A CONDITION WE SEEM TO FEAR: GENDER DYSPHORIA

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What would it be like to be this person? There is a condition where I truly am at a loss trying to answer that question. The *Diagnostic and Statistical Manual of Mental Disorders (5th ed.)* (DSM-5) (American Psychiatric Association [APA], 2013) calls it Gender Dysphoria (GD) noting that previously it was called Gender Identity Disorder (GID). I find the new term somehow demeaning so I will use GID.

In the 1970s I was working for Columbia Records, now Sony Music, when I first became aware of GID. We had a well-known recording artist named Walter Carlos. He had at least two albums that had sold over a million copies. I was involved in sales and marketing. The entire department was astonished when we were told that Walter Carlos was now Wendy Carlos. There was absolutely no thought what might lead to such a change nor any consideration about the feelings of someone who changed their sex. Frankly we were relieved when Wendy Carlos signed a recording contract with Warner Brothers. The 'image' problem was no longer ours. As I read professional literature about GID my sense is not much has changed. It seems a condition many people would like to quietly ignore.

Today I have personally known two people, one now dead, who had GID. Both surgically changed their sex. I was personally closer to a woman whose natal gender was male. She has died. The other is more an acquaintance. He was born female but is now male. Both chose surgery in adulthood. I knew the man who became a woman. He moved away. When she moved back to the area I was unaware it was the same person. One day when talking she spoke as if I was aware of her previous sex. In the time I knew her she was unhappy. While her physical sex matched her gender identification she did not culturally and socially become 'one of

the girls.' At the same time men were not attracted to her. She knew many people but had few close friends. In addition she had to take a great many medications to hormonally support her sex. As a functioning person in society she seemed as isolated after her surgery as she had been before. She became clinically depressed and was treated with pharmacotherapy. She was diagnosed with cancer and her existing pharmaceutical regimen interfered with treating her medical condition. Ultimately she died of cancer.

On the other hand, my friend who is now a man seems to have adjusted well. I did not know him before his sex change. He did not generally reveal it. A mutual friend first let me know in confidence. He has since become quite open about it and is active in support groups. He seems well adjusted and functional. However I am not personally close enough to really know.

I write about this as the day will probably come when someone with GID may look to me for advice about treatment. The DSM-5 (APA, 2013) has the cold clinical description of the condition. Craighead, Miklowitz, and Craighead (2013) do not discuss it. There is a certain detachment in the academic literature on the topic. It is possible I am not alone in my lack of immediate empathy for those with GID. David Schwartz (2012) wrote a fascinating article that discusses the biases and assumptions clinicians bring into encounters with children exhibiting signs of GID. He deals not so much with what clinicians say as the unexpressed implicit attitudes and biases they have. I am phrasing carefully. Dr. Schwartz questions whether children really are aware of their gender identity. Possibly they are they fantasizing. He also discusses the problems faced by parents and family in this situation. Can a clinician respond to what the child says without attempting to psychologically interpret what the child means? He believes that when a clinician truly incorporates the concept of essential existential gender from the

child's perspective the clinician will radically alter therapeutic approach. He concludes that it is imperative we ignore our personal cultural biases and expectations and specifically that we do not consciously or unconsciously support parental expectations. My sense is the clinician must accept the child's reality without assuming its permanence. Allow the child to live the gender identity they have. If it is a fantasy it will pass as the child becomes more socialized outside the family.

What is an appropriate therapeutic method if the child approaches puberty still exhibiting the symptoms of GID? I think the video from 16:12 The Bigger Picture (2012) provides an answer. The young German woman who was treated with hormones prior to puberty and who underwent surgery when sixteen indicates a course of treatment that appears to be quite successful. A man who at a later age surgically changed sex was unable to adapt. He reassumed the outward identity of a man. My friend who was unhappy with her new sex was similarly unhappy. Obviously a few cases are sufficient to draw conclusions. Given the gravity of the issue and treatment for the condition clinical trials are not likely! However observational studies could and should be done though finding subjects who undergo surgery as adolescents may be hard to find. The video also discusses some professional views. My sense is they reflect the preconceived ideas of the therapists and show the dangers that Schwartz (2012) warns against.

The concept of a surgical change of sex may well be mandated by culture more than by any inherent need. The Frameline (2012) video Two Spirit People is specifically about Native American attitudes concerning people who are physically attracted to the same sex. The historical attitude among many Native Americans tribes was that Two Spirit People were special and to be cherished. The condition was seen as an enhanced spirituality. Is it possible that a culture like this would accept transgender people who were attracted to the same biological sex

while having the internal identity of the other sex? It goes back to a core question: is a transgender person suffering from a psychological disorder or is our culture suffering from unwillingness to acknowledge the infinite variety of human realities? Yet an article criticizing this idea focused on finding the underlying causes of both GID and same-sex preference (Zucker, et. al., 2009). A key admission in this article is we know almost nothing about why these conditions exist. At the same time I would ask does it matter? When dealing with a human being who either has same-sex preference or GID how important is it to know why?

There is little question that social and cultural biases have serious consequences for those with GID. Brown University's summary (2013) showing the increased risk for both bullying and depression among people with GID. The article summarizes research showing that nonconforming behavior is a critical factor. The reasons are irrelevant. A study showed a heightened risk for several forms of rational aggression including bullying as well as a greater risk for suicidality (Goldblum, et. al., 2012). Ålgars, Alanko, Santtila, and Sandnabba (2012) found a relationship between eating disorders and GID. There was little specificity in the eating disorders but as a group the incidence was high. However of those who underwent surgery 25% reported some remission of their eating disorders while 11% found their eating disorders worsened. Simple arithmetic says there was no change for 64%. I think it also should be noted that remission was partial. It should be noted that all participants were adults. Might the results be different if the surgery were performed at an earlier age? There have also been studies showing comorbidity between GID and substance abuse (Talley, et. al., 2011). As it is possible the age of surgery is significant in the prognosis it would seem very advisable to replicate these studies with subjects who have not passed puberty and have GID. It is also imperative to know the age of onset for these comorbid conditions.

Somehow much of this may go back to the fundamental approach embodied by the DSM-5 (APA, 2013) and its predecessors. People go to professionals seeking help with common conditions like depression and substance abuse. The professional matches behaviors and feelings to the lists in the DSM-5 and matches to a disorder. Is this the problem? How often is depression a sign of a deeper problem the client, from shame and fear, is unwilling to divulge. Is the client reluctant because of our cultural biases, the unspoken attitudes David Schwartz (2012) warns us about? I have consciously known two people with Gender Identity Disorder. How many people do I know who have this condition but from fear and shame remain silent? In talking to someone who has the condition I do not know what it would be like to be this person. For me the only way to ever change this is to acknowledge my ignorance and encounter people with the condition and allow them to share their reality so that I may know their pain. While the condition is rare GID is a source of serious emotional pain for those who have it. The reason for the distress seems social and cultural. It is imperative for professionals to transcend our biases. Otherwise we easily collapse into a trap of being a further source of pain to these human beings. Ultimately the most important question remains: Who has the disorder, the person or a culture unwilling to embrace people in all life's wondrous variety?

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