Transgender and Transsexuality

From "Encyclopedia of Sex and Gender: Men and Women in the World's Cultures"

BRIEF INTELLECTUAL HISTORY OF TRANSGENDER
Ancient Greece and Rome

Plato, in his **Symposium**, allows Aristophanes the opportunity to speak on the concept of the power of love. In that speech, Aristophanes says:

> …For one thing, the race was divided into three; that is to say, besides the two sexes, male and female, which we have at present, there was a third which partook of the nature of both, and for which we still have a name, though the creature itself is forgotten. For though "hermaphrodite" [now called "intersexed"] is only used nowadays as a term of contempt, there really was a man-woman in those days, a being which was half male and half female…The three sexes, I may say, arose as follows. The males were descended from the Sun, the females from the Earth, and the hermaphrodites from the Moon, which partakes of either sex… (Harvey, 1997, p. 32)

The Greeks, forerunners of modern medicine, believed in the concept of more than one sex. It was well within their mythological construct and cultural norms. However, somewhere in between then and now, this concept of a "third sex/third gender" (Herdt, 1996) has been lost. It is not hard to conjecture how this loss came to be. The imposition of Judeo-Christian monotheism replaced the pantheistic view and brought the associated gender/sex continuum of the Greco-Roman era into the digital age (on or off, male or female). Perhaps the more amazing aspect of this disappearance of a conceptual construct is the fact that we now know that there is a population of individuals, currently living in Western cultural environments as well as other locations, whose birth sex should be defined as a third choice "intersexed"—even within the realm of the Western dual-sex perspective.

Defining the Body

The body exists as a shell (we see the body). It exists as a container (the person's body). Meaning and metaphorical reality are inferred from and transmitted through this shell. The body can act and be acted upon. The body can be active (initiating action) or reactive (responding to action). The body both displays and participates in the creation of the self (self-identity). It contains the brain, supposed seat of the mind, and yet the mind and spirit are also viewed as both part of and yet not part of the body. To a certain degree, the body is plastic in its ability to alter its physical construct to meet assorted needs, both internal as well as external. These alterations can lead to alterations that become learned behaviors, increased or decreased capabilities, and eventually even embodied actions that transcend the conscious attempt to understand them. The body can be viewed as separate from the mind or unified with it in a holistic fusion. The body has location in space and time. Fausto-Sterling (2000) addresses the complexity of the issues associated with the interplay of the body and sex.

The advent of political correctness added to the problems of dealing with this terminology by creating increased confusion over sex and gender and by creating an atmosphere of increased confusion wherein the two words became interchangeable. Further, the conservative religious backlash could not deal with

sexuality or sex in any form. Therefore, all reference to “sex” was squashed. The politically correct world provided the perfect atmosphere for the conservatives to squelch the use of “sex” in any document and to replace it with “gender.” For the fun of it, the first thing that I did, while writing this introductory section, was to ask MS Word to look up the word “sex” in its built-in dictionary. As it is programmed to do, MS Word automatically gives synonyms and it provided the word “gender” as a synonym for “sex.” One of the most widely used word-processing programs identifies sex and gender as interchangeable. Even the online Merriam-Webster's Collegiate Dictionary, which yields three entries for gender, lists entry 2 as “sex.” Pryzgoda and Chrisler (2000) ask the question: “Do people actually know what the word gender means?” In their paper, they report that for a sample of **n**=137 study participants a “variety of understandings and beliefs about gender that range from the common response that ‘gender’ is the same as ‘sex’ to less common responses that associate gender with females or discrimination” occurred.

Defining Sex

We live in a Western culture. That culture is dualistic, when it comes to looking at the subject of sex. When we ask a person “What sex are you?”, the implied/understood question is “what birth sex are you, what is the genitalia between your legs?” As a consequence of our evolution as a Western Judeo-Christian cultural environment, we are immersed in the cultural norm of the “Adam and Eve” mythology and hence, of there being only two birth-sex possibilities. This perspective is known as the **biblical norm of sex**. When we say “birth sex,” we are making the hidden assumption that we are saying the “sex defined by the genitalia seen, by a person authorized to interpret the genitalia as displayed at birth.” It is clear that this definition is made within the cultural context of the baby's birth. In Western culture, which has the biblical norm of sex already deeply and incontestably embedded within it (embodied norm; Cassell, 1998), the only way to interpret the genitalia is within this biblical norm and hence as either anatomically male or female.

As has already been illustrated, even the ancient Greeks recognized that there was a “third sex.” They called it **hermaphrodite**, which is now considered a pejorative term for an individual who displays both sexual organs at birth (actually, the anatomical presentation can be quite varied and does not necessarily require both complete organs to be displayed). The preferred current terminology is “intersexed.” The prevalence of intersexuality is estimated at 1 in 2,000 births. Additionally, it is estimated that there are nearly 65,000 intersex births worldwide per year.

Because Western medical culture specifically, and Western culture in general, is steeped in the biblical norm of sex, the concept of multiple genitalia or atypical genital anatomy has been deeply and profoundly problematic for the medical establishment. Up until very recently, intersexed children were “sexed” as soon after birth as was medically reasonable, a practice that continues to be sanctioned by the American Pediatric Association, despite voluminous protestation on the part of the Intersex Society of North America (ISNA) (**http://www.isna.org**) and other agencies.

The tie between sex, gender, genitalia (the body), and stigmatization/destigmatization via labels is also important here. For example, intersexed children have been sexed without parental permission or even with the parents' knowledge of the fact that their child is intersexed. It is almost as if it is “unspeakable.” Additionally, the forced sexing transfers the burden from the parents of the child to the child. Therefore politically correct language or medicalization terminology, such as nondominant genitalia or micro-phallus, is used to remove the stigma of the intersexuality. On the other hand, transsexuality and transgenderism are immediately stigmatized. Words like neo-clitoris, neo-phallus, pseudo-testicles, and neo-vagina disenfranchise the transsexual from the contragender status they so strongly desire to attain. This disenfranchisement and stigmatization are best illustrated by terminology used by the radical lesbian feminist movement. While they are willing to stretch their metaphor of reality to allow a male-to-female transsexual to be classified as a “woman,” they do not consider her a real woman. Rather, she is labeled as not “woman born woman.”

Current estimates are that sexing operations are performed five times per day across the United States alone. The term “sexed” is a verb that is used to mean that these children were subjected to genital surgery to remove the “non-dominant” genitalia. Hence a baby with a “micro-phallus” and a predominant “vaginal canal” would be sexed as a woman, and the micro-phallus removed surgically or surgically “sized” (thereby

risking permanent sexual response reduction). This “sexing” operation has led to many problems for these intersexed children; the most famous of them is the very recent case of John/Jane (Goodnow, 2000).

Defining Gender

Gender is, perhaps, a far more elusive concept. If we look up the definition of “gender,” we find that it states “an individual's self-conception as being male or female, as distinguished from actual biological sex. For most persons, gender identity and biological characteristics are the same. There are, however, circumstances in which an individual experiences little or no connection between sex and gender…” (Encyclopedia Britannica Online, 2001). This last point, concerning the connection between sex and gender, or the lack thereof, will be crucial when we address issues of sexuality. Other definitions of gender (e.g., Oxford English Dictionary Online, 2001) provide constructions that are more complex. Perhaps the most common understanding of gender may be found in Perry (1999, p. 8) who states that “gender is defined here as the cultural construction of femininity and masculinity as opposed to the biological sex (male or female) which we are born with.” Observe that both of these definitions are based upon the biblical norm of sex and hence of the associated construct that Witten (2004, in press) calls “the biblical norm of gender.” Contrast these definitions with the 1984 definition (Webster, 1984), which states that gender is “any of two or **more** [italics added] categories, as masculine, feminine, and neuter, into which words are divided and that determine agreement with or selection of modifiers or grammatical forms.” This viewpoint is further supported in the following statement from the Oxford English Dictionary Online (2001):

> b. By some recent philologists applied, in extended sense, to the “kinds” into which sbs. are discriminated by the syntactical laws of certain languages the grammar of which takes no account of sex. Thus the North American Indian languages are said to have two “genders,” animate and inanimate. With still greater departure from the original sense, the name “genders” has been applied to the many syntactically discriminated classes of sbs. in certain South African langs.

Hence, gender does not necessarily have anything to do with the discriminated classes of male and female. Rather, it can be used as a descriptor for any syntactically discriminated set of classes within a language.

Defining Sexuality

The Western biomedical model of sex and gender, coupled with the Judeo-Christian model of reproduction and sexuality, provides for only one socially acceptable model of sexuality, namely heterosexuality. The concept of heterosexuality is based upon a sexing of the body that forces the body to be seen as either male or female (based upon the observed genitalia) and either masculine or feminine (based upon the individual's self-perception), and is coupled with the expected reproductive role required of those two states of being. The tacit assumption is that a male (genetically XY), with masculine self-perception and social role acceptance—in the best of all reproductive worlds—when having sexual intercourse with a female (genetically XX), with feminine self-perception and social role acceptance, will produce a child having either of these two states. Such a construction is consistent with Cassells (1998) “right mind/right body” concept. With this construct as the socially accepted norm of reality, it is clear that any deviance would be dealt with as just that—a deviance—and handled within the resources of the social systems mechanism for dealing with deviance. In the case of intersexuality (right mind/wrong body [confused body]), the system medicalizes the problem and deals with it as a body issue. In the case of transsexuality (confused mind [wrong mind]/right body), the system medicalizes the problem and deals with it as a “mind” issue, as we have already discussed in a previous section.

As Western biomedical medicine holds to a bodyoriented philosophy, it is easy to see how “intersex,” which is body oriented, easily visually identified with the senses (body-oriented detectability), and remediable with “surgery” (body-oriented intervention consistent with the biomedical way of thinking) is far more acceptable than “transgender,” which is in the mind (mind oriented), not readily verifiable via any sort of Western biomedical rational means, and remediable with a set of counterintuitive surgical interventions that violate the visceral sanctity of the body public and private. Intersexuality is concretized within the “medicalization of illness,” as is understood through the western cultural norm of somaticizing medicine. It is not listed in the

Diagnostic and Statistical Manual of Mental Disorders (4th ed., text revision) (American Psychiatric Association, 2000). In fact, the intersex condition is an explicitly stated contraindication for diagnosis of gender identity disorder. On the other hand, transgenderism is too elusive; it is culture bound, a deviation at a visceral level of gender role "embodiment" (Cassell, 1998), inaccessible, and confounding.

DEFINING TRANSGENDER AND THE DEMOGRAPHY OF TRANSGENDER

Defining Transgender/Transsexual

The terminology describing the "gender" community is extremely dynamic, not just in the descriptors of gender, but also in the body/sex/sexuality and medical status terminology associated with a given gender identity. This, along with certain components of the population being unwilling to allow themselves to be labeled or categorized by labels fixed by someone else, makes it extremely difficult to obtain an accurate census or description of this population. For example, an individual who is born genetically female (XX), but states that she is actually male, might describe himself as an FTM (femaleto-male) transsexual, while another woman might claim the label transman. Others might choose to define themselves in terms of hormone usage (lo-ho, hi-ho) transman and still others might use their "operative status" as a description (pre-op transsexual, post-op transman). Yet others might claim that they were MBT (men born trans). Thus, categorizing the membership of the transgender community is exceedingly difficult.

Although they are frequently invisible and highly stigmatized within our society (i.e., marginal legal protection, noninclusion in hate crimes legislation and Equal Employment Opportunity Commission/Affirmative Action, and inclusion in **DSM IV-TR** (Currah & Minter, 2000; Witten & Eyler, 1999a) transgender individuals form more than a negligible percentage of the U.S. population. Understanding that there are labeling and power concerns of importance that surround any issue of subdividing a population,Witten and Eyler (1999a) address the definition of transgender stating that:

> The gender community includes **cross-dressers** (men and women who take on the appearance of the other gender, often on a social or part-time basis), **transgenders** (people whose psychological selfidentification is as the other sex and who alter behavior and appearance to conform with this internal perception, sometimes with the assistance of hormonal preparations), and **transsexuals**, both male-to-female (MTF) and female-to-male (FTM), who undertake hormonal and/or surgical sex reassignment therapies. In addition, it includes others with gender self-perceptions other than the traditional (Western) dichotomous gender world-view (i.e., including only male and female), such as persons with "non-Western" gender identities (Langevin, 1983; Godlewski, 1988; Hoenig & Kenna, 1974; Sigusch, 1991; Tsoi, 1988; van Kesteren et al., 1996; Wålinder, 1971a,b; Weitze & Osburg, 1996).

It is also important to mention that there are overlaps between the transgender and intersex communities with respect to the aforementioned definitions. As was pointed out earlier, because the majority of intersexuals have been and still are forcibly reassigned to the female gender at birth, the majority of intersexuals that seek sex reassignment are FTM. However, this does not mean that there are not some who are MTF as well. Thus the confluence of both gender and sex issues further adds to the problem of counting both the intersex and transgender populations.

Estimating the Prevalence of Transgenderism

With regard to population estimates of transsexuality, Tsoi (1988) has noted that, "A…problem confounding an epidemiological survey is that transsexuals tend to congregate in cities and in certain parts of cities, and most of them do not want to be identified." Much of our own research work has further substantiated this phenomenon. Nonetheless, Tsoi (1988) has also noted that, in Singapore (where sexual reassignment surgery [SRS] is well established and transsexuals are not "suppressed") diagnosed transsexualism is more than eight times more prevalent than in any other country for which estimates exist. Witten (2002a, 2003) has pointed out that estimates of the number of individuals claiming to have "alternative gender identities" in the United States, as well as in other countries, are confounded by the lack of a control group by which to test prevalence and incidence estimates. Even so, in an international random survey performed by Witten and Eyler (1999b), approximately 8% of the 300 respondents identified their gender self-perceptions as

something other than 100% male or 100% female. Taking only the international estimates for postoperative transsexuality as a basis (1-3%) (Godlewski, 1988; Hoenig & Kenna, 1974; Langevin, 1983; Sigusch, 1991; Tsoi, 1988; van Kesteren et al., 1996; Wålinder, 1971a,b; Weitze & Osburg, 1996), and using the approximate estimate of 300 million people for the U.S. population, this would imply that there are potentially 3-9 million potential postoperative transsexuals in the United States. While this estimate seems overly surprising, Witten (2002a, 2003) has discussed the rate of gender reassignment surgeries currently performed in the United States and Europe with some of the more prominent surgeons worldwide. A number of these surgeons indicate that they are performing two surgeries per day, 48 weeks per year, 4-5 days per week. Some state that they have waiting lists of upwards of 2 years. In France, the surgical waiting time is now 5 years. If we allow for the broader interpretation of transgender as including nonsurgical and cross-dressing individuals, the estimates increase to approximately 20 million people, depending upon definitional criteria. Others claim that the estimates for MTF prevalence are 1 in 1,000 to 1 in 30,000, while FTM prevalence estimates are significantly lower at 1 in 100,000. There are simply no statistically significant data from which one can draw strong conclusions. It is also important to recognize that each of these individuals touches numerous others in his or her life—family, friends, employers, employees, acquaintances, and random individuals on the street. Consequently, support services may well be necessary for many other individuals other than just the actual transgendered persons. This insight identifies the impact of the transgendered population and its needs as being significantly larger than the immediate population of the transgendered alone.

For brevity, in the upcoming discussion, the term **transgenders** will be used to signify the entire gender community, unless otherwise specified. It should also be pointed out that many indigenous peoples recognize genders other than male and female. For example, Tewa adults identify as women, men, and **kwido**, although their New Mexico birth records recognize only females and males (Jacobs & Cromwell, 1992). See also Elledge (2002) and his discussion of transgender myths from the Arapaho to the Zuni, as well as the work of Matzner (2001) discussing Hawaii's **mahu** and transgender communities. Persons with such “non-Western” gender identities will also be considered as belonging to the gender community.

Etiology of Transgender

What do we actually know about transgender and transsexuality in terms of its origins and risk factors? The answer is quite simple—not very much. The state of being “transgendered or transsexual” is classified by DSM IV-TR as a psychiatric disorder and given the name gender identity disorder (GID). A detailed discussion of GID can be found below in the section on diagnostic criteria.

Biological

There is no known biological reason for GID. Anecdotal discussion among some evolutionary biologists has looked at the GID issue as an evolutionary experiment in adaptivity of the human being. Some argue that it could be embedded within the “junk” DNA about which we know next to nothing. There is no scientific evidence to show that anything is true.

Social/Environmental

There is no evidence to indicate that there are social causes of GID, although social environment, roles, etc. are clearly implicated in GID. There is a psychosocial argument that GID may be induced by abuse in childhood and that GID is an extreme avoidance/dissociative response to the sexual, physical, and/or emotional abuse subjected upon such individuals (Devor, 1994). There are some studies in this area; none are conclusive one way or another. This particular theory is a chicken or egg first theory, and most data are anecdotal, at best, as accurate on violence against transgendered individuals is not readily available (Witten & Eyler, 1999a).

Medical/Psychological Aspects of Transgender
Medical

There is no known medical reason for GID. Suggested possibilities include possible in utero hormonal effects that create a vulnerability or propensity that is then exacerbated by subsequent environmental factors. Some

argue that there are morphological changes in the corpus callosum, but evidence is ambivalent (some studies say yes, others say no, some find it inconclusive). Some argue that other areas of the brain are altered. In particular, one study by Zhou, Hofman, Gooren, and Swaab (1997) argues that the central subdivision of the bed nucleus of the stria terminalis (BSTc) in transgendered individuals does, in fact, have features of the contragender brain structure. However, these results are based upon post-mortem analyses of a very small sample of transgender brains. Additionally, there are androgenic factors such as partial androgen insensitivity syndrome (PAIS), Turner's syndrome, or congenital adrenal hyperplasia (CAH) that may or may not play into the biomedical mix.

Psychological

Axis II disorders such as schizophrenia can play a part in a person's self-perception and therefore need to be ruled out, along with environmental factors such as drug abuse, depression, etc. Depression does not rule out GID as a diagnosis, but needs to be considered within the GID diagnostic context. Multiple personality disorder issues must be resolved, so that all the different personalities agree on the sex change procedures. Axis III disorders are also critical and need to be rigorously addressed before GID diagnostic assignment. A recent study from Scandinavia (Haraldsen & Dahl, 2000) has demonstrated that transsexual persons selected for sex reassignment show a relatively low level of self-rated psychopathology before and after treatment.

Significant pressure to remove GID from DSM is currently mounting. In order to understand the reasoning behind this pressure, let us examine the current diagnostic criteria for GID.

Diagnostic Criteria (DSM IV-TR)

GID is diagnosed via four criteria that must be met:

1. Evidence of a strong and persistent cross-gender identification (the desire to be or insistence that one is the other sex. The identification must not merely be a desire for perceived cultural advantages of being the other sex).
    1. Repeated stated desire to be, or insistence that he or she, is the other sex.
    2. In boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypic masculine clothing.
    3. Persistent preferences for cross-sex roles in makebelieve play or persistent fantasies of being the other sex.
    4. Intense desire to participate in the stereotypic games and pastimes of the other sex.
    5. Strong preference for playmates of the other sex.
2. There must be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex.
    1. In boys we see assertions that penis or testes are disgusting and will disappear or assertion that it would be better not to have a penis, or aversion towards roughand-tumble play and rejection of male stereotypical toys, games, and activities.
    2. In girls, we see rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.
    3. In adolescents and adults the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (requests for hormones, surgery, or other relief-based procedures), or the belief that he or she was born the wrong sex (born in the wrong body).

3. Intersex conditions and metabolic conditions such as PAIS or CAH rule out GID as a diagnosis.

4. To make the diagnosis there must be evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning.

A detailed discussion of the pros and cons of the **DSM IV-TR** GID diagnosis can be found at the website of the Harry Benjamin International Gender Dysphoria Association (HBIGDA) (**http://www.hbigda.org**), along with the current standards of care document. In the upcoming sections, we present a discussion of transgender and transsexuality in a number of countries as reported by researchers from those countries.

THE CULTURAL DIVERSITY OF THE TRANSGENDER POPULATION

Transsexuality and Transgender in Sweden

In 1972, Sweden was the first country to pass special legislation regulating surgical and legal measures required for sex reassignment, thereby granting the sex-reassigned person the rights and obligations of the new sex (Wålinder & Thuwe, 1976). Ever since then, unmarried Swedish citizens are allowed to obtain publicly financed sex reassignment if they are diagnosed as transsexuals. The patient applies to the National Board of Health and Welfare. An extensive medical certificate, in which documentation for the diagnosis is elaborated, must accompany the application. Because these data are always collected, this procedure implies that all data from all applicants for sex reassignment are on file, which facilitates phenomenological studies. Given that legislation is known to influence moral values in a society (Monteith, 1993), the Swedish law is likely to have boosted the public's positive views on transsexuals, as seen in a recent Swedish poll. Interestingly enough, this survey of attitudes towards transsexuals also demonstrated that those respondents who believed that transsexualism is caused by biological factors had a less restrictive view of transsexualism than those people who viewed transsexuality as a psychological problem (Landén & Innala, 2000).

A review of the annual frequency of applications for sex reassignments in Sweden between 1972 and 1992 showed a stable rate of, on average, 11.6 applications per year with an MTF/FTM sex ratio of 1.4/1.0 (Landén, Wålinder et al., 1996). Since then, however, the annual frequency has almost doubled in Sweden, an escalation attributable to an increase in MTF applicants, and this has changed the sex ratio accordingly. Phenomenological studies of the Swedish cohort have shown that transsexualism manifests itself differently in MTF and FTM (Landén, Wålinder et al., 1998). The MTF group are older than the FTM group when requesting sex reassignment surgery and have less cross-gender behavior as children, more frequent heterosexual experience, more frequent occurrence of fetishism, more frequent history of suicidal attempts, more often a history of marriage and parenting of children, and a lower level of education and socioeconomic status.

Most importantly, an outcome study of the Swedish cohort demonstrated that family opposition against the sex reassignment, belonging to the secondary group of transsexualism, and a history of psychotic disorder predicted regrets of sex reassignment (Landén, Hambert et al., 1998).

Transgender and Transsexuality in the United Kingdom

Transpeople now have a higher profile in the United Kingdom than ever before. There are popular transvestite entertainers (Eddie Izzard), prominent drag entertainers (Lily Savage), celebrated soap opera “transsexuals” (“Hayley” of **Coronation Street**), extensive media coverage of most aspects of trans, and a plethora of informal networks and support groups, formal organizations, and commercial ventures to cater for the needs of transsexuals, cross-dressers and transgendered people.

Sex reassignment surgery was pioneered in the 1940s by U.K. surgeon Sir Harold Gillies who operated on transman Michael Dillon (1944) and transwoman Roberta Cowell (1953). The first U.K. “gender identity clinic” was pioneered by psychiatrist John Randell at the Charing Cross Hospital in London in the 1960s, and has remained the most consistent source of medical intervention in the United Kingdom. Sex reassignment procedures are available through the National Health Service, but long waiting lists increasingly result in the use of private health care.

A number of U.K. transsexuals, namely April Ashley, Jan Morris, and Caroline Cossey, have become prominent internationally. Most notable of those who pioneered self-help groups for transpeople have been Alice (Beaumont Society, 1967 to date), Judy Cousins (Self Help Association for Transsexuals, 1979-1989), and Stephen Whittle (FTM Network, 1991 to date). From these beginnings emerged todayås gender identity clinics and networks of support and activist groups. Currently, the major trans support groups are the Beaumont Society (**http://www.beaumontsociety.org.uk/**), the Gender Trust (**http://www.gendertrust.org.uk/**), the Gendys Network (**http://www.gender.org.uk/gendys/index.htm**), and the FTM Network (**http://www.ftm.org.uk/**). This last organization reflects the greater visibility, more recently, of transmen within the transgender community.

Since 1970, the legal status of transsexuals has been determined by the judgment in the case of **Corbett v. Corbett**, [1970] 2 All ER 33. That judgment decided that transwoman April Ashley was still to be considered a man for the purposes of marriage, although it has been used to decide sex status in many other areas. The situation now looks set to change following two rulings by the European Court of Human Rights (July 2002, **Christine Goodwin v. UK Government**, Application No. 28957/95 [1995] ECHR; **I v. UK Government**, Application No. 25608/94 [1994] ECHR) which have held that the U.K. governmentås failure to alter the birth certificates of transsexual people or to allow them to marry in their new gender is a breach of the European Convention on Human Rights. Press for Change (PFC) (**http://www.pfc.org.uk**) has been the major U.K. pressure group lobbying for transgender rights since 1992, and the past decade has witnessed a gradual improvement towards equal rights and opportunities in areas such as employment, marriage, and parenting.

Most recently, radical transgender activists who have been a small but consistent undercurrent in U.K. transactivism since the 1960s have come to some prominence in the confluence of transgender politics and radical transgender writings in sociology, cultural studies, and queer theory. These developments have been documented by U.K. transgender theorists Ekins and King (1996) and More and Whittle (1999).

Transgenderism and Transsexualism in Portugal

Transgenderism is widely unknown in Portugal. There are no statistics concerning the transgender population, and investigation in this field is limited by the standard difficulties in accessing transgender individuals, as addressed earlier in this article. Transgendered individuals lack legal support and are stigmatized by society in general. There are many commonly accepted myths concerning transgenderism in Portugal. For example, one myth is that all transsexuals are prostitutes or that they have some other nightlife activity such as strip tease or drag show performance. In this way, Portuguese transgendered persons are frequently socially disregarded and made fun of in public, as well as discriminated against. Nevertheless, it should be noted that the traditional Portuguese “tolerance” (not true acceptance) towards what is considered different (homosexuality, ethnic minorities, etc.) is usually inclusive of the members of the Portuguese transgender community.

Some important issues concerning the Portuguese transsexual population were identified in a recent study (Bernardo et al., 1998). These authors conducted a small-sample study involving of 50 transsexual individuals, most of whom were sex workers (86%). The great majority of the sample came from rural parts of the country (72%), and many individuals had moved away from their birthplace because of their sexual orientation (28%). Some started to work as early as age 11. Additionally, the study identified some serious health problems in this sample. For example, 30% of these transsexuals knew they were HIV positive, although only 61% always used a condom. More on the subject of HIV/AIDS in transgender/transsexual populations can be found in Warren (1999) and Bockting, Rosser, and Coleman (1999). A significant percentage (70%) of the sample abused alcohol, tranquilizers, or heroin on a regular basis.

There are no specific laws in Portugal regarding transgenderism or transsexualism. Only a few court decisions serve as references, and they are sometimes contradictory (ILGA-Portugal, 1999). Until 1984 it was not possible to go through a legal gender identity change. That date marks the court decree regarding the case of a transsexual individual whose request for legal gender identity change was granted by the court. However, if this decision marks a completely new attitude of the Portuguese law towards these situations, this same attitude was not the rule for other judgments that followed it. Currently, the legal system

is more liberal towards change of gender identity requests and all of the requests for a legal sex change have been granted. The major problem is that, in general, the legal system in Portugal is very slow and it can take nearly 4 years for a decision to be given on a case. As it is only possible, in Portugal, to begin the legal process after the surgical sex change is completed, it can take over a decade until the whole process, both medical and legal, is completed.

Apart from the legal sex change procedure, any Portuguese citizen can change his or her name through a rather simple procedure. However, this change can only occur if the new name belongs to the same gender category as the previous one or the change is to a genderneutral name. This last option is frequently chosen by many transgender individuals as a means of avoiding the more complex procedure required to have their gender identity legally recognized.

Until 1996 any surgical sex change was expressly forbidden by the Portuguese Medical Order (PMO). After that date, surgical sex change was allowed. However, it is the only medical procedure that requires the prior authorization of the PMO. In order to address this issue, a commission composed exclusively of medical doctors was created. Unfortunately, the commission was considered biased, given the fact that transsexualism is a multidisciplinary issue that requires the technical evaluation of nonmedical specialists, such as psychologists and social workers. Consequently, an ad hoc group of specialists with expertise in the field was formed, including psychologists and other professionals. This ad hoc group has a consultative role in regards to the PMO, in that it first evaluates each request of sex change surgery that is made to the PMO.

In the meantime, no information is available regarding the true number of sex-change operations performed in Portugal. The Santa Maria Hospital, Lisbon, has the greatest experience in these surgeries. The process of having a sex-change operation is long, and carries with it the requirement of stringent psychological and psychiatric evaluation in order to verify whether or not the candidate is eligible for the surgical reassignment process. This evaluation period often takes about 2 years. However, it can take longer. Some transsexuals, confronted with the time they have to face in order to have their gender change completed, opt to medicate themselves with hormones and to go abroad to have the sex-change operation. Before 1996 and even to this day, many Portuguese transsexuals go to Morocco, or more recently to England, to have their operations. Unfortunately, the surgery is not always performed under the best sanitary and medical conditions, leaving the postoperative transsexual with serious health problems.

In conclusion, it can be stated that some important steps have been taken in Portugal toward the recognition of transsexualism as a condition that requires special medical and legal procedures, even if the process is not always simple or quick. Despite this progress, transgender individuals still have to face a social and cultural reality that has difficulty in understanding their condition and thus can be transphobic.

Transgender: The Israeli Experience

The discussion of the Israeli transgender experience is based on a survey of the transgender population members who consulted the Israeli Center for Human Sexuality and Gender Identity between 1997 and 2001.

The survey included 86 participants; 67 of them were genetic males and 19 of them were genetic females (the ratio of male to female is 3.5 : 1). The age range of the participants was 8-71 years with median of 31.4. Most of the participants (65%) were single, 23% were married, and 12% were divorced. The educational background of the participants was relatively high: 52% of them had obtained college degrees (42% had graduate degrees), 24% had high-school diplomas, and only 16% had not obtained a high-school diploma.

Occupationally, most participants were academic professionals (74%) with a high percentage of representation in the hightech industry (24%); 16% held bluecollar jobs, 3% worked in the sex industry, and 5% were unemployed. In terms of ethnic background, 65% of the participants were Ashkenazi Jews, 30% were Sephardic Jews, and 4% were Palestinian Arabs. Most of the participants in the sample (96%) were Jews, with only 4% Muslims and Christians.

Thus one can characterize the population of transgender clients in the Center as highly functional on personal, interpersonal, and occupational levels. Additionally, most of the clients in the Center expressed

interest in exploring gender identity issues before pursuing genital surgery.

In Israel, one can obtain free surgery for sex change through the national health system, following an evaluation and approval by a specialized gender identity committee. Other features, which may be unique to the Israeli society, are army service, the dominant influence of religion, and the strong nationalistic sentiments. These features impact the discourse on sex and gender and tend to be more transsexual confirming and less focused on identity politics. Despite the open and liberal nature of Israel towards the transsexual/transgendered person, there is a rigidity and polarization of femininity and masculinity in Israeli society.

Transgender and Transsexuality in Ukraine

Ukraine is located between Central Europe and Asia. Before integration with Russia in 1654, communication between Ukraine and Europe encountered few obstacles. Additionally, there was a strong influence of the East on Ukrainian culture. Christianity came to Ukraine in 988. Before the arrival of Christianity, Ukrainian religions were based upon polytheism or many gods. Upon reading many of the writings by the old authors, it can be discerned that there were many holidays in which it was commonplace to wear the dress of the opposite gender. Moreover, there were performing artists called **schomorochs** and, based upon the ancient writings, it is possible to find some elements of transvestism appearing in their performances.

Traditionally, the head of the Ukrainian family has always been male. It was the male's duty to hold the power in the family and to provide sufficient means for the family. The women's duties were to take care of the home and the children. The woman's role changed, to some extent, with the appearance of one of the first leaders of the Ukrainian state (then called Kyiv Rush), Queen Olga, who ruled from 945 to 969. With her appearance, the precedent for a woman to have a leading role was established. On the death of her husband, King Oleg, she finally became Queen of Ukraine. Olga was famous as the first woman to become a Christian Queen of Kyiv Rush.

The emergence of Queen Olga encouraged women to become highly educated, engendering a deep respect within the Ukrainian social structure. For example, in the Middle Ages, one Ukrainian woman prisoner became a wife of the Turkish Sultan and played a significant role in governing this Islamic country. Despite the acknowledged abilities of Ukrainian women during these times, it was not until the end of the 19th century that we begin to read about the leading roles of women in state life in Ukraine. Thus, like many of the Central European countries at that time, while women's knowledge and roles were highly respected, the traditional gender roles predominated in Ukrainian society.

During the Soviet period (1917-1991), homosexuality, transvestism, and transsexuality were considered to be psychiatric disorders. Moreover, people who had one of these “diagnoses” were forced to obtain treatment in psychiatric hospitals. Additionally, these disorders were persecuted under an assortment of Soviet laws.

In 1994, a special commission addressing questions of transsexuality was organized within the Ukrainian Ministry of Public Health. This commission decided to legalize transsexuality. As a result of this new legalization, a number of Ukrainians decided to undergo sex reassignment. According to the rules of the commission, patients who wish to change their gender must be observed by a sexologist in an outpatient setting for a period of a year. Additionally, a psychiatrist in a hospital must see them for a period of at least a month. After these specialists diagnose the individual as being transsexual, he or she is allowed to have gender reassignment surgery upon submitting an application for the surgery to the commission. Once the commission has given a positive decision, it is also possible for the gender of the individual to be changed on his or her passport.

Reconstructing Sex: Australian and New Zealand Transgender Reform Jurisprudence

Australian transgender jurisprudence now represents the frontier of transgender law reform, for it is in Australia that the most radical legal reconstruction of sex has recently occurred. In order to understand this claim it is necessary to sketch the background to this reform moment. Transgender jurisprudence is of relatively recent origin. It emerged in the postwar period and coincided with advances in sex reassignment

surgical techniques. This jurisprudence has led to two distinct approaches to the legal determination of sex claims. In the first approach the courts have selected particular biological factors and have insisted that sex is determined at birth (the biological approach), (**Corbett v. Corbett** [1970] 2 All ER 33). This has led to the denial of the sex claims of transgender claimants. Within the second approach the courts have focused instead on present realities and, in particular, on the fact of sex reassignment surgery (the **psychological and anatomical harmony approach**), (**Re Anonymous** 293 NYS 2d 834 (1968); MT v. JT 355 A 2d 204 (1976)). This latter approach has enabled legal recognition of sex claims for a variety of purposes.

While the reform approach appears to be gaining the upper hand at judicial[1] and, especially, legislative levels (the sex claims of postoperative transgender people have been recognized through legislation in New Zealand and in many states or provinces within the United States, Canada, and Australia, and similar legislation has been enacted by nearly all the European Community members and by other nation states), the biological approach continues to find favor.[2] However, these two approaches should not be thought of as mutually exclusive. Rather, they share a number of commonalities. In particular, both approaches have privileged the genital factor in determining sex. Thus within the biological approach three factors are specified, namely, chromosomes, gonads, and genitalia at birth. Where these factors are "incongruent," however, it is the genital factor that proves decisive.[3] In relation to reform jurisprudence, on the other hand, it is the surgical removal and reconstruction of genitalia subsequent to birth that proves crucial. Moreover, it is not merely a concern with bodily esthetics that has led to this focus. Rather, legal analysis has also exhibited concern over postoperative sexual functioning. In the biological approach this has manifested itself in terms of judicial horror at the prospect of "unnatural" sexual intercourse. Within reform jurisprudence it is the capacity for penetrative heterosexual intercourse postoperatively that has been emphasized repeatedly. In New Zealand the judiciary have dispensed with the requirement of postoperative sexual function (**Attorney-General v. Otathuhu Family Court** [1995] 1 NZLR 603). However, New Zealand law still requires genital reassignment surgery (see Sharpe, 2002).

Indeed, prior to a recent decision of the Family Court of Australia, no superior court or legislature anywhere in the world had recognized the sex claims of a transgender person whose genitalia had not been brought into "conformity" with his or her psychological sex. In **Re Kevin and Jennifer v. Attorney General for the Commonwealth of Australia** (**Re Kevin and Jennifer v. Attorney-General for the Commonwealth of Australia** [2001] FamCA 1074) the court held Kevin, a transgender man who had not undertaken phalloplastic surgery (phalloplasty refers to the surgical construction of a penis), to be a man for the purposes of Australian marriage law. The decision is especially significant, dealing as it does with marriage, for it has been in relation to issues of marriage that the greatest resistance to transgender law reform has been apparent across jurisdictions. In effect the decision rearticulates the reform test of **psychological and anatomical harmony**, one that had received prior endorsement by Australian courts (**R v. Harris and McGuiness** [1989] 17 NSWLR 158; **Secretary, Department of Social Security v. HH** [1991] 23 ALD 58; **Secretary, Department of Social Security v. SRA** [1993] 118 ALR 467), so as to uncouple sex claims from the genitocentrism of law. In this respect, and while the court placed emphasis on the fact that Kevin had undergone other irreversible surgical procedures (in addition to receiving hormone treatment Kevin had undergone a breast reduction procedure and a total hysterectomy), this decision represents a major step forward for transgender people. For a critique of the decision, see Sharpe, (2003).

Transsexuality and Transgender in Japan

In 1969, a Japanese gynecologist was tried and found guilty of performing SRS for three MTF transsexuals. Since then, medical treatment, and even discussion of transsexuality, has been practically a taboo in Japan. For this reason some transsexuals have obtained their SRS abroad, while others have received hormonal therapy and/or SRS underground at home.

However, this situation is now changing. In 1998, Dr Harashina performed the first SRS in Japan that was legally admitted. Today, Japan has two gender clinics that perform SRS in Saitama Medical College and Okayama University Hospital. From 1998 to 2002 over 1000 transsexuals and transgenders came to gender clinics and about 20 transsexuals received SRS. However, because it takes long time to follow Japanese guidelines, there are still many transsexuals who receive SRS in other countries. It is estimated that there

are about 500 postoperative transsexuals in Japan.

Change of sex registration of transsexuality is still very difficult. Recently, Saitama Family Court rejected an appeal of change of sex registration from an FTM who had received legally admitted SRS. The main reason for rejection is “biological etiology of transsexuality is not clear.” In his decision, the judge stated: “I hesitate to admit the change of sex registration.”

However, there is now a new movement in the Diet. Some lawmakers have set up a study team to make a new law about changing a transsexualås sex registration. Last year, **Kinpachii Sensei**, a very popular school television drama, spotlighted an FTM student and a famous professional boat-racer came out as an FTM. These nationwide topics teach us that Japanese have a positive attitude toward transsexuals and transgenders. With these developments, the situation for transsexuals and transgenders in Japan continues to improve. For additional discussion on sex reassignment surgery in Japan, see Ako et al. (2001).

Transgender and Transsexualism in Norway

In the western hemisphere there is a need to date all descriptions concerning diversities in genderland. Much change is taking place: new insights, new words, concepts, and contexts are constantly being inspired as others are being expired.

Norway has two organizations for transpeople. The oldest is FPE-NE which was founded in 1968 to meet the needs of “heterosexual transvestites.” Today members of the FPE-NE form a continuum from classical parttime cross-dressing, through self-defined bigendered, to transgendered, to transsexuals. By 2002 FPE-NE had a membership of 142 individuals.

The younger organization is LFTS. It was founded in January 2000 on three main premises. The most urgent of these was the size of offers from the Norwegian State to transsexuals seeking gender-confirming surgery. The second was the willingness of some transsexuals to display themselves as transsexual women and men, thus generating the power to influence on most levels in society, including the arenas of politics and media. The third reason was the need for transsexuals to come into contact with other transsexuals and/or other transpeople, to generate a context where each could find friendships, insights, and addresses of approved therapists in the field. LFTS currently has a membership of 120 individuals. There is the option of a supportive membership with cheaper fees for parents, siblings of transpeople, and any others that might find such a membership meaningful. LFTS does receive economic support from the Norwegian State, but is not yet securely financed.

On the public scene, during the past years several transpeople have been extremely active in trans-advocacy. In part, this activism has been due to the founding of the LFTS. One of these individuals has actually been named the “Norwegian national trans-person,” and her/his/hir (hir is a common genderless contraction of his and her) son has made a documentary entitled **All about my Father** which has won a number of prizes both internationally and nationally. Most notably, it won the Norwegian Amanda Prize for the best film of the year.

Through all this openness combined with persistent work by the LFTS and other transpeople, conditions, especially for transsexuals seeking surgery, have been greatly improved in the one hospital where such surgery is performed. The standards of the HBIGDA are followed at least to an acceptable degree, even though the most officially recognized therapists in the field are not members of the organization. The surgery and consequent convalescence are funded totally by the Norwegian State.

On the legal side, transsexuals in Norway have the right to a new birth certificate and social security number once genital surgery has been completed. Additionally, couples do not have to divorce if one partner undergoes complete hormonal and surgical treatment.

Overall, there is very little discrimination against transgendered persons in Norwegian society. People seem to have a great deal of respect for otherness. Employers are very supportive of transpeople crossing the boundary between the two gender majorities which still exists. Families are seeking advice from well-known therapists, who are themselves expressing gendered otherness, instead of rejecting their children and young

adults. Presently, in some respects, Norway represents a society that lets its members explore the diversities of gender.

Other Countries

Many other countries have transgender/transsexual populations ranging from those that exist in absolute secrecy (Arab Countries, South America, Mexico) to the open and accepting policies of countries such as Canada and Israel. India has a population of transgendered individuals called the **hijra**, while in Malaysia the MTF transsexuals are known as **mak nyah** (Teh, 2001). For a discussion of transgender in Thailand, see Winter and Udomsak (2002). For an excellent introduction to the cross-cultural aspects of transgender and transsexual, see Green (1966).

WHAT WE DO NOT KNOW

Longitudinal/Cohort Studies

Currently, much is unknown about the long-term effects of contragender hormonal treatment. In light of recent studies on increased breast cancer risk in non-transgendered females due to hormone replacement therapy, it is critical that longitudinal studies are undertaken in the transgender community. Questions of increased risk of breast cancer in MTF transsexuals remain open, as do questions of breast cancer in the FTM transsexual community. Questions of the effect of estrogen on bone mass in this population are also important and go unanswered, as do questions of the effect of estrogen on oral health and the potential to affect cardiovascular problems. Only recently have studies begun to address the issues of excessive smoking in this population. Little is known about the effects of replacing estrogen with testosterone in FTM transsexuals with respect to potentiating onset of Alzheimer's disease due to the absence of estrogenic protection. Comorbidity of disease states due to contragender hormone treatment and elevated stress states due to the social stigma associated with being transgendered (Witten, 2002a, 2003; Witten & Eyler, 1999) remain unstudied. To date, only one study has examined the mortality risk of contragender hormones (Asscherman, Gooren, & Eklund, 1989). For a review of issues associated with MTF hormone treatment, see Gooren (1999).

It is also important to address life-course issues. Very little is known about transgender and transsexual issues in individuals under the age of 18. Studies in this domain are complicated by strict human subject requirements that involve consent of the parents as well as the child. Some discussion of child and adolescent gender identity issues can be found in Ceglie, Freedman, McPherson, and Richardson (2002).

Additionally, very little is known about issues of middle to later life in this community. Questions of social support networks and other long-term quality-of-life components of society still remain open for investigation. Little is known about transgender and intersex elder abuse (Cook-Daniels, 1995). The impact of transgendered parents on their children is unstudied. Family dynamics and restructuring due to transgendering in the family are relatively unknown, except anecdotally (Boenke, 1999).

Issues of late life are also unstudied. The gerontological literature is replete with documentation supporting the importance of social network structure (family, spirituality, and friends, to name but a few items [Pinquart & Sorenson, 2000]) on the morbidity and mortality rates of heterosexual elders. There is no reason to believe that these results do not apply to nontraditional gender identities, gender expressions, sexualities, sexes, and body forms. The work of Witten and Eyler (1999a) indicates that nearly 50% of the respondents are living alone (a significant risk factor for the elderly), and only 10% of the respondents indicate that they are either living with or have children (a potentially deleterious factor indicating diminished social support networks [Everard, Lach, Fisher, & Baum, 2000; Rautio, Heikkinen, & Heikkinen, 2001]).

Among the transgendered populations, it is reasonable to assume that while spirituality may or may not be an important component of their lives, there is little formal outlet for religious interaction and support, as transsexuality in particular, and transgenderism in general, are highly stigmatized within the traditional Judeo-Christian-Islamic religions. Lack of access to religious support—emotional, physical, or otherwise—is also a significant risk factor for the elderly. Among transgenders, divorce is very high (estimates are not available; however, TLARS results indicate that 20% of the respondents were separated and another 10%

were divorced). This further exacerbates the diminished social support network structures well known to be critical in the later life.

The impact of transgender on quality of life, caregiving and caregiver burden, longevity, wisdom, healthcare utilization and access (Witten, 2002c), and social isolation remain open for study. Financial issues are equally important (Crystal, Johnson, Harman, Sambamoorthi, & Kumar, 2000). Multiracial and multicultural issues within the transgender and intersex populations, as they relate to life-course issues, also remain relatively unstudied.

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TarynnM.Witten Esben EstherPirelliBenestad IlanaBerger RichardEkins RandiEttner KatsukiHarima DaveKing MikaelLandén NunoNodin VolodymyrP'yatokha AndrewN.Sharpe

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See, for example, **Richards v. United States Tennis Association** 400 NYS 2d 276 (1977); **Vecchione v. Vecchione** No 95D003769 (Orange County, Calif filed 23 April 1996); **Re the Estate of Marshall G Gardiner** Kan App LEXIS 376 (2001); **R v. Harris and McGuiness** [1989] 17 NSWLR 158; **Secretary, Department of Social Security v. HH** [1991] 23 ALD 58; **Secretary, Department of Social Security v. SRA** [1993] 118 ALR 467; **M v. M** [1991] NZFLR 337; **Goodwin v. UK** ECHR [2002] 2 FCR 577.

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See for example, **R v. Tan** [1983] QB 1053; **Re Ladrach** 32 Ohio Misc 2d 6 (1987); **Lim Ying v. Hiok Kian**

Ming Eric (1992) 1 SLR 184; **Littleton v. Prange** 9 S.W. 3d 223 (Tx App 1999); **Bellinger v. Bellinger** (unreported, CA [2001] EWCA Civ 1140, 17/7/01).

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See **Corbett v. Corbett** [1970] 2 All ER 33 at 48 per Ormrod J. See also **W v. W** [2001] 2 WLR 674.