

Testimony of  
Quinnipiac University School of Law Civil Justice Clinic

**In Support of Raised Bill 7006**

Public Health Committee  
March 18, 2015

My name is Jenna Lorusso, and I am a resident of Watertown and a third-year law student in Quinnipiac's Civil Justice Clinic, which provides free legal services to low-income people and advocates for policy reforms that benefit low-income and underrepresented groups. The Clinic supports Raised Bill 7006, *An Act Concerning Birth Certificate Amendments*, which would modernize standards authorizing the amendment of birth certificates to reflect a change in gender.<sup>1</sup>

Connecticut law currently requires a transgender person to submit proof of having undergone surgery in order to correct the gender designation on their birth certificates.<sup>2</sup> This requirement is outdated and not supported by contemporary medical views. As discussed below, Gender Dysphoria, or "GD," is a serious medical condition that can be ameliorated through individualized medical treatment. The medical community agrees that, while some individuals need surgery to alleviate their GD, many others do not.

Raised Bill 7006 would change the standard for correcting the gender designation on a birth certificate from one that requires proof of surgery to one that requires proof of "surgical, hormonal or other treatment clinically appropriate . . . for the purpose of gender transition," as evidenced by a letter from a licensed healthcare provider with knowledge of the facts and circumstances of the individual's health care needs. This bill would align Connecticut law with a contemporary understanding of the medical needs of transgender people, and we therefore urge this Committee to approve it.

**I. Gender Dysphoria is a Serious Medical Condition.**

To understand the diagnosis and treatment of GD, it is first helpful to understand the meaning of "transgender." A transgender person is someone whose gender identity—that is, an

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<sup>1</sup> See CONN. GEN. LAWS §§ 19a-42, 42b.

<sup>2</sup> CONN. AGENCIES REGS. § 19a-41-9(e) ("In order to request a gender change amendment the following documents shall be submitted to the commissioner: (1) Affidavit from a licensed psychiatrist, psychologist or clinical social worker performing a psycho-social evaluation, attesting to the fact that the registrant is socially, psychologically and mentally the designated sex; (2) Affidavit from the surgeon performing the sex change operation, attesting to the fact that the surgery was performed; (3) Court order for legal name change if applicable."); see also CONN. GEN. STAT. ANN. § 19a-42b (stating that for Connecticut residents born out-of-state, "probate courts in this state shall have jurisdiction to issue" a court decree "amend[ing] a birth certificate to reflect a change in gender," provided that such person provide "an affidavit from a physician attesting that the applicant has physically changed gender and an affidavit from a psychologist, psychiatrist or a licensed clinical social worker attesting that the applicant has socially and psychologically changed gender.").

individual's internal sense of being male or female—does not align with his or her assigned sex at birth.<sup>3</sup> Usually, people born with the physical characteristics of males psychologically identify as men, and those with the physical characteristics of females psychologically identify as women. However, for a transgender person, this is not true; the person's body and the person's gender identity do not match.<sup>4</sup> A growing body of medical research suggests that this incongruence is caused by “genetics and/or in utero exposure to the ‘wrong’ hormones during the development of the brain, such that the anatomic physical body and the brain develop in different gender paths.”<sup>5</sup>

For many transgender people, this incongruence between gender identity and assigned sex does not interfere with their lives; they are completely comfortable living just the way they are.<sup>6</sup> For some transgender people, however, the incongruence results in gender dysphoria—i.e., a feeling of stress and discomfort with one's assigned sex.<sup>7</sup> Such gender dysphoria, if clinically significant and persistent, is a serious medical condition.

According to the fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (“DSM-5”), GD is characterized by: (1) a marked incongruence between one's gender identity and one's assigned sex, which is often accompanied by a strong desire to be rid of one's primary and secondary sex characteristics and/or to acquire primary/secondary sex characteristics of the other gender; and (2) intense emotional pain and suffering resulting from this incongruence.<sup>8</sup> Among adolescents and adults, GD often begins in early childhood, around the ages of 2-3 (“Early onset gender dysphoria”), but it may also occur around puberty or even later in life (“Late-onset gender dysphoria”).<sup>9</sup> If left medically untreated, GD can result in debilitating depression, anxiety and, for some people, suicidality and death.<sup>10</sup>

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<sup>3</sup> See, e.g., AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 451 (5th ed. 2013) [hereinafter “DSM-5”]; U.S. OFFICE OF PERSONNEL MANAGEMENT, GUIDANCE REGARDING THE EMPLOYMENT OF TRANSGENDER INDIVIDUALS IN THE FEDERAL WORKPLACE [hereinafter “OPM GUIDANCE”], <http://www.opm.gov/policy-data-oversight/diversity-and-inclusion/reference-materials/gender-identity-guidance/>.

<sup>4</sup> DSM-5, *supra* note 3, at 452-53.

<sup>5</sup> Christine Michelle Duffy, *The Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973, in Gender Identity and Sexual Orientation Discrimination in the Workplace: A Practical Guide* 16-77 (Christine Michelle Duffy ed. Bloomberg BNA 2014) (discussing recent medical studies); see also DSM-5, *supra* note 3, at 457 (discussing genetic and, possibly, hormonal contribution to GD).

<sup>6</sup> See Duffy, *supra* note 5, at 16-10; see also DSM-5, *supra* note 3, at 453 (stating that, in addition to a marked incongruence between gender identity and assigned sex, individuals with gender dysphoria exhibit “distress about this incongruence”).

<sup>7</sup> DSM-5, *supra* note 3, at 451 (“Gender dysphoria as a general descriptive term refers to an individual's affective/cognitive discontent with the assigned gender but is more specifically defined when used as a diagnostic category.”).

<sup>8</sup> See DSM-5, *supra* note 3, at 452 (“The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.”).

<sup>9</sup> DSM-5, *supra* note 3, at 455-56.

<sup>10</sup> *Id.* at 454-55.

## II. Medically-Appropriate Treatment for GD Does Not Always Include Surgery.

Like other medical conditions, GD can be ameliorated through medical treatment, but there is no single course of medical treatment that is appropriate for every person with GD.<sup>11</sup> Instead, the World Professional Association For Transgender Health, Inc. (“WPATH”) (formerly known as “The Harry Benjamin International Gender Dysphoria Association, Inc.”), has established internationally accepted Standards of Care (“SOC”) for the treatment of people with GD.<sup>12</sup> The SOC, which are “based on the best available science and expert professional consensus,” were originally approved in 1979 and have undergone seven revisions through 2012.<sup>13</sup> As part of the SOC, many transgender individuals with GD undergo a medically-recommended and supervised gender transition in order to live life consistent with their gender identity.<sup>14</sup>

The current SOC—an excerpt of which is attached to this testimony—recommend an *individualized* approach to gender transition, consisting of a medically-appropriate combination of hormone therapy, “living part time or full time in another gender role, consistent with one’s gender identity,” gender reassignment surgery, and/or psychotherapy.<sup>15</sup> Living consistent with one’s desired gender role consists of “present[ing] consistently, on a day-to-day basis and across all settings of life, in [one’s] desired gender role,” which is “based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery.”<sup>16</sup> To complete their medical transition, some transgender individuals may only need to live part time or full time in their desired gender role without undergoing hormone therapy or surgery.<sup>17</sup> Others may decide with their health care provider that it is medically necessary for them to undergo hormone therapy and/or gender reassignment surgery as well.<sup>18</sup> The correct course of treatment for any given individual—in order for the patient to achieve genuine and lasting comfort with his or her sex—can only be determined by the treating physician and the patient.<sup>19</sup> According to the SOC:

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<sup>11</sup> See WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH, STANDARDS OF CARE 5 (7th ed., 2012) [hereinafter “SOC”], available at [http://admin.associationsonline.com/uploaded\\_files/140/files/Standards%20of%20Care,%20V7%20Full%20Book.pdf](http://admin.associationsonline.com/uploaded_files/140/files/Standards%20of%20Care,%20V7%20Full%20Book.pdf) (“Gender dysphoria can in large part be alleviated through treatment.”); see also DSM-5, *supra* note 3, at 451 (stating that “many [individuals] are distressed if the desired physical interventions by means of hormone and/or surgery are not available”) (emphasis added).

<sup>12</sup> See SOC, *supra* note 11, at 1.

<sup>13</sup> *Id.* at 1.

<sup>14</sup> See *id.* at 9-10; see also OPM GUIDANCE, *supra* note 3 (discussing gender transition).

<sup>15</sup> SOC, *supra* note 11, at 9.

<sup>16</sup> *Id.* at 60-61.

<sup>17</sup> *Id.* at 8 (“[W]hile many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither.”); see also DSM-5, *supra* note 3, at 454 (discussing those who resolve incongruence between gender identity and assigned sex “without seeking medical treatment to alter body characteristics”).

<sup>18</sup> SOC, *supra* note 11, at 10; see also DSM-5, *supra* note 3, at 453 (recognizing “cross-sex medical procedure[s] or treatment regimen[s]—namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender . . .”).

<sup>19</sup> SOC, *supra* note 11, at 5 (“Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person.”).

[W]hile many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither. . . . Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate gender dysphoria. Some patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery, but not hormones. In other words, treatment for gender dysphoria has become more individualized.<sup>20</sup>

### **III. Having a Birth Certificate that Does Not Reflect the Correct Gender Designation Harms Transgender People.**

For many transgender individuals, having a birth certificate that does not reflect the correct gender designation can be mentally harmful and emotionally traumatic. Accordingly, the ability to change one's gender designation so that it is consistent with one's gender identity is an important and indispensable step in many transgender individuals' medically prescribed and necessary gender transition process. Indeed, the SOC explicitly state that "care for gender dysphoria" may include "[c]hanges in name and gender marker on identity documents."<sup>21</sup>

In addition to improving transgender individuals' emotional well-being, having the correct gender designation on a birth certificate also helps transgender individuals avoid the pervasive discrimination that faces the transgender community. As the District of Columbia Court of Appeals recently observed, "the hostility and discrimination that transgender individuals face in our society today is well-documented."<sup>22</sup> Transgender people are disproportionately at risk for discrimination in almost all aspects of life, including employment, housing, education, public accommodations, and access to government services.<sup>23</sup> Rather than having to give up those normal life activities that call for the production of a birth certificate, transgender individuals whose birth certificates reflect their gender identity are free to live their lives, support their families and contribute to society through work, volunteering and civic engagement without fear of discrimination.

In recognition of the harms avoided and benefits conferred by modernizing the standards authorizing the amendment of birth certificates, jurisdictions such as California, New York, Oregon, Rhode Island, Vermont, Washington, and the District of Columbia have amended their laws as Raised Bill 7006 would do. Raised Bill 7006 would therefore not be blazing new trails; it would be traveling a well-worn road.

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<sup>20</sup> *Id.* at 8-9.

<sup>21</sup> *Id.* at 10.

<sup>22</sup> *Brocksmith v. United States*, 99 A.3d 690, 698 n.8 (D.C. 2014).

<sup>23</sup> *See, e.g.*, JAIME M. GRANT, ET AL., INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY, NAT'L CTR. FOR TRANSGENDER EQUALITY AND NAT'L GAY AND LESBIAN TASKFORCE 2-8 (2011).

#### **IV. Conclusion**

In conclusion, Connecticut law's requirement that transgender people submit proof of having undergone surgery in order to correct the gender designation on their birth certificates is outdated, unsupported by contemporary medical views, and harmful to transgender people. Raised Bill 7006 would bring Connecticut law into compliance with a contemporary understanding of the medical needs of transgender people, and we therefore urge this Committee to approve it.

Thank you very much for the opportunity to present this testimony.

Quinnipiac University School of Law Civil Justice Clinic

By: Jenna Lorusso, Law Student Intern  
Kevin Barry, Supervising Attorney

Quinnipiac Univ. School of Law Civil Justice Clinic  
275 Mount Carmel Ave.  
Hamden, Connecticut 06518  
legalclinic@quinnipiac.edu

**Attachment**

Excerpt of World Professional Association for Transgender Health  
Standards of Care (7th ed., 2012)

## Purpose and Use of the *Standards of Care*

The World Professional Association for Transgender Health (WPATH)<sup>I</sup> is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transsexual and transgender health. The vision of WPATH is a world wherein transsexual, transgender, and gender-nonconforming people benefit from access to evidence-based health care, social services, justice, and equality.

One of the main functions of WPATH is to promote the highest standards of health care for individuals through the articulation of *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People*. The SOC are based on the best available science and expert professional consensus.<sup>II</sup> Most of the research and experience in this field comes from a North American and Western European perspective; thus, adaptations of the SOC to other parts of the world are necessary. Suggestions for ways of thinking about cultural relativity and cultural competence are included in this version of the SOC.

The overall goal of the SOC is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender-nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments. While this is primarily a document for health professionals, the SOC may also be used by individuals, their families, and social institutions to understand how they can assist with promoting optimal health for members of this diverse population.

WPATH recognizes that health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that promote tolerance and equity

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I Formerly the Harry Benjamin International Gender Dysphoria Association

II The *Standards of Care (SOC), Version 7*, represents a significant departure from previous versions. Changes in this version are based upon significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise for transsexual, transgender, and gender-nonconforming people beyond hormone therapy and surgery (Coleman, 2009a, b, c, d).

for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these changes in public policies and legal reforms.

## The *Standards of Care* Are Flexible Clinical Guidelines

The *SOC* are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender-nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria—broadly defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

As in all previous versions of the *SOC*, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm-reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care—and the *SOC*—to evolve.

The *SOC* articulate standards of care but also acknowledge the role of making informed choices and the value of harm-reduction approaches. In addition, this version of the *SOC* recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments. Some patients who present for care will have made significant self-directed progress towards gender role changes, transition, or other resolutions regarding their gender identity or gender dysphoria. Other patients will require more intensive services. Health professionals can use the *SOC* to help patients consider the full range of health services open to them, in accordance with their clinical needs and goals for gender expression.

## Global Applicability of the *Standards of Care*

While the *SOC* are intended for worldwide use, WPATH acknowledges that much of the recorded clinical experience and knowledge in this area of health care is derived from North American and Western European sources. From place to place, both across and within nations, there are differences in all of the following: social attitudes towards transsexual, transgender, and gender-nonconforming people; constructions of gender roles and identities; language used to describe different gender identities; epidemiology of gender dysphoria; access to and cost of treatment; therapies offered; number and type of professionals who provide care; and legal and policy issues related to this area of health care (Winter, 2009).

It is impossible for the *SOC* to reflect all of these differences. In applying these standards to other cultural contexts, health professionals must be sensitive to these differences and adapt the *SOC* according to local realities. For example, in a number of cultures, gender-nonconforming people are found in such numbers and living in such ways as to make them highly socially visible (Peletz, 2006). In settings such as these, it is common for people to initiate a change in their gender expression and physical characteristics while in their teens or even earlier. Many grow up and live in a social, cultural, and even linguistic context quite unlike that of Western cultures. Yet almost all experience prejudice (Peletz, 2006; Winter, 2009). In many cultures, social stigma towards gender nonconformity is widespread and gender roles are highly prescriptive (Winter et al., 2009). Gender-nonconforming people in these settings are forced to be hidden and, therefore, may lack opportunities for adequate health care (Winter, 2009).

The *SOC* are not intended to limit efforts to provide the best available care to all individuals. Health professionals throughout the world—even in areas with limited resources and training opportunities—can apply the many core principles that undergird the *SOC*. These principles include the following: Exhibit respect for patients with nonconforming gender identities (do not pathologize differences in gender identity or expression); provide care (or refer to knowledgeable colleagues) that affirms patients' gender identities and reduces the distress of gender dysphoria, when present; become knowledgeable about the health care needs of transsexual, transgender, and gender-nonconforming people, including the benefits and risks of treatment options for gender dysphoria; match the treatment approach to the specific needs of patients, particularly their goals for gender expression and need for relief from gender dysphoria; facilitate access to appropriate care; seek patients' informed consent before providing treatment; offer continuity of care; and be prepared to support and advocate for patients within their families and communities (schools, workplaces, and other settings).

Terminology is culture- and time-dependent and is rapidly evolving. It is important to use respectful language in different places and times, and among different people. As the SOC are translated into other languages, great care must be taken to ensure that the meanings of terms are accurately translated. Terminology in English may not be easily translated into other languages, and vice versa. Some languages do not have equivalent words to describe the various terms within this document; hence, translators should be cognizant of the underlying goals of treatment and articulate culturally applicable guidance for reaching those goals.



## **The Difference Between Gender Nonconformity and Gender Dysphoria**

### **Being Transsexual, Transgender, or Gender-Nonconforming Is a Matter of Diversity, Not Pathology**

WPATH released a statement in May 2010 urging the de-psychopathologization of gender nonconformity worldwide (WPATH Board of Directors, 2010). This statement noted that “the expression of gender characteristics, including identities, that are not stereotypically associated with one’s assigned sex at birth is a common and culturally diverse human phenomenon [that] should not be judged as inherently pathological or negative.”

Unfortunately, there is stigma attached to gender nonconformity in many societies around the world. Such stigma can lead to prejudice and discrimination, resulting in “minority stress” (I. H. Meyer, 2003). Minority stress is unique (additive to general stressors experienced by all people), socially based, and chronic, and may make transsexual, transgender, and gender-nonconforming individuals more vulnerable to developing mental health concerns such as anxiety and depression (Institute of Medicine, 2011). In addition to prejudice and discrimination in society at large, stigma can contribute to abuse and neglect in one’s relationships with peers and family members, which in turn can lead to psychological distress. However, these symptoms are socially induced and are not inherent to being transsexual, transgender, or gender-nonconforming.

## Gender Nonconformity Is Not the Same as Gender Dysphoria

*Gender nonconformity* refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Institute of Medicine, 2011). *Gender dysphoria* refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b). Only *some* gender-nonconforming people experience gender dysphoria at *some* point in their lives.

Treatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them (Bockting & Goldberg, 2006). Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person. This process may or may not involve a change in gender expression or body modifications. Medical treatment options include, for example, feminization or masculinization of the body through hormone therapy and/or surgery, which are effective in alleviating gender dysphoria and are medically necessary for many people. Gender identities and expressions are diverse, and hormones and surgery are just two of many options available to assist people with achieving comfort with self and identity.

Gender dysphoria can in large part be alleviated through treatment (Murad et al., 2010). Hence, while transsexual, transgender, and gender-nonconforming people may experience gender dysphoria at some points in their lives, many individuals who receive treatment will find a gender role and expression that is comfortable for them, even if these differ from those associated with their sex assigned at birth, or from prevailing gender norms and expectations.

## Diagnoses Related to Gender Dysphoria

Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder. Such a diagnosis is not a license for stigmatization or for the deprivation of civil and human rights. Existing classification systems such as the *Diagnostic Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association, 2000) and the *International Classification of Diseases (ICD)* (World Health Organization, 2007) define hundreds of mental disorders that vary in onset, duration, pathogenesis, functional disability, and treatability. All of these systems attempt to classify clusters of symptoms and conditions, not the individuals themselves. A disorder is a description of something with which a person might struggle, not a description of the person or the person's identity.

Thus, transsexual, transgender, and gender-nonconforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available. The existence of a diagnosis for such dysphoria often facilitates access to health care and can guide further research into effective treatments.

Research is leading to new diagnostic nomenclatures, and terms are changing in both the *DSM* (Cohen-Kettenis & Pfäfflin, 2010; Knudson, De Cuypere, & Bockting, 2010b; Meyer-Bahlburg, 2010; Zucker, 2010) and the *ICD*. For this reason, familiar terms are employed in the *SOC* and definitions are provided for terms that may be emerging. Health professionals should refer to the most current diagnostic criteria and appropriate codes to apply in their practice areas.

## IV

### Epidemiologic Considerations

Formal epidemiologic studies on the incidence<sup>III</sup> and prevalence<sup>IV</sup> of transsexualism specifically or transgender and gender-nonconforming identities in general have not been conducted, and efforts to achieve realistic estimates are fraught with enormous difficulties (Institute of Medicine, 2011; Zucker & Lawrence, 2009). Even if epidemiologic studies established that a similar proportion of transsexual, transgender, or gender-nonconforming people existed all over the world, it is likely that cultural differences from one country to another would alter both the behavioral expressions of different gender identities and the extent to which gender dysphoria—distinct from one's gender identity—is actually occurring in a population. While in most countries, crossing normative gender boundaries generates moral censure rather than compassion, there are examples in certain cultures of gender-nonconforming behaviors (e.g., in spiritual leaders) that are less stigmatized and even revered (Besnier, 1994; Bolin, 1988; Chiñas, 1995; Coleman, Colgan, & Gooren, 1992; Costa & Matzner, 2007; Jackson & Sullivan, 1999; Nanda, 1998; Taywaditep, Coleman, & Dumronggittigule, 1997).

For various reasons, researchers who have studied incidence and prevalence have tended to focus on the most easily counted subgroup of gender-nonconforming individuals: transsexual individuals who experience gender dysphoria and who present for gender-transition-related care at specialist gender clinics (Zucker & Lawrence, 2009). Most studies have been conducted in European countries such as Sweden (Wälinder, 1968, 1971), the United Kingdom (Hoenig & Kenna, 1974),

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III **incidence**—the number of new cases arising in a given period (e.g., a year)

IV **prevalence**—the number of individuals having a condition, divided by the number of people in the general population

the Netherlands (Bakker, Van Kesteren, Gooren, & Bezemer, 1993; Eklund, Gooren, & Bezemer, 1988; van Kesteren, Gooren, & Megens, 1996), Germany (Weitze & Osburg, 1996), and Belgium (De Cuypere et al., 2007). One was conducted in Singapore (Tsoi, 1988).

De Cuypere and colleagues (2007) reviewed such studies, as well as conducted their own. Together, those studies span 39 years. Leaving aside two outlier findings from Pauly in 1965 and Tsoi in 1988, ten studies involving eight countries remain. The prevalence figures reported in these ten studies range from 1:11,900 to 1:45,000 for male-to-female individuals (MtF) and 1:30,400 to 1:200,000 for female-to-male (FtM) individuals. Some scholars have suggested that the prevalence is much higher, depending on the methodology used in the research (e.g., Olyslager & Conway, 2007).

Direct comparisons across studies are impossible, as each differed in their data collection methods and in their criteria for documenting a person as transsexual (e.g., whether or not a person had undergone genital reconstruction, versus had initiated hormone therapy, versus had come to the clinic seeking medically supervised transition services). The trend appears to be towards higher prevalence rates in the more recent studies, possibly indicating increasing numbers of people seeking clinical care. Support for this interpretation comes from research by Reed and colleagues (2009), who reported a doubling of the numbers of people accessing care at gender clinics in the United Kingdom every five or six years. Similarly, Zucker and colleagues (2008) reported a four- to five-fold increase in child and adolescent referrals to their Toronto, Canada clinic over a 30-year period.

The numbers yielded by studies such as these can be considered minimum estimates at best. The published figures are mostly derived from clinics where patients met criteria for severe gender dysphoria and had access to health care at those clinics. These estimates do not take into account that treatments offered in a particular clinic setting might not be perceived as affordable, useful, or acceptable by all self-identified gender dysphoric individuals in a given area. By counting only those people who present at clinics for a specific type of treatment, an unspecified number of gender dysphoric individuals are overlooked.

Other clinical observations (not yet firmly supported by systematic study) support the likelihood of a higher prevalence of gender dysphoria: (i) Previously unrecognized gender dysphoria is occasionally diagnosed when patients are seen with anxiety, depression, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, sexual disorders, and disorders of sex development (Cole, O'Boyle, Emory, & Meyer III, 1997). (ii) Some crossdressers, drag queens/kings or female/male impersonators, and gay and lesbian individuals may be experiencing gender dysphoria (Bullough & Bullough, 1993). (iii) The intensity of some people's gender dysphoria fluctuates below and above a clinical threshold (Docter, 1988). (iv) Gender nonconformity among FtM individuals tends to be relatively invisible in many cultures, particularly to Western health

professionals and researchers who have conducted most of the studies on which the current estimates of prevalence and incidence are based (Winter, 2009).

Overall, the existing data should be considered a starting point, and health care would benefit from more rigorous epidemiologic study in different locations worldwide.



## Overview of Therapeutic Approaches for Gender Dysphoria

### Advancements in the Knowledge and Treatment of Gender Dysphoria

In the second half of the 20<sup>th</sup> century, awareness of the phenomenon of gender dysphoria increased when health professionals began to provide assistance to alleviate gender dysphoria by supporting changes in primary and secondary sex characteristics through hormone therapy and surgery, along with a change in gender role. Although Harry Benjamin already acknowledged a spectrum of gender nonconformity (Benjamin, 1966), the initial clinical approach largely focused on identifying who was an appropriate candidate for sex reassignment to facilitate a physical change from male to female or female to male as completely as possible (e.g., Green & Fleming, 1990; Hastings, 1974). This approach was extensively evaluated and proved to be highly effective. Satisfaction rates across studies ranged from 87% of MtF patients to 97% of FtM patients (Green & Fleming, 1990), and regrets were extremely rare (1–1.5% of MtF patients and <1% of FtM patients; Pfäfflin, 1993). Indeed, hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many people (American Medical Association, 2008; Anton, 2009; World Professional Association for Transgender Health, 2008).

As the field matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither (Bockting & Goldberg, 2006; Bockting, 2008; Lev, 2004). Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate

gender dysphoria. Some patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery, but not hormones. In other words, treatment for gender dysphoria has become more individualized.

As a generation of transsexual, transgender, and gender-nonconforming individuals has come of age—many of whom have benefitted from different therapeutic approaches—they have become more visible as a community and demonstrated considerable diversity in their gender identities, roles, and expressions. Some individuals describe themselves not as gender-nonconforming but as unambiguously cross-sexed (i.e., as a member of the other sex; Bockting, 2008). Other individuals affirm their unique gender identity and no longer consider themselves to be either male or female (Bornstein, 1994; Kimberly, 1997; Stone, 1991; Warren, 1993). Instead, they may describe their gender identity in specific terms such as transgender, bigender, or genderqueer, affirming their unique experiences that may transcend a male/female binary understanding of gender (Bockting, 2008; Ekins & King, 2006; Nestle, Wilchins, & Howell, 2002). They may not experience their process of identity affirmation as a “transition,” because they never fully embraced the gender role they were assigned at birth or because they actualize their gender identity, role, and expression in a way that does not involve a change from one gender role to another. For example, some youth identifying as genderqueer have always experienced their gender identity and role as such (genderqueer). Greater public visibility and awareness of gender diversity (Feinberg, 1996) has further expanded options for people with gender dysphoria to actualize an identity and find a gender role and expression that are comfortable for them.

Health professionals can assist gender dysphoric individuals with affirming their gender identity, exploring different options for expression of that identity, and making decisions about medical treatment options for alleviating gender dysphoria.

## Options for Psychological and Medical Treatment of Gender Dysphoria

For individuals seeking care for gender dysphoria, a variety of therapeutic options can be considered. The number and type of interventions applied and the order in which these take place may differ from person to person (e.g., Bockting, Knudson, & Goldberg, 2006; Bolin, 1994; Rachlin, 1999; Rachlin, Green, & Lombardi, 2008; Rachlin, Hansbury, & Pardo, 2010). Treatment options include the following:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one’s gender identity);
- Hormone therapy to feminize or masculinize the body;

- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

## Options for Social Support and Changes in Gender Expression

In addition (or as an alternative) to the psychological- and medical-treatment options described above, other options can be considered to help alleviate gender dysphoria, for example:

- In-person and online peer support resources, groups, or community organizations that provide avenues for social support and advocacy;
- In-person and online support resources for families and friends;
- Voice and communication therapy to help individuals develop verbal and non-verbal communication skills that facilitate comfort with their gender identity;
- Hair removal through electrolysis, laser treatment, or waxing;
- Breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks;
- Changes in name and gender marker on identity documents.

# VI

## Assessment and Treatment of Children and Adolescents With Gender Dysphoria

There are a number of differences in the phenomenology, developmental course, and treatment approaches for gender dysphoria in children, adolescents, and adults. In children and adolescents, a rapid and dramatic developmental process (physical, psychological, and sexual) is involved and