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July 1998

Buffalo Belles

BUFFALO BELLES

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July, 1998

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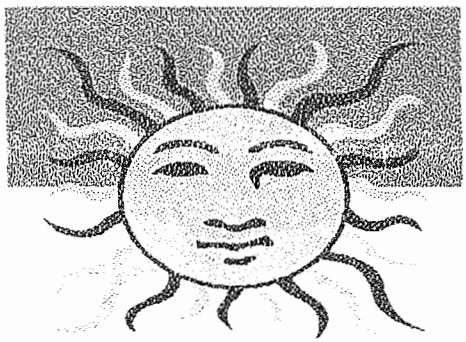


Hello girlfriends!

Hope you've been enjoying your summer so far. If you are, that's great! If not, then what have you been doing to get some joy into your life? I wish that your joy were attending Buffalo Belle meetings. But judging from the most recent gathering on Saturday, June 6 (8 members attended), going to the meeting is not as important as it used to be for a lot of us. I know that summer meetings are usually attended by a lesser number of members. Summer vacations, visiting friends and relatives, yard work, a rare Friday meeting, make-up melt down, etc., tend to keep are numbers down. And I'm aware that we lose a few members each year, but we also gain new ones as well. So that doesn't explain all the recent small turn-outs. What does? I've brought this issue up in past newsletters, so I won't beat that horse again. If you have any ideas regarding poor attendance or some new ideas to help increase turnout let me or any other officer know about it. Active participation keeps groups like ours togethe and strong. Remember, we're here for you!

I would like to welcome our two newest members to the Buffalo Belles: Allyson and Celeste. They attended their first meeting, June 6. Hope we'll be seeing both of you often at future meetings.

Discussions during the informal 'business' part of the meeting involved some upcoming summer events, the August picnic and a September trip to Toronto (more on that in the next issue).

After the meeting ended, five of us went downtown to the Stage Door for a few drinks and some live entertainment at the upstairs piano bar. We discovered that the Stage Door is being sold and will change its name and offer more activities to increase patronage. What they have in mind

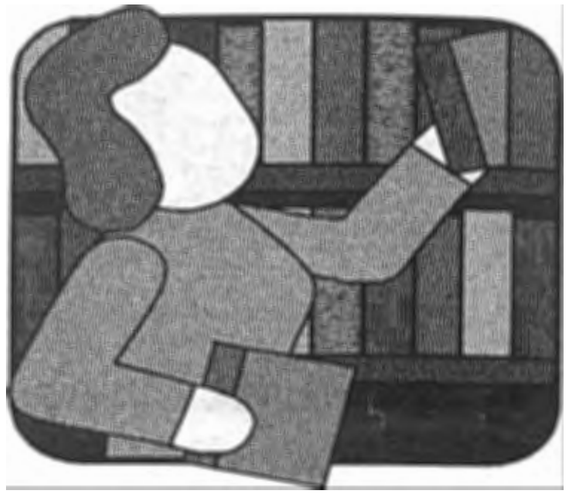
is unknown (to us) at this time. Soon afterward our small troupe headed to Club Marcella and watched the fun unfold there. The place is loud but always interesting. It's my favorite place at the moment.

Well, it's been a generally slow month for me so far, but I'm trying to get out and find some things for the group to do. Come to the next meeting, July 11, where we'll discuss a few details about some Belles activities such as the picnic in August and maybe a road trip or two. And in the meantime, do what you can to find your joy.

Hugs, Camille

June Attendace:

Allyson
Becky
Camille
Celeste
Debbie
Joy
Patti



GENDERARTICLES

This regularly posted Internet column provides educational information regarding transgender living. (TS/TG/CD/SO) Each column has been written to inspire contemplation and dialogue. Authored by Gianna E. Israel, columns may be reprinted in any medium insofar as each article, its introduction and the author's contact information remains unaltered. Previous articles may be found at the Gianna E. Israel Gender Library, which may be accessed through Ms Israel's homepage at http://members.aol.com/msgianna/transgender.html

Shoshanna Gillick, MD (#19)
Interviewed by Gianna E. Israel

In the past I have received requests that I interview progressive persons who are careproviders or leaders within the transgender community. As an gender specializing counselor I find interviewing exciting. I enjoy asking informed questions, and having an opportunity to share with you new advances with our community.

Shoshanna Gillick, MD has three board certifications in General Psychiatry, Child/Adolescent Psychiatry and Forensic Psychiatry. She has over 20 years experience as a psychiatrist. As a Lt. Commander in the United States Navy she has made rounds in Japan, the Philippines, Guam, Hawaii, and Southern California. Prior to transitioning she also worked as an associate professor at the University of Southern California School of Medicine. Among numerous accomplishments post-transitionally, Dr. Gillick is experienced HMO psychiatric provider, DSM-IV expert, and a psychopharmacologist expert.

Recently Dr. Gillick relocated to the Northern California. She maintains a private practice in San Francisco. Earlier this month Dr. Gillick and I met for dinner at San Francisco's Union Square. Meeting her was exciting over a Japanese dinner. I had sushi and she had a delicious steak. Having recently attended theater, she was dressed in a pretty navy blue and gold combination pantsuit. She has a wonderful sense of humor, and a fascinating perspective on gender identity issues. I hope you enjoy her interview, as much as I enjoyed meeting with her.

Gianna

Dr. Gillick, before I frighten off my readers, I believe it is important people accurately understand what psychiatry is, and how it fits into the medical-mental health system. If my understanding is correct, psychiatry is that profession where medical training, psychological perspective and treating mental illness are practiced. Psychiatrists are frequently misunderstood and feared by the average person on the street. Because transgender persons have been treated in a deprecating fashion in the past by the medical-mental healthcare system, these individuals may not realize what benefits can be gained from seeing a psychiatrist. Could you tell me when it would be appropriate for a person to see a psychiatrist? And, how psychiatric treatment might differ from psychotherapy or gender-specialized counseling?

Dr. Gillick

A psychiatrist is a medical doctor, who after graduating from medical school, takes on specialty training, for four years, learning about disorders of personality development, thinking and mood. These disorders over the last thirty years, have been successfully diagnosed and treated with a number of medications that can substantially improve a patient's ability to handle life situations over and above normal daily stress. Suicidal thinking and behavior, profound depression and psychotic delusions are among the symptoms that require psychiatric evaluation and medication that stabilizes brain chemistry.

Gianna

Over the years I have counseled individuals in the beginning of transition who greatly feared being institutionalized because they have gender identity issues. In the past transgender men and women have been institutionalized by psychiatrists. Frequently they were misdiagnosed or hospitalized by family members. Moreover, in today's age of modern medicine, many medical and mental health practitioners know very little about gender identity issues. Is there any information you can provide my readers which would help them understand this issue better? Also, what can be done if a transgender man or woman believes he or she is being held or institutionalized on the basis of having a transgender identity?

Dr. Gillick

In my experience the overwhelming majority of transgender people do not display mental impairment that would require or even benefit from involuntary psychiatric treatment in a hospital setting. It would be malpractice to incarcerate anyone for being transgendered in and of itself. However, like everyone else, transgendered people are at risk for depression and other psychiatric disorders that may present an acute threat to a patient's survival and ability to care for oneself. In all

50 of the United States, statutes limit the time a person can be involuntarily hospitalized without judicial determination of dangerousness to self and others that would justify extension of involuntary hospitalization. Patient's right advocates are legal representatives who, again in my experience, fight vigorously to support non-dangerous patients who no longer desire or need inpatient hospitalization.

Gianna

Doctor, I'd like to ask you a couple questions about hormones since you are an experienced psychopharmacologist. Can you explain how estrogens and progesterones actually work in transgender women, and how testosterone actually works in transgender men? Also, Transgender Care advises that MTF individual's estrogen and testosterone levels should mimic the blood chemistry of pre-menopausal women, and that FTM individual's testosterone levels should mimic that of genetic men. As I understand it, a person's body chemistry is actually a very finely tuned process. However some transgender people believe that "more hormones is better." What actually happens when a person takes to many hormones?

Dr. Gillick

First of all I am not an endocrinologist. I am a transgendered psychiatrist who has read alot about hormones, and have been on estrogen and progesterone for the past eight years. In 1997 we still basically do not know exactly what these hormones do. We do know however that profound changes in body chemistry do occur. Very recently we have learned that there are estrogen and testosterone receptors all over the body, including the brain, and that the effects of these two hormones are not limited to the secondary sex characteristics. As a psychiatrist I am aware that emotional changes are frequent in both sexes when they are given either male or female hormones.

The attempt to mimic normal male and female hormone levels is one approach to feminization in the biological males and masculinization in biological females. The use of hormone blood levels to monitor the body chemistry changes is not universally followed by the endocrinologists to whom I have spoken. I would recommend that transgender clients openly discuss with their physicians the rationale for any hormone recipe being proposed. The philosophy that more is better is a dangerous one. Both testosterone and estrogen occasionally have serious and/or dangerous physical and emotional side effects that may require their termination or at least a major change of dosage.

Gianna

I recently read an article written by you, published in the Northern California Psychiatric Physician (07/08 '97), which has sparked a great deal of controversy in the Bay Area. I have two questions regarding that article which discusses the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM- series). In your article you state that "tearing out the GID page from the DSM-IV would plunge (the) hurting children and adolescents back into the closet to fester and suppurate." Suppurate means to leak and ooze all over the place. Your statement sounds very dramatic, what did you mean by it?

Dr. Gillick

I am a developmental child psychiatrist trained and experienced in evaluating children and adolescents. As both a child and an adolescent with GID, I was seriously leaking gender, and can recall on a daily basis festering and suppurating while attempting to construct a workable core gender identity. Before there was a GID diagnosis I experienced a gender identity disorder which made for one confused and extremely unhappy little boy.

My article strongly differentiated between "gender nonconforming" children and adolescents who displayed variant gender behavior but did not present with the emotional distress and functional impairment of a psychiatric disorder. Unfortunately, most of my psychiatric colleagues are either or both insensitive or ignorant of gender developmental issues, and lump all individuals who display crossgender identification or behavior as sick, weird or psychotic.

I have attempted to educate my brothers and sisters in psychiatry to the complexities of gender development, maintenance, leakage and breakdown. I presented a workshop at the Gay & Lesbian Medical Association Convention in August '97, and will be presenting interactive workshops in San Francisco in the coming months that will be geared for both the careprovider and gender community.

Gianna

People's emotions become quickly charged when it comes to discussing inclusion of GID (Gender Identity Disorder) within the DSM-IV, and forthcoming DSM-V. Rightly so, transgender people recognize that its inclusion can lead non-transgender individuals to believe persons having gender identity issues are mentally disordered and medically diseased. Politically, many transgender people want references to GID and crossdressing to be completely removed from the DSM-series, much as references to homosexuality were removed during the 1970's. However, unlike gays and lesbians, no other group of people requires hormonal and surgical intervention as routinely as transgender persons do. Consequently, the removal of GID from the DSM- series may undermine potential insurance benefits and services provided to transgender persons. Finally, some people have suggested moving GID to the International Classification of Diseases (ICD-9) in order to remove the stigma associated with a mental classification.

Doctor, this is a complex issue for consumers, careproviders and policy-makers, would you shed some light on the subject for us? Moreover, as long as GID remains within the DSM-series, what suggestions do you have for careproviders and consumers to help insure that transgender people are not treated in a deprecating fashion. Finally, what advantages and disadvantages are there with inclusion versus exclusion of GID in the DSM-series?

Dr. Gillick

Rather than abolish GID, I suggest a more accurate picture of the diversity of gender presentations. Under the heading of "gender variants" I include non-pathological phenomena such as healthy gender independence, healthy gender-blending, and healthy gender-questioning in youth and adults. Variants means simply different presentations, which are not better or worse than the "normal" masculine or feminine flavors. My concept of "gender deviants" implies a symptomatic, painful, jumping off the track of the gender train. I have introduced a clinical syndrome of anatomical rejection/disgust with the genitalia of birth or "genital dysphoria." A separate condition which I term "gender dysphoria" is a rejection of the gender role and behavior associated with the genitalia at birth. When these two serious clinical syndromes combine that is what I am calling gender identity disorder. I got it, and its no fun.

The diagnosis of GID is very different from the observation of non-pathological gender non-conformity that may be frequently seen in sissy boys, tomboys, and androgynes, and intersexes. An important task for the clinicians is to differentiate between healthy and hurting gender diversity. Treating the healthy makes no sense at all, and ignoring the hurting is unacceptable to ethical careproviders. In my suggestions for DSM-V, I include transsexualism and transgenderism under a new category of "transitional identities of sex and gender." Both represent an individual seeking a more healthy adaptation to anatomical and gender role incongruity.

If the transsexual and transgenderist after transition does not display clinical distress or behavioral dysfunction, the individual leaves DSM-V and is referred to as either a sexually-redefined individual or a gender-redefined individual. This linear roadmap is quite concrete in specifying that anatomically and gender role incongruent people can substantially improve and escape the symptoms and stigma of deviance. They graduate after doing the difficult coursework of reworking the rough edges of incongruence into a more smoothly fitting-together gender identity.

To answer your specific question, it is my opinion there is no advantage to abolishing the GID diagnosis. On the contrary, constructing a more accurate picture of gender development and gender deviance makes it much more likely that these children, adolescents and adults, will find the help that they need to achieve a happier and more adaptive anatomical and gender role integration.

Gianna

Like the general population, transgender men and women experience depression. Depression is characterized by a continued sense of low-self worth, sadness, even helplessness. It interrupts people's regular ability to function, eat and sleep. Sometimes people may be depressed for a day or two, sometimes for weeks on end. Depression can be helped with a combination of supportive counselor or psychotherapy, and anti-depressant medications. In fact, if a person is able to improve upon their circumstances, with good support it is possible to find significant relief from depression. Could you provide us with some basic pointers which will help transgender persons and gender-specialized careproviders to understand the significance of this mental health issue?

Dr. Gillick

Periodic demoralization is quite common for both the transgendered and anyone else coping with a challenging and often confusing mismatch of mind and body. Usually we find ways of coping that resolve the demoralization and return us to a generally acceptable mood. When this demoralization becomes generalized, deeper and resistant to even our most vigorous efforts to fight it off, a "clinical depression" crystallizes with hopelessness, helplessness, profound sadness, sleep disturbance and impaired self-esteem that may progress to active self- destructive thinking. This is a medical emergency that usually requires prescription of specific anti-depressant medication to correct the imbalance in the chemical soup of the brain.

Gianna

There are a variety of opinions regarding the prescribing of anti-depressants while a person is on hormones. Also, some physicians are extremely hesitant to provide hormones to a transgender person who is severely depressed, when in fact sometimes the patient believes if he or she can just get hormones the depression will go away. Could you provide us some more information on this subject?

Dr. Gillick

Sometimes transgender individuals display serious, life-threatening depression that will not get better with hormones, SRS or even chocolate. A clinician must carefully diagnose, select medication and monitor the patient's response to anti-depressant medication. My personal opinion is that prescription of hormones should await the substantial resolution of the depression. Even people responding well to hormones may develop a clinical depression that will require combining anti-depressant medication with the hormone regimen to permit the patient to function and proceed in their gender reassignment. The internal medicine doctor and the psychiatrist need to collaborate in treating the depressed transgender patient for optimal clinical care of the entire individual.

Gianna

Self-identified transgender youth, and gender-questioning youth, are now becoming more prevalent as transgender issues become more visible within society. What words of advise do you have for these young persons, their parents and careproviders?

Dr. Gillick

Every adolescent questions gender and wonders where in the gender spectrum they are, and where they will end up as an adult. Self-identification of 13-year olds as pre-operative transsexuals is premature. It precludes the normal trial and error, and trying on of various identities, genders and clothing styles. If a youngster is hurting and manifesting symptoms of GID, gender-specialized counseling is advised to help the patient and the family system explore options that will not be limited to exclusive heterosexual, homosexual and gender-rigid categories.

In the past gender-variance has been misdiagnosed as GID and inappropriately (and often tragically) involuntarily hospitalized to cure them of their deviance. I strongly condemn this misuse of the DSM to stigmatize, pathologize, and incarcerate gender-nonconformist children and adolescents. In other words, crossgender identification is not in and of itself sufficient for a clinician to determine a diagnosis or need for treatment.

Gianna

In addition to being gender specialists, we are both familiar with forensic mental health and medicine. For my readers, forensics is the point where legal issues and medical/mental health issues interact. For example, Dr. Gillick may evaluate and testify regarding a client's mental welfare within family, civil or criminal court. Forensics is also the profession which provides psychiatric services to sex offenders and the criminally insane. Surprisingly, a significant proportion of gender-specialized careproviders also specialize within forensics. The treatment models used for providing forensic services are understandably rigid, because the careprovider is charged with the responsibility of treating the criminal and protecting society.

I have noticed my colleagues with forensic backgrounds routinely to treat transgender people as they would criminals. For example, these careproviders frequently refer to transgender people with incorrect pronouns, in writing and conversation. They seem to have an attitude that transgender people are incapable of self-defining their gender identity. Frequently, using a forensic model, transgender persons must first prove they can live in role (often for up to a year) before being treated with hormones. In any event, these forensic careproviders seem to view transgender persons as deviant and pathological. I believe this is wrong, and that my colleagues with forensic backgrounds need to apply a different treatment model when providing services to transgender persons. Could you share with us your viewpoints and suggestions on this issue?

Dr. Gillick

Unfortunately, like the HBIGDA Standards of Care, the standards of education and training of so-called forensic experts is woefully inadequate. As a graduate of the USC Institute of Psychiatry, Law and the Behavioral Sciences (1978-1979), and as a card-carrying forensic psychiatrist, I can testify that most of my colleagues are either, or both, insensitive and ignorant about the transgender community. Many of them are phobic of us and express hostility even to the possibility of learning something that doesn't quite fit in to their academic cubbyholes. A forensic psychiatrist is no better at understanding or treating a transgender client than the non-forensic psychiatrist. Both groups have had little or no gender-specialized training or experience with the gender community. Again, unfortunately, it has been my experience that even in the relatively enlightened San Francisco psychiatric community there is a strong resistance to dialogue with the gender community. Specifically, I have encountered resistace and indifference from the training director of the psychiatric residency training program at the University of California- San Francisco, Langley Porter. I have offered to meet with him as a psychiatric colleague and transgender consumer of services, but these were turned down and he has not responded to further offers.

Gianna

Doctor, I appreciated having an opportunity to interview with you. However, before ending, do you have any closing comments for my readers. Also, outside of your profession, could you tell us a little about yourself. As careproviders our clients often like to hear about our interests and hobbies. Perhaps you could tell us about yours.

Dr. Gillick

In closing, I would conclude that identifying oneself as transgendered is merely a beginning toward understanding the dynamics of the biological, psychological and social factors affecting the individual. Choice of treatment, path of gender realignment, and sexual and gender integration remain to be explored. It ain't easy, and it doesn't magically resolve itself when you transition genders. For some of us it is a matter of life and death. It requires our most serious attention to finding our way in the world. On a lighter note, I'm a 53 year-old tough little Jewish boy from Newark with GID. I am most proud of my 23 year-old daughter who is preparing to apply to medical school and clean up some of her father's theories.

I am also a enthusiastic student of popular culture who learned most of what I know about gender from the American cinema from the 1950's, '60's and '70's, I dig rock and roll music, and American musical theater. I also continue my love of baseball, after estrogen and progesterone wiped out my previous attraction to professional football and basketball. Theoretically, I think Freud was really on to something in his discovery of childhood sexuality, and I further believe that gender organizes and structures sexuality and identity of the developing individual during childhood. I still have allot to learn, but most people agree that I am getting better at accessorizing.

Gianna

Readers, my guest Shoshanna Gillick, MD can be reached at (415) 621-8346 or written to at 2710 California Street, San Francisco, CA 94113. Later this year I will be interviewing Barbara Anderson, Ph.D. Dr. Anderson is a gender-specialist, clinical sexologist and family therapist; with over 35 years experience. I welcome questions, comments from you regarding my column contents and interviews.

****G I A N N A E. I S R A E L provides nationwide telephone consultation, individual & relationship counseling, evaluations and referrals. She is principal author of the Transgender Care (Temple University / in press 1997). She also writes Transgender Tapestry's "Ask Gianna" column; is an AEGIS board member and HBIGDA member. She can be contacted at (415) 558-8058, at P.O. Box 424447 San Francisco, CA 94142, or via e-mail at Gianna@counselsuite.com.

Hope you enjoyed this insert in this months newsletter. There will be more to follow from this author. With your approval, of course. Let us know what you think. This is ***YOUR*** group paper. Your thought, input and suggestions help put together this paper. With out **YOU** it may not happen.