits can be altered surgically: unwanted hair removed by electrolysis, genitals refashioned by surgery, faces or breasts or Adam's apples reshaped by the scalpel of the plastic surgeon; hair transplanted. Desired behavioral patterns can be learned through observation of others and by practice and self-monitoring, and undesired behavioral patterns are eliminated in the same way.

Despite the myriad differences between the sexes, it is possible to change one's body; it is

possible to come to look like, sound like, and live as the opposite sex. Surgery, hormonal therapy, and hard work—over time—can do it. One must, of course, take a hard look at what one has to work with: a five foot and two inch tall woman will be a five foot and two inch tall man. A man with size thirteen feet will be a woman with size thirteen feet. But most men and women can come to tip the balance so that they are perceived as the gender of choice. ☞

The Standards of Care: what are they?

By Dallas

Most transsexual persons, and probably most physicians and psychologists, do not realize that there is a set of minimal guidelines for hormonal and surgical treatment of transsexual people. These guidelines were developed in 1979 and last revised in 1981. They are called the Standards of Care.

The Harry Benjamin International Gender Dysphoria Association, Inc. (HBI/GDA) is comprised of physicians and clinical behavioral scientists (psychologists and social workers) who provide diagnosis and therapy for transsexual people. Concerned by a lack of standardization of treatment, HBI/GDA's Standards Committee developed the Standards of Care to provide protection for both service providers and transsexual persons. Before the Standards were published, requirements varied according to the beliefs or value systems of the clinics or persons providing services. Some had very harsh requirements and some had almost none—hormonal and surgical reassignment on demand, as it were.

The Standards of Care brought some order out of chaos. For the first time, there was some quality assurance for treatment of transsexual persons. As with most standards, however, there is some latitude for interpretation, and modern-day service providers may still have varying requirements—but the variation is much less than that which existed before the Standards. It should be noted that the Standards are minimal rather than optimal, and can, and in the opinion of the Standards Committee, often should be exceeded.

Many transsexual people consider the Stan-

dards of Care a series of hurdles that they must leap. In a sense, they are. They require the individual to seek services—like psychotherapy—that (s)he may not feel (s)he needs; and these services are often expensive. They may delay hormonal or surgical reassignment—indeinitely, in some cases, if the individual does not meet the diagnostic criteria for gender dysphoria. Many transsexual people want and even demand hormones and sex-reassignment surgery on demand. They feel, with reason, that their bodies are their own to do with as they please. Physicians feel, with reason, that hormones and surgery may be counterindicated in some instances. Understandably, these different feelings make for some friction between the transsexual and medical communities—and doubtless between many transsexual people and their individual physicians and therapists.

The Standards minimize the chance of prematurely making irreversible changes to the body. For example, surgical reassignment procedures are allowed only late in the game, after the transsexual person has successfully lived in the gender of choice (is somatically gender-consonant) and is unlikely to revert to the original gender.

The first step for the transsexual person is to obtain the services of a clinical behavioral scientist (therapist). The therapist will give a diagnosis. If the diagnosis is gender dysphoria (transsexualism), the therapist will write a letter indicating so. The transsexual person will take this letter to an endocrinologist, who will prescribe hormones. After an indeterminate time on the hormones, and after electrolysis for the male-to-female, the transsexual person will enter a period of real-life-test (RLT), living in the gender of choice. Reassignment surgery is done only after one to two years of RLT and with letters from two therapists. The transsexual person must maintain an ongoing relationship with at least one of the clinicians; in this way the therapist can verify that the desire for gender change is ongoing and not of recent origin.

Most transsexual people can negotiate the hurdles imposed by the Standards of Care. Despite the criticisms of the Standards by some factions of the gender community, and despite their inadequacies, they were a major step forward. Before there was uncertainty; now there is a clearly defined series of steps (or hurdles, if you will). ☞