

# Transsexualism is *not* Gender Dysphoria

## *A appeal to the medical profession*

One of the areas that get most word space in the field of human sexuality is definitions. Definitions are vital, they tie us in knots, and they cause flaming arguments. One woman's 'transgenderism' is another woman's 'Jocks in Frocks', for example. In this article, the discussion is not about that, but about something considerably more basic for those of us with the real McCoy. And when I talk about the real McCoy, we *know* what we're talking about, in a way that others simply can't.

Notwithstanding the tornado that wreaks havoc in our personal lives, and for which no definitions are adequate, definitions *do* matter, because they affect our relations with all those people vital in our rehabilitation. These people are not just members of society in general, but the individuals most directly involved. I'm speaking here of doctors and nurses, lawyers and judges, and at the end of the day, civil servants and politicians. We must interact with these people to get better, in many cases we need their active and willing assistance, and how well or badly those interactions go depend on their perceptions of us. There are two basic views:

- A. Are we people with a serious medical condition for whom there is a there is a solid therapeutic regimen, who should be treated with courtesy and compassion, and assisted through the medical, bureaucratic and legal mazes?
- B. Or are we deluded fools at best, sexual perverts at worst, from whom decent folk should turn away, and who should have psychiatric treatment for our mental pathology?

Sure, [the best of modern medical thinking](#) is really very enlightened, most countries have [laws of varying quality](#) to provide for life after transition, and attitudes in general have improved markedly in recent years. However, there are still some basic issues which stem from definitions: the right to seek state-funded treatment (where such exists) is one; the right to correct one's official legal existence is another; but perhaps the most fundamental – in terms of perceptions – is the right to be perceived as a 'woman with a physical problem' . . . and not a 'man with a mental one'. (I'll only speak of T>F people, because that's my experience, but vice versa for blokes, of course.)

I feel that society in general has grasped this, however dimly. I look at the Daily Mail in England, for example, and there is a (now) rare article on a transsexual woman. It's the case of an officer in the Parachute Regiment transitioning. It was reported that 'The first transsexual officer . . . spoke last night of "surprise and relief" at receiving overwhelming support from former colleagues.' And she said: "Most of my former colleagues have said that I did what was asked of me for my country and that now I should do what I need to do for myself. Not a day goes by that I'm not in tears reading these emails." In an earlier report, there were 16 reader comments. One was frivolous, the other 15 were supportive and favourable. None were negative.

If society in general has grasped this fundamental, and truly clued-in medical people like Russell Reid, Tim Terry, Peggy Cohen-Kettenis, Dick Swaab, Milton Diamond, and other highly distinguished individuals can write "The scientific evidence supports the paradigm that transsexualism is strongly associated with the neurodevelopment of the brain", then it's equally clear that this

fundamental has not become pervasive within the medical profession. The phenomenon of transsexualism in the Western world is seen by most to be primarily a medical issue, no matter where one stands on the neurodevelopmental biology/mental pathology divide. Laws and lawmaking proceed from medical advice, and social sanction or otherwise will flow from that framework and infrastructure.

True, there is also the mass media, and their attitudes. There is also personal experience. To try to separate the various influences that make up the social and cultural milieu in which we live is pointless, but the essential remains: for the body of the medical profession, what they learn in school depends on their diagnostic bibles, and those in turn are a catechism of definitions.

*So definitions really do matter.* Whether we perceived to be ‘normal’ type A people with an unusual medical condition, or ‘sick, twisted’ type Bs, really does depend in large part on the initial *medical* definition. In North America, the Diagnostic and Statistical Manual IV is the bible (DSM-IV). For much of the rest of the world, it is the International Classification of Diseases 10 (ICD-10). They are quite similar.

Here’s DSM-IV:

Category: Sexual Disorders Sub-category: Gender Identity Disorders

*Gender Identity Disorder in (Adolescents or) Adults (302.85)* has four criteria:

1. A strong and persistent cross-gender identification
2. Persistent discomfort with their assigned natal sex and its associated gender role
3. Absence of any physical intersex condition
4. Clinically significant distress or impairment of social or occupational functioning.

And here’s ICD-10:

*Transsexualism (F64.0)* has three criteria:

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

Note what they have in common. “Opposite sex” and “cross-gender”. “Persistent discomfort” and “present persistently”. “Strong identification” and “live . . . as opposite”. In many ways, these are just different forms of the same thing. Importantly, both DSM and ICD have but a *single* diagnostic code for the condition. More on this point later. One major difference is the DSM references “clinically significant distress” and the ICD does not. I prefer DSM, on balance.

Further, in the DSM, “each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.” (APA, 1994)

Enough background. We have many of the top medical authorities in the world stating [their view](#) that “transsexualism is strongly associated with the neurodevelopment of the brain.”. They go on to

state: “The condition has not been found to be overcome by contrary socialisation, nor by psychological or psychiatric treatments”. Such a viewpoint, along with that of enlightened lawmakers who take the stand that it does not matter how people got this way, they have a basic human right to decent treatment, means that a stake ought to be effectively driven through the heart of the type B perception.

But how can it, when Transsexualism (ICD) or Gender Identity Disorder (DSM) remains a *mental disorder*? Indeed, I have argued elsewhere (see Status in the UK) that it is *indeed* a mental disorder, and ought to be treated as such! I have also argued that the cure is “social, endocrinological, and surgical”.

Here is the crux of my argument: there needs to be **two** diagnoses here, not one. It also covers the entire age spectrum, including both children (sometimes called early-onset transsexualism) and adults (sometimes called late-onset transsexualism).

- I accept as proven that the vast majority of people have an innate gender identity as either man or woman (although I *can* accept as a hypothesis that a tiny, *miniscule* percentage may never settle for one or other).
- I also accept as a working hypothesis that transsexualism is an embryonic neurodevelopmental intersex condition. This is our very best data.

Thus, Transsexualism is a congenital condition, present at birth. And Gender Dysphoria – the mental disorder – never appears in those children whose gender identity (and social milieu) is such that they express their innate gender identity early on. Whilst most, perhaps ten, a hundred times as many, proceed to adulthood suppressing and *lying* about it. (Oh gosh, yes! We lie. We lie to our chums, we lie to our nearest and dearest, and most of all we lie to ourselves. See Eggshell Theory). And then it all gets too much, and we cannot cope. And then Gender Dysphoria, just like described in DSM. Typically around 40 years old  $\pm 5$ , but the variation in age is wide.

So: there needs to be **two** definitions, and **two** diagnoses:

**Transsexualism.** The person was born with a sex-reversed incongruence between brain and body. This is a congenital condition that will require life-long exogenous sex steroid administration following genital reconstruction surgery (GRS), together with annual blood work-ups to ensure (at least) proper liver and thyroid function, after therapeutic gender role transition.

**Gender Dysphoria.** The adult person is suffering from the realisation that she was born with Transsexualism, *and that realisation has caused the Gender Dysphoria*. (It’s not the symptoms, honest; when it got really bad we *knew* what was wrong with us, we just did not want to admit it to anyone.) It is manifested in depression, excessive alcohol consumption, inability to function at work, and so on. This is a curable mental disorder. It will require therapeutic gender role transition, perhaps involving psychotherapy for some, exogenous sex steroid administration for all, re-socialisation into the appropriate gender role, and it will involve GRS. It may also involve facial feminization surgery (FFS). Other therapies will likely include electrolysis of facial hair and voice therapy. The cost and time involved in this therapeutic regime is a small fraction of the costs involved in leaving this illness untreated.

By definition, if a person is formally diagnosed with Gender Dysphoria, then they are also diagnosed with Transsexualism. However, unlike the DSM and ICD classifications, my definition of Gender Dysphoria has *an exit clause*. It would be normal for a person to be fully cured of Gender Dysphoria months or perhaps at most a couple of years after completing the therapeutic transition regime. Most of the symptoms are alleviated simply by initiation of the therapeutic transition regime. There may well be long term issues that need dealing with, of course, but that's part of anyone's life after surviving such a serious illness. Most importantly, the mental health issue has gone away. The person born transsexual need not carry the 'mental disorder' tag (which many folk translate as 'mentally ill') around for the rest of their lives. Why should they? They're cured.

For the medical profession, this re-definition offers tremendous opportunity. Within this new paradigm of transsexualism, there is the genuine possibility of doing good, of giving help and succour, and of curing seriously ill people. And after all, is not that your calling?

One thought I'd leave you with is that *there is no such thing as Gender Identity Disorder*. The problem is that the sufferer knows all too well what her core, her innate Gender Identity is. It just does not match her physical and social reality. Dysphoria is the result, not an Identity Disorder.

In passing, I'd just mention that I *do* know that Transsexualism is the only condition that is – in reality – self-diagnosed. Nevertheless, there is a need for a formal imprimatur from a state-recognized doctor. For many people, this is a requirement before accessing medical services. And for some, it is an important sober second thought against foolish impetuosity. I'm not uncomfortable that such a thing exists.

Concluding, my thought is this: with this two-definition scheme, the emphasis changes from illness to cure. The notion of 'it's all in the head' becomes 'well, when you know who you are, you do what you got to do'. And that's a better world for all of us.

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