Transgender Research Literature Review

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There is very little research on transgender college students. Most studies on the transgender population focus on medical aspects of gender identity and not the psychosocial identity of the individual. The medical research that exists is pathological in nature, that is, it assumes transgender people have a mental illness. Non-medical research emphasizes the need to look at the person as unique with a gender identity. This research acknowledges gender does not exist on a binary system. Rather, gender exists on a continuum.

The term transgender is “used to describe a broad range of people who experience and/or express their gender somewhat differently from what most people expect” (HRC, 2004a, ¶ 1). Bilodeau (2005) gives a sample of terms that describe transgender identities: transsexuals (preoperative, postoperative), transvestites, drag queens, drag kings, male to female (MTF), female to male (FTM), cross dressers, and gender benders. Transgender is an umbrella term that encompasses all these gender variant identities.

The medical profession dominates the body of research regarding transgender people. This review outlines some research of transgendered people from both a medical stance and a psychosocial perspective. The paper begins with an overview of the medical ideas surrounding the diagnosis and treatment of Gender Identity Disorder (GID). Next, medical models of GID are analyzed followed by the mental health implications these models contain. The paper’s analysis then shifts to identity-focused aspects of research and non-medical models of identity development for transgender people. The paper concludes with recommendations for future research regarding the transgender population.

Medical Aspects of Transgenderism

An appropriate document to begin the medical analysis of transgenderism is the

*Diagnostic Statistical Manual of Mental Disorders (DSM)*. The *DSM* is the handbook used most
often when diagnosing mental disorders of all types (Wikipedia, 2005). GID first appeared in the American Psychiatric Association’s 1980 version of the *Diagnostic Statistical Manual, Third Edition (DSM-III)*. Essentially, a person has GID if there is incongruence between her or his internal sense of gender and the expectation society has for her or his gender (American Psychiatric Association, 1980). Since 1980, there have been three more editions of the *DSM* released. The current edition, the *Diagnostic Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR)*, establishes four criteria that must be met before a diagnosis of GID can be given (American Psychiatric Association, 2000). First, the person must have a strong and persistent cross-gender identification. Second, this cross-gender identification must not merely be a desire for any perceived cultural advantages. Also, the person must experience persistent discomfort with her or his given sex. Third, the person must not have an intersexed condition. Finally, the disturbance the person experiences must cause significant clinical distress or other impairment.

The Human Rights Campaign (2004b) identifies there is a current discussion about the inclusion of GID in the *DSM-IV-TR*. Because GID is included in the *DSM-IV-TR*, there are some legal protections that could be afforded to transgender people. For example, insurance providers could be forced to cover hormones and sexual reassignment surgery (SRS) (HRC, 2004b). Alternatively, some groups believe that the inclusion in the *DSM-IV-TR* is pathological and harmful for transgender people (e.g., Bornstein, 1994; GID Reform Advocates, 2004). The GID Reform Advocates (2004) strive to make the medical professions “affirm that difference is not disease, nonconformity is not pathology, and uniqueness is not illness” (¶ 6). Because of the inclusion of GID in the *DSM-IV-TR*, an individual must be documented as having a mental illness before they can receive SRS (Bilodeau, 2005).
Seil (2004) discussed the diagnosis and treatment of transgendered patients. GID “illustrates that another factor unknown at birth plays an important role in the later life of the child. This is gender identity” (Seil, 2004, p. 101). Gender identity is the subjective sense a person has of her or his own gender, regardless of biological sex. The diagnosis of GID relies heavily on self-reportage of the patient. The only way of making a diagnosis is by listening to the patient (Seil, 2004). Treatment requires the “intervention of a team of professionals from general medicine, endocrinology, surgery, psychiatry, psychology, and social work” (Seil, 2004, p. 103). The treatment Seil presented reinforces the binary gender system, the belief that there are only two genders, man and woman. A person with GID is seen on the wrong side of the gender fence and the goal of treatment is to help her or him transition to the other gender. This treatment recommendation is consistent with what the DSM-IV-TR recommends.

Medical Identities as Transgender

Docter and Fleming (2001) sought to further identify the components of transgenderism in their study. The DSM-IV-TR identified four criteria that a person must meet before being diagnosed with GID; Docter and Fleming wanted to know more about other factors that affect this diagnosis. A total of 455 transvestites and 61 transsexuals were the subjects of this study (Docter & Fleming, 2001). The study performed was not very inclusive of the wide range of transgender identities that exists. Only biological males who were diagnosed as transsexuals or transvestites were used in this study. Five factors were “identified and interpreted: Transgender Identity, Role, Sexual Arousal, Androallure, and Pleasure” (Docter & Fleming, 2001, p. 255). The findings of this study show that GID is too simple of an explanation for most people. Specifically, GID “offers a one dimensional focus on what [the authors] see as highly complex, multidimensional cognition and behavior of the transsexual” (Docter & Fleming, 2001, p. 267).
Docter and Fleming (2001) also attempted to explain the connection of sexual orientation to person’s identity as transgender. After the study, they had to conclude transgenderism is likely “independent of sexual partner preference” (Docter & Fleming, 2001, p. 271).

Lawrence (2004) contended a different connection between sexual orientation and gender identity. He examined autogynephilia, defined as “a male’s propensity to be sexually aroused by the thought or image of himself as female” (Lawrence, 2004, p. 69). This study also examines only biological males. Autogynephilia can be considered a sexual orientation of its own (Lawrence, 2004). Many autogynephiles are more than just sexually aroused by the idea of himself as female; he is comforted, inspired, and transformed to something that makes sense. GID may provide “the ‘push’ toward [SRS], … autogynephilic sexual desire provides the ‘pull’” (Lawrence, 2004, p. 75). The medical community accepts as a valid reason to pursue SRS (Lawrence, 2004). Autogynephilia meets the criteria set forth by the DSM-IV-TR for GID and the treatment that typically follows. The autogynephilia model is not without critics. Allison (2001) complains that many transsexual people transition to relieve her or his discomfort, not for sexual desire. Autogynephilic individuals typically feel intense guilt and shame in the sexual nature of their cross-gender identification.

Mental Health Implications for Transgender People

Transgender people face unique challenges based solely on their gender identity. Seil (2004) found that a disturbingly large number of transgender people have other mental health diagnoses; 37.2% of all transgender patients in his study had secondary diagnoses other than substance abuse and GID. Also, 32.1% of his study had a positive history for drug and alcohol abuse (Seil, 2004). There are many reasons that account for these high numbers. One reason could be the isolation many transgender people experience in relation to their gender identity.
Another explanation could be the guilt that typically accompanies their cross-gender identification.

Schaefer and Wheeler (2004) looked closely at the guilt many transgender people feel in relation to their cross-gender tendencies. They gathered data on 787 patients and found 13 themes of guilt. “Guilt is often the motivating factor that dictates how gender-distressed persons interpret, manage, and live their lives” (Schaefer & Wheeler, 2004, p. 118). These feelings of guilt focus on who the patient is instead of something the patient has done wrong. The guilt transgender people experience includes: not being normal, appearing to be one gender but feeling another, and religious or spiritual guilt (Schaefer & Wheeler, 2004). Schaefer and Wheeler (2004) contend that medical professionals must be aware of the crucial impact guilt has on GID.

Carroll and Gilroy (2002) completed additional examination of a counselor’s role with GID patients. They found that counselors must help GID individuals handle the guilt that is presented with their identity. The counselors must recognize traditional approaches “have pathologized individuals with nontraditional gender identities” (Carroll & Gilroy, 2002, p. 233). This is partly due to the *DSM-IV-TR*’s assumption that gender identity is a binary system. Transgender people inherently have little trust for mental health professionals (Carroll & Gilroy, 2002). Counselors and other professionals must have a client-centered approach to therapy and work to reverse this distrust. A therapist must validate the patients’ feelings. It is “especially paramount to the therapy because of the discrimination and negative stigma that await [transgender people] outside the therapy zone” (Carroll & Gilroy, 2002, p. 238).

A transgender person’s identity must be affirmed for the emotional well being of the individual. Nuttbrock, Rosenblum, and Blumenstein (2002) presented four processes that are crucial to mental health in transgender people. The first process, *identity awareness*, entails the
person making others aware of her or his transgender identity. The second process, *identity performance*, is the act of a transgender person acting on cross-gender desires. The third process, *identity congruence*, refers to the establishment of relationships with others surrounding the transgender identity. The final process, *identity support*, concentrates on feedback the individual receives from relationships with others focusing on the transgender identity. The creation of positive identity support is crucial to negate many mental health issues that are associated with being transgender (Nuttbrock, Rosenblum, & Blumenstein, 2002). Professionals that work with transgender students of all ages should engage the transgender person in a way that positively affirms the person’s gender identity.

**Psychosocial Identity Research**

Given the research that exists on transgender people, some might think it is simply a mental disorder that must be diagnosed and treated by trained medical professionals. Some researchers are recognizing gender is another aspect of identity along with religion, race, sexual orientation, or class (e.g., Bilodeau 2003, 2005; Bornstein, 1994; Ekins & King, 1997; Lev, 2004). The medicalization of the transgender population brought with it new conditions and created new identities to be forced upon these people (Ekins & King, 1997). Part of identity-based research is the acknowledgement that gender is not a binary system. Ekins and King (1997) claim that traditional medical categories for GID patients presume pathology and do not fully describe the variety of gender identities. The increased diversity within the transgender community has contributed to a greater sense unity (Ekins & King, 1997). Categories of gender confine people. These categories must be eliminated to allow people with nontraditional gender identities to express themselves and not be marginalized.
Lev (2004) wrote a book to help practitioners work with transgender people and their families. There are four parts of a person’s sexual identity: biological sex, gender identity, gender role, and sexual orientation (Lev, 2004). These aspects of sexual identity “interact with one another in complex ways and develop and integrate in various patterns” (Lev, 2004, p. 87) to create a unique sense of identity for each person. Each aspect exists on a continuum. A person can identify anywhere on that continuum and “can exist in more than one place at the same time” (Lev, 2004, p. 97). The societal assumption of duality and biological determinism is challenged by Lev. There is a large diversity of individuals that do not fall within traditional sexual identities that must be accounted for in some way, but the binary and medical approaches are not sufficient for doing this.

Transgender Identity Models

In addition to research based on gender identity, some researchers have begun to create models to explain transgender identity development (e.g., Bilodeau, 2003; Devor, 2004). There are not many models for transgender identity. Bilodeau and Renn (2005) called for new transgender theoretical models, especially those focused on college students. These models should be from an identity development perspective and not the traditional medical perspective.

Bilodeau (2003) introduced a model of transgender identity development that closely mirrors D’Augelli’s (1994) framework for homosexual individuals. There are six processes that transgender students work through on the way to a healthy identity. The first process, exiting a traditionally gendered identity, “involves recognizing that one is gender variant” (Bilodeau, 2005, p. 29). The second process, developing a personal transgender identity, focuses on knowing oneself in relation to the gender variance. The third process, developing a transgender social identity, involves creating a network of support for one’s identity. The fourth process,
becoming a transgender offspring, entails coming out to family members and reevaluating these familial relationships. The fifth process, developing a transgender intimacy status, consists of establishment of intimate personal and emotional relationships. The final process, entering a transgender community, means becoming involved politically and socially with transgender communities. This model removes some of the stigma that has come with transgender research and turned the focus back onto the transgender person as an individual. It validates what the person is feeling and the many areas they must endure change in to establish a healthy gender identity.

Devor (2004) mirrored another important sexual identity model. He adapted Cass’s (1979) model of homosexual identity formation to represent transgender identity. It should be noted this model did not come out of a formal study. Devor based it on 20 years of informal study and sociological practice. Cass (1979) had a total of six stages that began with identity confusion and ended with identity pride and synthesis. Devor (2004) added several stages and ended with 14 total. At the beginning of development, the person must let go of her or his socially constructed gender and recognize she or he is gender-variant. Then, the person discovers and compares their experience to other transgender people. Eventually, the person accepts her or his transgender identity and works toward transition and pride. This model, along with Bilodeau’s (2003) model, helps to validate the transgender experience. The person is no longer fighting a mental disorder; they are integrating an important part of identity into her or his core.

Conclusion and Recommendations for Future Research

Much of the research that exists on the transgender population is based on medical practices and the use of the DSM. Because of this, transgender people are pathologized. The
studies assume transgender people have a mental disorder and even require this diagnosis and treatment to fully transition and receive SRS. Some authors are beginning to recognize the psychosocial aspects of gender identity as well as gender’s socially constructed nature. These authors acknowledge gender is not binary; it exists on a continuum with perfect male/masculine at one extreme and perfectly female/feminine at the other end. A person can exist anywhere along the continuum or even in multiple places at one time (Lev, 2004).

Much of the research is based on many years of clinical observations of medical professionals. It is rarely based on a formal study that looks at being transgender through the eyes of the patient. Bilodeau (2005) proposed a study that will be based on the qualitative ethnography methodology. He will have qualitative interviews with transgender people and attempt to understand the world through their eyes. Scholars should continue to emphasize the identity aspects and struggles of transgender people in their studies.

Along with more formal and identity-based research, attention should be paid to biological females. The research that exists has a heavy concentration on biological males that identify as transsexual or as a transvestite. It may be difficult to find biological females to study; the *DSM-IV-TR* estimates that 1 in 30,000 biological males have GID (American Psychiatric Association, 2000). On the other hand, only 1 in 100,000 biological females have GID (American Psychiatric Association, 2000). Even given these disparities, researchers should seek out biological females to avoid creating an invisible minority.
References


