

Connectivity

Volume 7, Issue 2-3

Special double issue

February 2003

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From the Editors

This double issue of *Connectivity* holds many gems. Besides the very interesting results of a survey we conducted of mental health needs and issues in our community, highlights include:

- first-person articles and poetry about living with trauma, paranoia, other people's "scripts", autoimmune hypothyroid disease, bipolar disorder, and issues youth face in accessing care;
- articles on the mental health needs of female partners, parents and children of Ts, those with trauma histories, and those who are going through a gender transition;
- articles on spiritual, body and energy, and self-esteem approaches to mental health; plus
- what to look for in a therapist, and a review of what one national mainstream mental health group tells its constituents about "LGBT" mental health needs.

Our next issue is on the theme of sexuality. Survey responses (see separate insert) are due April 30, 2003, editorial submissions (see page 54) are due April 30, 2003.

Much to our chagrin, this, our second edition of *Connectivity*, was a year in the making.

And yet the topic of this issue – mental health – has much to do with the publication's delay. As the survivors of a suicide (Marcelle Cook-Daniels, 3/1/1960 – 4/21/2000), we have found that the process of grieving and rebuilding after such a tremendous loss is unpredictable, long, and tough. More than

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Connectivity illuminates the dynamic, multifaceted, challenging, and interrelated process by which personal, interpersonal, and community growth and development occurs. It is dedicated to helping move the fragmented trans+/SOFFA communities beyond identity politics and forge a movement that embraces and empowers our diverse complexities.

Connectivity is a publication of FORGE (For Ourselves: Reworking Gender Expression). FORGE is the parent organization of constituency groups including TAN (Transgender Aging Network), STRIKE (Strong TransRadicals Into Kink Everywhere) and TransWords.

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once we had to use scheduled "work on *Connectivity* time" for intensive griefwork when trauma memories were unexpectedly triggered.

We also had to cope with the suicide of another of our community's leaders, Alexander John (Bear) Goodrum (10/3/1960 – 09/28/2002). This tremendous personal and community loss spurred us to try to create a national task force to work on suicide prevention in our community. To our great sadness, however, some community members' concerns that the call for this task force was issued by two people who are perceived to be white, when both suicides we named in our call were by FTMs of color, quickly led us to disband the effort. As this edition of *Connectivity* shows, however, we will continue to work on this topic. We will also explore more about the implications, pros and cons of "only" space in Volume 8, Issue 2.

Finally, production of this issue was slowed by a now 10-month old campaign, we believe spearheaded by white supremacists, of hate crimes and terrorism against our family on the basis of race, gender, and sexual orientation. At this writing, we are just beginning the process of coping with a recent, horrible escalation by these terrorists. Because we are very actively trying to determine the source of and stop these horrendous crimes, we will not say more at this point. But clearly, these attacks dramatically show that while trans+/SOFFAs have "typical" human mental health concerns, we also sometimes face extraordinary challenges to maintaining our sanity.

We hope you find this edition of *Connectivity* helpful on your own path of achieving and maintaining a comfortable level of mental and emotional well-being.

Loree Cook-Daniels

michael munson

Connectivity

Join. Read. Think. Write. Connect. Create community.

Trans+/SOFFAs and Mental Health: Survey Results

*"I wanted to say this is great that you are doing this! I have talked with other trans people about whether the rate of mental illness in the trans community was particularly high, or if it is just **our** friends who are loony."*

We cannot answer whether people who are trans+/SOFFAs have a higher rate of mental illness than do non-trans people, both because we did not have many non-trans people answer and because it is entirely possible that those with no mental health issues chose to skip a survey entitled, "Mental Health Survey." However, among those who did answer, the results are stunning.

- Three-quarters have at least considered suicide.
- Two-thirds have had two or more mental illness diagnoses.
- Two-thirds are or have been depressed; nearly half have had an anxiety disorder, and a third have post-traumatic stress disorder.
- Nearly 18% have a current mental health condition they rate as "debilitating."
- Most say their mental health condition is/was at least partially related to being trans+/SOFFA.
- Thirty percent (30%) have had treatment forced upon them.

On the positive side,

- Seventy percent (70%) of those with a long-term condition found that starting hormones improved the

condition.

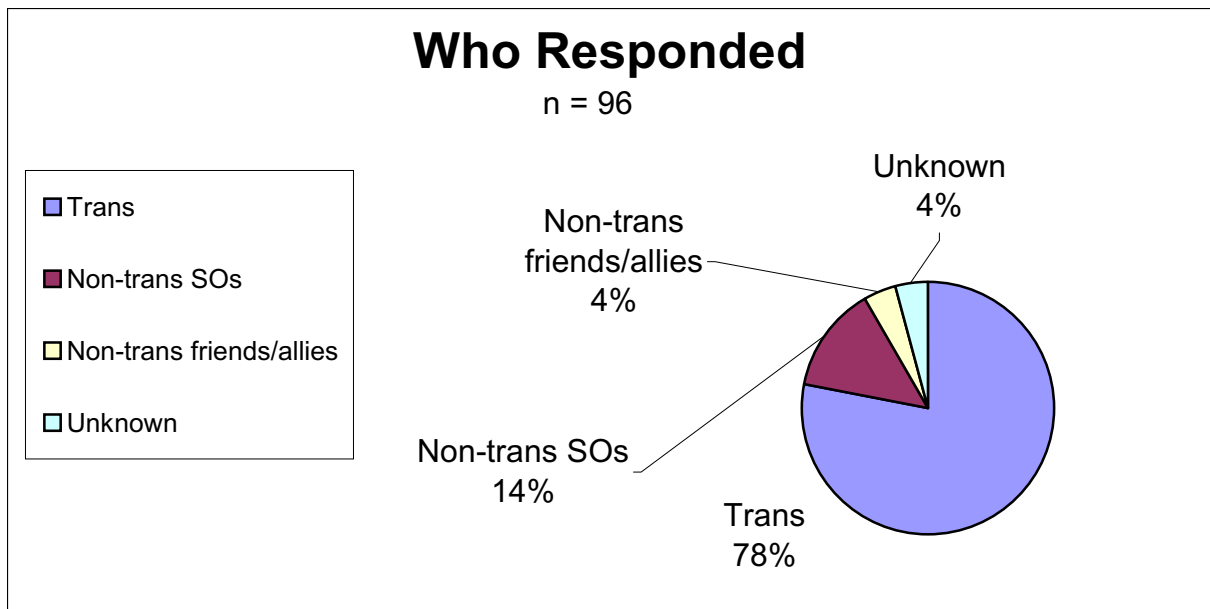
- Most of us have multiple techniques for improving or maintaining our mental health.
- Almost half of us have mental health insurance coverage.

Read on for more details.

Who Responded

Ninety-six (96) individuals answered our 19-item survey. The vast majority – 78% (N=75) – indicated explicitly or through their comments that they were or had been trans. Thirteen (13%) were non-trans significant others (several of these checked additional identities, as well). Four were non-trans friends or allies, and four did not check any of our demographics boxes.

Although we did not specifically ask whether trans+ respondents were male-to-female (MTF) or female-to-



(Continued on page 4)

Mental Health Survey Results (cont.)

(Continued from page 3)

male (FTM), the sources of the survey returns and comments made suggest the vast majority was FTM.

Six respondents said they were helping professionals themselves. However, all of these also checked another box (two were trans, three were non-trans significant others, and one was a non-trans friend).

Ninety-three (93) of the respondents gave their age. A third (38%) were aged 35-44, and nearly another third (30%) were aged 25-34. Seventeen percent (17%) of our respondents were aged 45-54, and 13% were aged 19-24. We had two respondents under age 18 and none age 55 and older.

Of the 85 respondents who answered where they lived, 52% were in urban environments, 45% were in the suburbs, and 3% lived in rural areas.

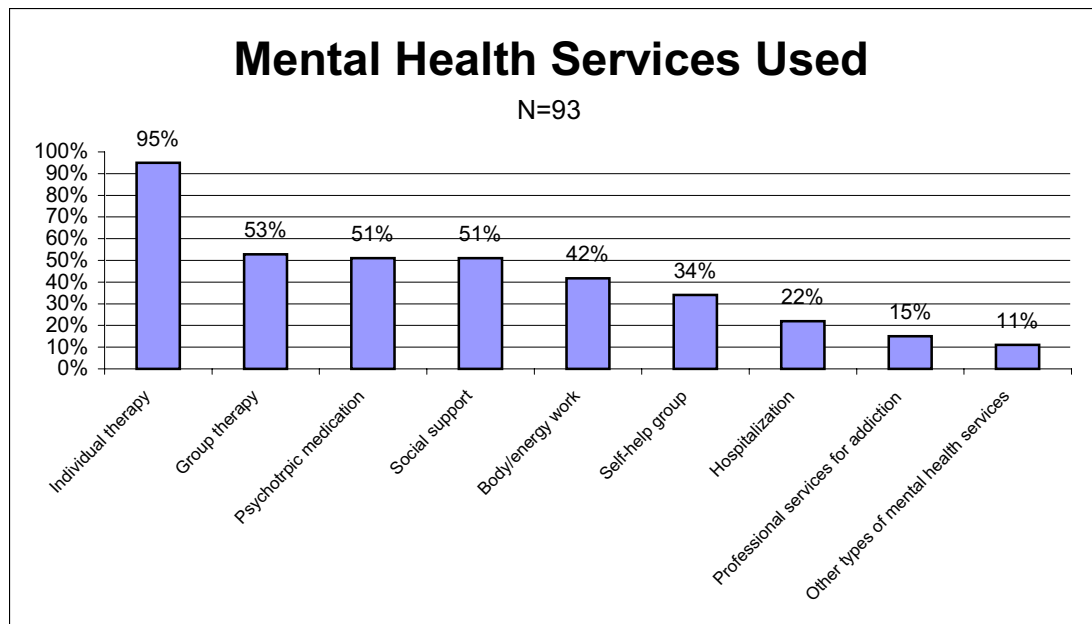
Many people gave multiple answers when we asked about economic backgrounds and current statuses; therefore, we had 126 answers to this question. "Middle class" or "upper middle class" was marked by 44%. Working class was selected by 19%, student by 13%, disabled by 11%, lower class by 10%, and upper class by 2%.

Mental Health Services Used

Our survey respondents were almost universally mental health services consumers; only one said sie had used NO mental health services, and two others declined to respond to the question. The vast majority – 88% -- had sought more than one type of service.

Individual therapy was the most common service type, with 95% of our respondents (N = 91) having used it. The use of psychotropic medications was also popular; more than half – 51% -- had taken them. Group therapy was commonly utilized; half our sample (N=48) had been involved in group therapy, and 51% had attended social support groups. A third (N = 31) had belonged to a self-help group such as Alcoholics Anonymous, Narcotics Anonymous, and Overeaters Anonymous. Another 15% (N=14) had used professional services for addiction.

"Alternative" methods of healing were frequently



used. Forty percent (N=38) had sought body work or energy work, and another 11% had used "other" types of mental health services such as acupuncture, biofeedback, cognitive skills building classes, family/marital therapy, meditation, occult practices, reiki, self-help books, and yoga.

One-fifth of our respondents (N = 20) had been hospitalized for mental health reasons. This represents 23% of the trans respondents and 23% of the non-trans significant others. No one who identified as non-trans and a friend or ally, on the other hand, had been hospitalized. Only

(Continued on page 5)

Mental Health Survey Results (cont.)

(Continued from page 4)

one of the 14 respondents aged 24 or younger had ever been hospitalized.

Reasons for Therapy

The vast majority of our respondents sought therapy for its own sake. Of the 91 who saw a therapist, just seven (8%) saw a therapist *only* to obtain a letter for hormones and/or surgery. Eighty-four (92%) wanted individual therapy, and thirty-two (35%) had sought couples or relationship counseling.

Nearly half (47%) said they had seen a therapist at least in part to get a letter approving them to receive hormones, and 27% had sought a therapist's help in obtaining a letter approving them

Other than asking whether people had sought therapy for a letter, we did not ask them to specify whether they saw a therapist for trans/SOFFA issues or something unrelated. And as some respondents pointed out, making such distinctions can be difficult, anyway:

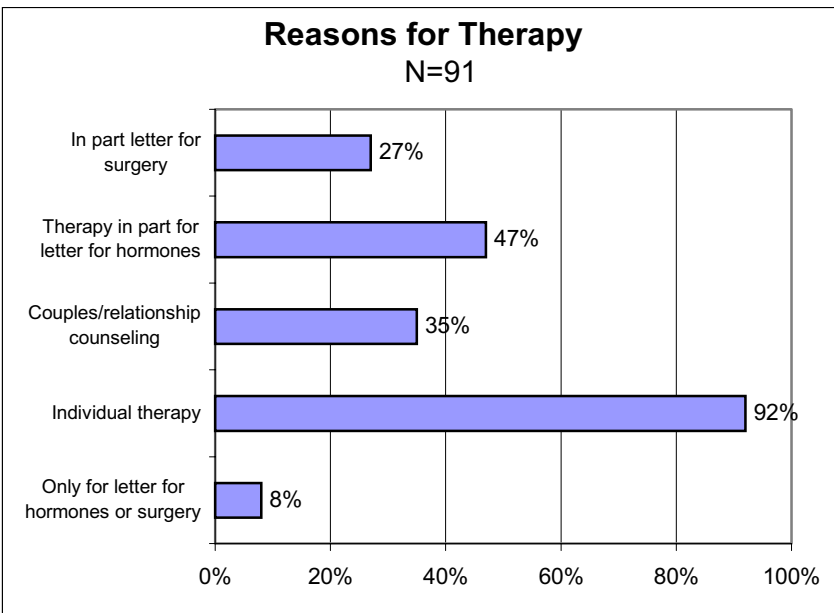
As a teen I was treated for depression and behavioral problems, but then not again until my mid 20s. After getting on anti-depressants I was un-depressed for the first time in my life. It was then that I was able to address a whole host of issues in my life, including my transsexuality.

The relationship issues that are already present can be really accentuated by a partner's transition.

I have been in and out of therapy for 20 years and it was my gender therapist who was the first person to suggest that I get checked for ADD [attention deficit disorder]. As it turns out, I have an anxiety disorder and ADHD! In the past, I've just been given antidepressants, which only helped slightly and temporarily.

I have noticed ever since I came out and admitted to myself that I am a trans guy I have felt better and happier. So now I am starting to take care of my mental stuff better.

Started treatment for depression before recognizing trans identity.



for gender-related surgery.

I believe that the process used to screen trans people is an adversarial process. I wasn't there because I had issues to work through, but because I wanted access to hormones. I found it a complete waste of time and money as opposed to the times that I sought therapy to resolve or address issues that were bothering me.

Diagnoses

Only eight of our respondents said they had no mental health diagnoses or declined to answer the question. Of the 88 respondents (92%) who had a mental health diagnosis, 73% (N = 65) had at least two.

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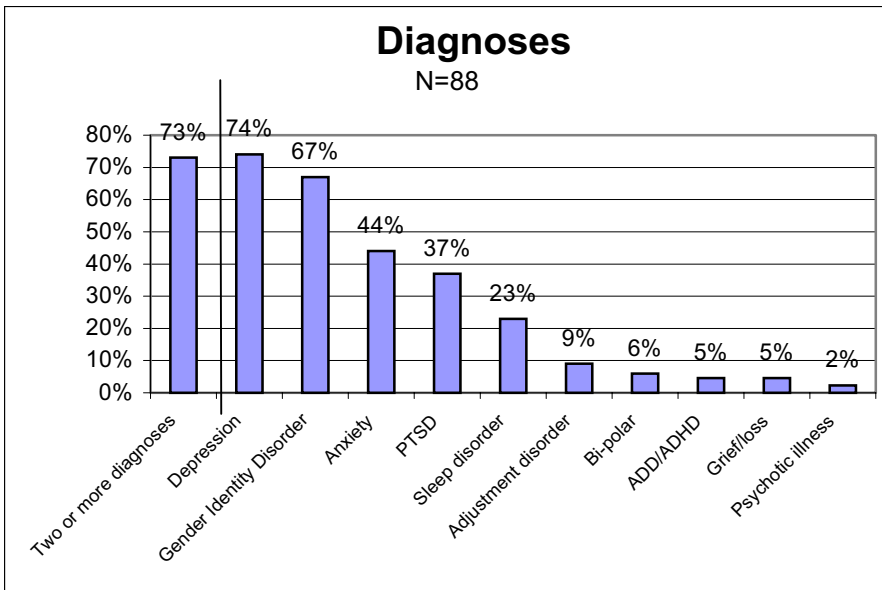
Mental Health Survey Results (cont.)

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Three-quarters (74%, N = 65) of the respondents had depression, and nearly as many – 67% -- had been given the diagnosis gender identity disorder. Nearly half (44%) had been diagnosed with anxiety, and more than a third (37%) had post traumatic stress disorder (PTSD). About a quarter (23%) had a sleep disorder.

majority, however (61%), had not considered it. One of the non-trans SOs had sought help for hir own gender issues as well as help in dealing with hir partner’s transness.

In contrast, none of the four non-trans, non-partner friends and allies had sought or considered getting professional help in dealing with trans issues.



Psychotropic Drug Use

Of the 89 persons who answered a question about psychotropic drug use, a third (35%; N = 57) were currently using such drugs and twenty-six (29%) had taken them in the past.

There was a significant difference in psychotropic drug use among trans and non-trans respondents: nearly half of non-trans SOFFAs had never taken psychotropic drugs (47%; N = 8), compared to only 27% (N = 24) of the trans respondents.

The other diagnoses respondents had were: adjustment disorder (9%; N = 8); bipolar disorder or manic depressive (6%; N = 5); attention deficit disorder (with or without hyperactivity) (N = 4); grief or depression due to a death or loss (N = 4); and psychotic illness (N = 2).

Of the 24 respondents with only one diagnosis, eight were non-trans SOFFAs. Trans respondents were therefore significantly more likely to have multiple diagnoses; only about 21% of the trans respondents had just one. The most common sole diagnoses were gender identity disorder and depression (both with 9% of all respondents).

SOFFA Therapy About Trans Issues

About a quarter of non-trans partners (N = 3) had received professional help to deal with trans issues; two others had considered seeking such help. The

The Practical Impact of Mental Illness

Our question about the impact of mental illness was poorly worded. (“If you have a mental health condition, how much has it interfered with your daily function?”) The question did not clearly distinguish between current difficulties and past difficulties, and some respondents designed their own new categories to make those distinctions. Because others may have used the existing categories to reflect past but not current issues, the numbers associated with these answers should be interpreted with more than the typical level of caution.

Fifteen respondents did not answer the impact question, six added comments indicating their difficulties were only in the past, and 15 said the category was not applicable. That leaves 66 who

(Continued on page 19)

Dear Gearhead:

I'm a female partner of an FTM who's had chest surgery and has been on hormones for 8 years. We've been a couple for 11 years and have been through a lot together. Recently, his hair has been receding significantly, as well as graying as he's growing older. I love him and his body, and have absolutely no vanity issues with his balding head!

However, I am the survivor of childhood sexual abuse. My abuser was balding and had short gray hair. I'm struggling with flashbacks much more these days because my partner's hair pattern is nearly identical to that of my abuser. We've talked about it a little, but I feel really bad that this is something he cannot help and it's triggering painful memories for me. I don't want to make him feel bad or self-conscious. I want to talk more with him about it; but also am just not sure how to change my subconscious reactions to the painful memories associated with his receding hairline and the connections it makes to my past, painful memories.

--battling with hairless(ness) in seattle

Dear Battling:

Many people are victims/survivors of childhood (and adult) sexual abuse. Recovering from sexual trauma often takes many, many years. Survivors and supporters can be surprised when another piece of the puzzle shows up from out of the blue and doesn't seem to easily fit anywhere.

Triggers (innocuous stimuli that "trigger" the recall of a memory) can come in many forms, and can come from the strangest sources. Triggers can be sounds, smells, visual or other perceptual cues.

If you want to work on reducing the power of this trigger, open communication with your partner is likely going to be an essential component. It may be more comfortable to bring this up in a

therapeutic setting (or in the company of trusted, good friends, or with other survivors/partners), so both of you can feel more supported. If you are going to discuss this with your partner alone, remember to pick a time and place that isn't filled with other stresses or challenges (i.e. not after a long day at work, or when one of you isn't feeling well). Of course, a one-time discussion likely won't change the triggering effect of his balding, but it's a first step in moving through this re-traumatization.

Although asking someone to change isn't typically emotionally healthy for either person, you may want to see if you and your partner could find some ways to make some minor or major changes - perhaps temporarily - until you work towards greater resolution of this issue. For example, would he be willing to shave his head or change the greying color? Would a change in his facial hair shift his appearance enough to stop or change your response? Can you work on focusing on his eyes or lips when you look at him, and avoid looking at his whole head? If this trigger is particularly strong during love-making, would he be willing to wear a bandana on his head or have the lights out? Again, asking others to change can infringe on their personal choices and identity, but some couples are willing to do a lot for their partners, especially when the changes are temporary and are part of a greater healing process.

Another suggestion would be to get a photograph of your perpetrator and one of your partner. Even though it could be painful, studying the pictures carefully and seeing all the differences - physically - could prove useful in combating the flashbacks. In combination with noting their physical differences, try making a list of all the positive qualities of each person. I bet your partner will have a huge list of positive characteristics!

Many individuals benefit from the numerous self-help books and resources available on sexual

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What to Look for in a Therapist: A Trans Perspective

by Reid Vanderburgh, MA

Making the decision about whether or not to physically transition is probably the most crucial choice any trans person ever faces. It can be helpful to have a therapist ally to facilitate this decision-making process. However, it can be counterproductive when the trans person encounters a therapist who is ill-informed about trans issues, and is unwilling to learn. A trans person with such a therapist ends up paying the therapist while also trying to educate them, and may not receive the very guidance they were seeking to begin with. You may be fortunate enough to have trans friends who have already educated a local therapist for you, who can provide you with a referral to someone who did good work with them. If not, however, you may end up shopping for a therapist and not knowing how to find a good one. Further, a therapist who works well with one person may not be a good match for someone else. You can't always expect to resonate with someone else's therapist, however well they've come to understand gender issues.

It has been my experience that clients in the beginning stages of exploring transition options often find it difficult to put their feelings into words and may not be able to express what they need from a therapist. For many, talking to me openly about their deepest feelings concerning gender and how it has played out in their lives marks a milestone, the first time anyone (other than trans friends) has ever taken them seriously or been encouraging in their inner exploration. While they look to me for guidance as a therapist, more than one has also remarked at the end of our first session how relieved they are that they don't have to *explain* as much to me as they felt they would to a non-trans therapist. "You already *get it*," one FTM client said, with a great deal of relief in his voice.

This client is fortunate enough to live in Portland,

Oregon, as do I. But what about the budding FTM who finds himself living in Tulsa, Oklahoma? Or the MTF coming of age in Butte, Montana? How different might Brandon Teena's life have been had there been an openly trans therapist in Lincoln, Nebraska? Most trans people end up seeing therapists who are not trans and don't have a great deal of knowledge about trans issues. This doesn't have to be a discouraging situation, however, if the client knows what questions to ask when looking for a therapist to help them process their way through these life-transforming decisions.

The first thing to pay attention to is how comfortable you feel with the therapist. If the energy feels wrong, if you feel uncomfortable with the therapist as a person (regardless of how well they understand gender issues), you are probably going to have difficulty establishing what's called a therapeutic alliance. Therapy is a joint venture – the therapist is the guide,

What matters most is that you feel comfortable with them, that they are willing to do their homework on their own time and not on your nickel, and that they realize that you are the only one who should be making decisions about your gender identity.

but the client must be able to fully trust the therapist as a person in order to take full advantage of the guidance. Be honest with yourself: It may be that you are going into the room *expecting* to distrust this person, which can end up becoming a self-fulfilling prophecy. There is a fine line between trusting your gut instinct and stacking the deck against the therapist in advance by expecting the worst.

If you feel good about your prospective therapist as a person, they've passed the first test. The next thing to explore with the therapist goes beyond their level of knowledge about trans issues. Most will not know much beyond the

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*What to Look for in a Therapist (cont.)**(Continued from page 8)*

textbook distinction between gender identity and sexual orientation. (Some older therapists may not even know this much, as such distinctions have only made it into human sexuality texts in the last decade or so.) What you really need to know about this person is how willing they are to learn about your issues *on their own time*. Are they willing to do internet research, to find resources to help them learn the issues? Are they willing to contact people like me to consult? Are they willing to rethink the paradigm they most likely learned in school, that being trans is a psychological disorder known as GID (Gender Identity Disorder)? Are they willing to consider instead that gender identity is just that, an aspect of core identity, and that psychological problems arising in clients are often a result of growing up in a trans-hostile culture, not an automatic by-product of being trans? These are specific questions you can ask of a prospective therapist, to learn more of their philosophy and flexibility in the face of challenging new knowledge.

Ask questions about how they view homosexuality. It is common that a therapist who reveals prejudices and blatant misunderstandings about gays and lesbians will also have a negative bias about trans people. What you are looking for is a therapist who says something like, "I don't think there's anything wrong with any particular sexual orientation. When I work with a gay or lesbian client, I don't try to change their sexuality, but help them accept that this is part of who they are." This is a therapist who views sexuality as a fundamental aspect of core identity, not as an issue of psychological pathology. More than likely, a therapist holding this point of view can also come to see that gender is likewise an aspect of core identity and not an issue of psychological pathology. This therapist has passed the second test.

The third test involves interpretation of the Harry Benjamin Standards of Care (SOC). I saw three therapists early in my own transition process. The

first two saw their role as determining whether or not I was trans. This is how they interpreted the SOC: They were supposed to ask me questions, based on the "symptoms" of GID, and then make a diagnosis. I didn't trust either of them, and did not do good work with them as a result.

The third therapist I saw asked me questions, also, but she was not going down a list of symptoms in order to make a diagnosis. She wanted to know how well I knew myself, and how well I knew what the various physical options were. She wanted to know whether my expectations of hormones and surgery were realistic. When she saw that I had good self-knowledge, and that I knew that hormones and surgery would not, for instance, make me capable of fathering children, she gave me a letter of referral for surgery, to use as I saw fit. The crucial difference is this: The first two therapists saw their role as determining my gender for me, while the third therapist saw her role as making sure I knew who I really was, on a deep level. It didn't take her long to make that determination – I only saw her for three or four hours. She is a therapist who would pass the third test.

In the long run, it doesn't matter much what theoretical orientation a therapist has, or what their favorite techniques or methods are. What matters most is that you feel comfortable with them, that they are willing to do their homework on their own time and not on your nickel, and that they realize that you are the only one who should be making decisions about your gender identity. In all likelihood, you will not be working with a trans therapist. But that doesn't mean you can't find a therapist with whom you can do good work.

Pulling Our Hair Out: Transition and Stress

By Elizabeth Maples-Bays, RN, BSN

Entering the world of the trans community can be a new and exciting experience for the female significant other of a transman. Meeting new people, going to local support groups, socializing with other FTMs (Female-To-Males) and SOs (Significant Others), going to conferences, reading the literature, interacting online...all of these things can be fun. They can also be utterly overwhelming and leave one with a real sense of culture shock. If being in a primary or other important relationship with a transman is new to the SO, s/he may be ill equipped to handle the changes that are coming. Many female SOs come from the lesbian community while others are bisexual or heterosexual before partnering with a transman. In any case, the entrance to the trans milieu may be simultaneously exciting and frightening for those of us who are new to this scene. Learning the terminology, watching our partners grow and change, helping them to feel more comfortable in their own skin...all of these things can be extremely rewarding.

But in many cases, the tides can turn fairly quickly once the "shine is off the penny". The stressors that are often inherent in the transition process can take their toll on the SO, the FTM, and the

relationship. I have personally been told more than once that the "transition belongs to the FTM". In the bio-chemical and body image sense, that is certainly true. But for any committed couple, the psychosocial changes are shared...not to mention the financial implications. The stresses can be devastating to all involved and can precipitate the need for professional intervention.

A lot of emphasis is placed in the literature regarding the necessity for therapeutic intervention in the lives of transpersons...and rightly so at times. In some cases, the SO may

have as great or a greater need for this as well, and, in fact, so may the **couple**. Couples therapy is often undergone by straight and lesbian couples in times of crisis in the relationship. There is no doubt in my mind that a crisis can well be precipitated when one partner transitions to another sex. Unfortunately support for couples that would encourage longevity of the relationship is nearly nonexistent in the trans community. It is unfortunate, but true that short-term relationships are all too common. If that is the desire of the two people involved, that is well and good. But many times relationships fail due to outside pressures that decry the needs of the SO to the point that it is really intolerable for her*...resulting in her leaving the relationship altogether.

The implications for the SO are myriad, and there is very little if any support for many of us on the local level. FTM community meetings are sometimes open to SOs, but are often solely focused on the needs and interests of the FTMs. If you live in a large, urban area, there may be a

support group for the SOs. These can often be helpful, however they can be harmful as well. The prevailing view in many trans circles that all things are wonderful when you are partnered with a transman can do a great deal of harm to

I have personally been told more than once that the "transition belongs to the FTM". In the bio-chemical and body image sense, that is certainly true. But for any committed couple, the psychosocial changes are shared...not to mention the financial implications. The stresses can be devastating to all involved and can precipitate the need for professional intervention.

those SOs who struggle with identity or abuse issues. The content of these meetings often consists of nothing more than information on how to be supportive to the transitioning FTM. The SO's needs are often completely ignored. The resulting feelings of alienation and isolation can lead to depression and other problems. Often these problems are addressed out of context, when they are addressed at all. The chance to give real support to a woman in need is often lost.

Other issues encountered by SOs include financial

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*Pulling Our Hair Out: Transition and Stress (cont.)**(Continued from page 10)*

stress due to the exorbitant costs of transitioning. Physician visits, laboratory tests, medications, surgeries, new wardrobes, legal costs, and all the other costs related to transition can put a strain on **any** relationship. Whether brand new or of several years duration, the relationship strain experienced by SOs and their FTMs secondary to bills, bills, and more bills leads them to a common area of conflict, for many couples. The reality of putting the SO's material needs aside for the entire transition period is a reality for many couples. Her health needs, in particular, may be neglected. Certainly mental health needs, unless of crisis proportions, are often set aside due to "lack of cash", especially since many health insurance plans do not reimburse for these types of services...or if they do, the co-pay is much higher than for physical health needs.

If you are an SO who is experiencing depression, anxiety, or other mental health problems and feel that you would benefit from professional intervention, it is just as important for **you** to find competent practitioners who are familiar with Gender Identity Disorder (GID) as it is for your partner. While other caregivers may or may not be well intentioned, if they are not schooled in this area they may not be able to adequately assess your situation and come up with a treatment plan that is helpful for you. You have probably already learned a lot about the needs of FTMs, the Harry Benjamin Standards of Care, the various terms and treatments involved in treating GID for your guy. But, have you ever thought that your needs are just as specific as his are? They are. A counselor or therapist unfamiliar with GID cannot possibly understand your problems without a great deal of preliminary research. If you come from a lesbian background, the same can be said regarding that milieu. If a counselor is willing to do the homework required, they can certainly **learn** how to be helpful, but it takes a commitment

on their part to do this. Many counselors are willing to do so. Some are not. The best way to approach this is to simply **ask** them in the intake interview what their experiences are in this area. If they indicate they have none, just ask them if they would be comfortable proceeding with therapy **after** they have done the required research or if they would be more comfortable providing you with a referral to someone else.

** This article is written from the perspective of a bio-female woman-identified FTMSO. The intent is to address the needs of such persons specifically without ignoring the fact that there are other types of FTMSOs. Those persons are, in my opinion, better qualified to speak to their own needs in this regard.*

TRANSCEND

Transgender Support & Education Society

...Working to support trans people, intersex people and SOFFAs through peer support, advocacy, development of community resources, and education/workshops for service providers on issues that affect our community relating to sex and gender diversity, equity, the law, the workplace, and health.

Check out our website for a wealth of information and the latest on trans and intersex issues in our community.

www.transgender.org/transcend

PO Box 8673, Victoria, BC Canada V8X 3S2
Tel: (250) 413-3220 Email: transcend@islandnet.com

By jane heenan, ms mfti <TSANevada@aol.com>

"People are blamed for their own oppression, and the mental health system works in conjunction with the legal and criminal justice systems to maintain the status quo." -- James I. Martin, 1997, "Political aspects of mental health treatment," p.43. In T.R. Watkins & J.W. Callicutt (Eds.), Mental health policy and practice today, Thousand Oaks, CA: Sage Publications.

Given the context of our transphobic and heterosexist culture, it would seem non-controversial to state that gender variant persons are at increased risk of traumatic victimization in a variety of ways, in a variety of environments, by a variety of persons. Some of these assaults are overt and take the form of verbal or physical abuse, while other kinds of abuse are the result of employment, health care, and housing discrimination, or exclusion from family and other social and spiritual gatherings and groups.

A variety of wounds -- physical, psychological, spiritual, economic -- also accrue in response to more subtle enforcement of normative gender rules in our simultaneously anti-sex and sex-pre-occupied culture: diagnosis as mentally disordered as defined in the Gender Identity Disorder found in the DSM-IV (APA, 1996); stereotyping via media images; and victimization and revictimization by law enforcement officers, and legal and political systems. These cultural demands are often internalized and create additional difficulties for gender variant persons who shame and sometimes hate themselves in what may be recognized as an understandable response to prejudice, hatred, and violence.

Additionally, many gender variant persons know others like them who have been murdered or mutilated as a result of expressing their individual gender identity and, like others who struggle with survivor's guilt, may suffer from the complicated affects of being a survivor in what may be characterized as a gender "war." An ongoing fear of victimization, even after many years of passing

as a nondescript member of one's chosen gender, often adds yet another layer to the exploration of the trauma endured by gender variant persons.

Indeed, professionals often encourage their patients to pursue a status as "normal" men or women, even, to cite a common example, telling persons to fabricate personal life histories about their childhood. It has been my experience as a helping professional that even trans persons who seem to pass even in such intimate places as in their marriages and in their gynecologist's office cannot pass in all places. Additionally, they often live in fear of meeting someone either from their past or who has a well-developed sense of reading trans persons. Some of the results of this fear of being read are not unlike the symptoms listed in the DSM-IV diagnosis for post traumatic stress disorder (PTSD): persistently re-experiencing distress as evidenced by, for example, intense psychological distress and physiological reactivity on exposure to reminders of one's lived gender history; persistent avoidance of stimuli associated with one's lived gender history; and persistent symptoms of increased arousal such as irritability or outbursts of anger, or hypervigilance, in a variety of contexts. What is even more tragic about the persons with whom I have worked who struggle with these contradictions is that a powerful component of healing, coming out, is simply not available to them. It is as if they had traded one lie for another during their transition from living in the role of "one" gender to living in the role of the "other" and that to tell the truth at this stage would threaten their very existence.

DSM-IV Diagnosis

There is presently a high degree of agreement on diagnosis of PTSD among the general population. Briefly, the DSM-IV diagnosis of PTSD includes four criteria: the person has been exposed to a traumatic event and responded with intense fear, helplessness, or

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*Gender Variant Persons and Trauma (cont.)**(Continued from page 12)*

horror; this event is persistently re-experienced; the person persistently avoids trauma-related stimuli and is emotionally numbed following the event; and the person has persistent symptoms of increased arousal following the event. Horowitz discusses a variety of causes of PTSD, including social, biological, and psychological causes. Biological responses to trauma, including chronic alteration of synaptic transmission of brain-alerting systems and changes in serotonin subtype chemistry, can cause a trauma-response cycle which leaves the person increasingly vulnerable. Psychological reorganization of internal cognitive maps or activation of latent, weak, damaged, defective, or bad concepts of self or of other persons in response to acute or cumulative trauma may cause dependent self-positioning, impoverishment of self-competence, or may lead to chronic emotional vulnerabilities such as depression, rage, shame, or fear. Failures in expected social support and exploitation of culturally less powerful persons by culturally more powerful persons are among the social causes of PTSD. These social causes happen to gender variant persons with great frequency and in many arenas.

The effects of these traumas and effective ways to promote healing for gender variant persons are not well documented within the professional literature of psychotherapy nor are they well understood by the vast majority of those who practice psychotherapy. This lack of documentation and understanding is the "epidemiological invisibility" of gender variant persons within a variety of arenas which include social, political, spiritual, and governmental institutions. However invisible, the trauma endured by trans persons is no less hurtful to these individuals.

Trauma and Gender Variant Persons

Gender variant persons face social and employment discrimination and are at considerable risk for victimization in a variety of arenas, yet there is no available research describing interventions for the unique population of gender variant persons who

have been victimized or who are suffering from the aftereffects of trauma. In addition, my perspectives as author, helping professional, and trans person inform my recognition that specific interventions which emanate from a transphobic culture and which are defined as modernist "treatments" for "symptoms" cannot be applied to gender variant persons without more careful consideration than effect sizes can show.

J.J. Sherman, in a 1998 article, "Effects of Psychotherapeutic Treatments for PTSD: A Meta-analysis of Controlled Clinical Trials," published in the *Journal of Traumatic Stress*, describes general goals of treatments for symptoms of posttraumatic stress. These goals include developing a realistic appraisal of threat, overcoming avoidance of the cues and reminders

Unlike trauma victims whose struggles result from singular events, trans persons may not be able to remove themselves from the experiences of trauma in their everyday lives.

of trauma, making meaning out of traumatic experiences, and working through trauma via re-exposure and subsequent reinterpretation.

For gender variant persons, Sherman's first goal, developing a realistic appraisal of threat, would include considerations in general areas such as personal, family and other relationships, work, and community. Personal considerations may include questions like how well does ze pass; how well does ze wish to pass; does ze seek a more stable or more fluid gender expression; and does ze have any experiences of positive acceptance of hir gender variant expression from others with whom ze has regular contact. Concerns about employment for persons with a job may include such things as what is hir work environment; is ze out at work; what is the status of hir state-issued documentation; what workplace policies, or legal or statutory

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Giving Voice: Gender Identity and Sexual Trauma

By *michael munson*

When I started openly discussing the possibility of medically and legally transitioning, I heard from other trans+ folks that no one wanted to hear about the details of their transness. It was taboo. The intricacies of transitioning or genderbending were supposed to be private matters. What could be discussed were the broad (and often superficial) aspects: name change, paperwork, how to get hormones, which surgeons were the best, etc. People weren't talking – and were often silenced by peers and professionals – about how gender affects partners, learning to love and accept our bodies (even if we were changing parts of our bodies surgically or hormonally), misogyny, male feminism, creating support networks for our parents and siblings, breaking free from patriarchal "macho" roles of masculinity, transitioning and ending up identifying as femme, or many other issues.

I started to quickly realize that the silencing was not enforced for my self-interest or healing, but rather was because of their discomfort...

These hard issues aren't the problem though. The silence is.

I know; I'd gone through the silencing before. Prior to transitioning, I had spend hundreds of hours in therapy working on issues that emerged from a trauma that occurred when i was 17 years old. Just as many trans+ folks have to fight to talk about all of themselves in therapy, I had to start confronting therapists who discouraged me from telling the details of my sexual trauma. I started to quickly realize that the silencing was not enforced for my self-interest or healing, but rather was because of their discomfort in hearing about blood, permanent cervical damage, screaming,

force, fear of future violence....

As I started refusing to live in fear and silence, I discovered that giving voice to the pain transcended it and transformed me into a stronger, more vibrant person who was not imprisoned by the dictates of others – both in gender and in healing from sexual trauma.

I had to speak the unspeakable, forge forward into uncharted territory, face the fears and images and constructs that haunted me, and be willing to accept the challenges and complexities.

Some of those complex challenges emerged within the contact of (or along with) my gender identity. One such challenge was confronting how I could want to become a "man"

when some men wield power with their penises. What would others ascribe to me based on what they saw as my gender? How could I live differently than many men in our society and not use "male power" in ways that were destructive or harmful? What kind of "hatred" was I holding against *all* men vs. acknowledging that some men (and women) rape? How could I both love men (wanting to be male, as well as being attracted to men) AND despise the culturally constructed macho masculinity that all "men" were supposed to aspire to?

Questions of masculinity, privilege and power are exceedingly intricate and likely won't be answered to my satisfaction and resolution in my lifetime. However, they were exceedingly important questions in my process of healing from a sexual assault on my female body and

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*PTSD (cont.)**(Continued from page 14)*

my masculine soul, by a male perpetrator.

People living with PTSD (post traumatic stress disorder) house memories in their bodies, just as trans people do. And like trans people, many individuals who have lived through inappropriate or unwanted sexual contact frequently disengage from their bodies. Even though I didn't/don't hate my body or have "off limits" zones, parts of my body contain what feels like very gendered memories and trauma. In some ways, the violence that penetrated my vagina also fucked my gender. I had been able to assimilate a masculine identity within a body that had an additional hole and a chest with excess tissue – but somehow the physical and psychic pain created dissonance between my identity/soul and the body it was housed in.

In order to accept and integrate the violence that had been perpetrated on my body, I needed the freedom to be able to talk openly about how my body was damaged, as well as how it had scarred me emotionally and spiritually. One therapeutic option that wasn't available to me – either before, during or after transition – was survivors' support groups. All of them were single-gendered. Men only. Women only. I not only didn't feel comfortable in "only" spaces, but I could not authentically talk about my experience. I did attend one all women's group very near the beginning of starting on hormones. I felt very uncomfortable, because I couldn't relate to the issues brought up by the others, and I also couldn't discuss things like how being raped affected my self-image as a gay man. I was asked to not return because I DID discuss being anally raped and discussed permanent damage, which made others feel uncomfortable.

Many years later, I had the opportunity to join a men's survivors group, run by a gay male therapist who has worked with many trans people as well as survivors. In the pre-screening for this group, he specifically asked me not to be out as a trans person in the group – or at least to not discuss any parts of my body (or history/experience) that were different from the non-trans men in the group. I had learned long ago that being silenced made me sick, so the choice not to participate was obvious.

One of the greatest gifts in my healing process, though, came as a complete, unexpected surprise. Something that could not be anticipated – and even if someone told me it would happen, I would not have believed them. Prior to starting on hormones, seven out of 28 days were frequently filled with flashbacks. The trigger of bleeding every month, multiple days in a row, from that area of my body – threw me into irrational thoughts and vivid imagery, creating a walking state of panic. I had one, minimal menstrual cycle after my first shot, and the flow of my PTSD has forever changed. The trigger that had long been tied for first in potency, was totally removed.

Clearly, for me, the process of striving towards greater authenticity – of reaching to achieve a higher Self – braided together the many cords of Truths within. Freeing myself from caged secrets was filled with roars and resistance – but freedom rarely comes from quiet passivity.

The visible emergence of my gender identity and the healing from sexual trauma were tightly intertwined. Finding voice for both – and not accepting or conforming to the dismissal, dislike, and enforced silence of either, by others – has created a life full of integrity and dignity.

By Strauss <ostraussey@yahoo.com>

When my friends at school turn eighteen, they always sarcastically exclaim, "Now I can buy porn!" (For whatever it means, they're never as excited about getting to vote as the whole porn thing. Such is our society.) They make fun of me for being young—I won't be eighteen until my freshman year of college—but they don't understand why eighteen is such a magic number for me.

Health providers aren't very friendly to minors. Most minors are on their parents' insurance, if they have insurance at all. Unless their parents are unusually cool, it's highly unlikely that transgender and transsexual youth will be able to find the support they need, let alone transition if they want to.

I remember the shrink my parents used to make me go see. She would meet with my parents after me, and tell them stuff I'd said. I had no recourse, as my parents were paying for the "treatment." I know that I've been lucky. I know who I am and that only dorks refuse to acknowledge/validate my identity (though that's often hard to remember after a long day at school). I have a support network of both online and real-world people. My dad has a great insurance policy. Oh, and yeah, I have a really hot boyfriend.

I was harassed for all of 10th grade due to my gender presentation, and assaulted on school grounds by one of those harassers. The school then refused to take action. I tried to kill myself. After that, my parents let me see an lgbt-friendly therapist, not the one they'd been making me see. Very cool. But I remember the day I finally stopped dancing around the subject and told my therapist, "I want t [testosterone]. I want to get my chest chopped off." I remember her response, too. Nothing about how scared I'd been to tell her, or that I'd been talking around it for eighteen months. Nothing about what options I had, or if she would support me through my transition. "You're not eighteen," she said. "You're out of luck. We can talk again after your eighteenth birthday."

So far I've been patient, though if I knew where or how to get illegal hormones, I'd be a lot happier.

I'll be eighteen in six months now, and can hopefully live my life the way I want to. I don't know whether my parents would have okayed me starting t, especially while still in high school. I highly doubt it, though I'll always wonder. They never got the chance to say no—the mental health clinic in my town did it first.

Connectivity Publication Schedule

The next four issues of Connectivity will be on Sexuality, "Only" Space, Hormones, and Spirituality and Rituals. See the grid for submission deadlines, survey cut off dates, and publication dates. All submissions are welcome via email (editor@forge-forward.org) or by snailmail: PO Box 1272, Milwaukee, WI 53201.

Topic	Deadline for Submissions	Deadline for Surveys	Publication Date
Sexuality	4/30/03	4/30/03	6/1/03
Only Space	6/15/03	6/15/03	7/15/03
Hormones	8/15/03	8/15/03	9/15/03
Rituals	11/15/03	11/15/03	12/15/03

Children of Trans Parents: Mental Health Issues

Interview by Loree Cook-Daniels

To get a sense of some of the issues children of trans parents might bring to therapy, we talked to Laurie Cicotello, adult daughter of an MTF parent and her spouse. Laurie was the original co-founder of Teenage Kids of Ts – TAKOTS – and has spoken widely at conferences and to the media about children of trans parents. She currently serves on the board of Children of Lesbians and Gays Everywhere (COLAGE).

Connectivity: Did you go to therapy after your dad came out to you about being MTF?

Cicotello: Yes. I was 14 when my dad came out, and shortly afterwards my dad recommended that I see her therapist. I saw this woman, a noted gender specialist, for about six months.

Connectivity: Did you find the therapy helpful?

Cicotello: No! It made things *much* worse for me. She explained that my dad was going to go through puberty, and that her puberty was far more important than mine. She told me to expect my dad to start wearing my clothes and make-up.

I didn't *want* my dad wearing my clothes and make-up! So I quit wearing make-up and I began to gain weight so that my clothes wouldn't fit her. What that therapist said to me about her puberty being more important than mine was very damaging. It's taken me a lot of years to pull out of that aspect of it.

Connectivity: Did she do anything positive for you?

Cicotello: She did give me good information about the trans community and the various types of trans people, and what changes my parent would go through. But that got pushed to the wayside because of what she said about the puberty issue. She did also help me get in touch with another daughter of a transperson who was

about my age, and we started Teenage Kids of Ts – TAKOTS. It was a group that met at the Gender Identity Center of Colorado for awhile, but no one ever came. The word was that people wanted their kids to come, but the parent always had some reason why they couldn't be there. Then my co-leader's mom decided she was going to try to distance her from her trans parent, and pulled HER out of the group. So I ended up just kind of being a resource for other kids.

Connectivity: What did you do with these other kids?

Cicotello: A couple of them had always been in trouble with the law, and I really started to figure out that the kids of trans parents a lot of times are just crying out for attention by doing crazy, weird, stupid things. I did it when I was 18, trying to get my dad's attention. You crave attention from your mom and dad so much you'd even get into trouble. When that doesn't get their attention, you take it a little further and a little further....

Connectivity: What can a parent do to help prevent this acting-out?

Cicotello: Kids in this community are invisible. When I go to [trans] conferences, I almost become the celebrity of the conference because no kids come. The trans parents are hurting so badly over the loss of their kids. Yet, they've kind of screwed it up. From the perspective of MTF parents, what I see a lot of parents doing is charging after their kids saying, "Wait, wait, read this pamphlet!" and the kids are like, "leave me alone!"

The problem is that everything revolves around the parent being trans. A lot of times there's so much self-centeredness in all of this, so much narcissism. They can't even see their families for what they are. All the attention that should be going to the kids is instead going to the trans

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Children of Trans Parents (cont.)

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parent. The parent thinks every conversation with the kid is their big opportunity to get the kid to understand their transness. I have people come up to me at conferences and say, "I sent my daughter your article. I know she'll love it." She probably won't!

If you really want your kid to be your kid again, put away *your* issues and talk about what *they're* doing. What's going on in *their* lives? Do something that shows the kid that your whole life doesn't revolve around your transgenderism.

They want us so badly to understand their issues! And it's so sad to watch that happen, over and over. If parents would just listen to their kids, we could get so much more done.

Connectivity: Could therapists help promote this conversation?

Cicotello: It's really difficult for therapists to break through this impasse because they don't see this aspect of the family dynamics. It's like when the focus of a family becomes the alcoholic. This is where the family falls apart, because so much is going on in the parent's life they don't have time for their kids. I just don't think the therapists are seeing this part of the picture.

One of the biggest complaints I hear from parents is, "I took my kids to therapist G, who knew nothing about trans issues, so I ended up teaching therapist G about trans issues." My question is, "Why aren't you talking to your kids directly? Why are you educating a therapist to educate your kids?"

There's always going to be some bias from the therapist. Parents need to take some initiative to make sure they really know what this person is going to talk to their kids about. Will the therapist look at where the kids are coming from? What is the outcome supposed to be? Is the goal that everyone has to be happy and ok with what everyone else is doing? If that's the case, it may

be that the parents need some help in creating a dialogue with their kids, or maybe the therapist needs to focus on why the communication in the family is such that the kids won't talk to their mom or dad about their issues.

One thing that definitely gets overlooked many times is that there may be other problems going on. A lot of times the therapist doesn't take into account all the other issues that are going on in the family; they just focus everything on the trans issues. If the therapist my dad took me to had been more inquisitive about me, she would have found out that I'd been sexually molested a few years before and had already developed something of an eating disorder, but those were never brought up. Then you slap this whole thing on me that my dad's going to wear my stuff...it was all about my dad and my dad's problems. There was no talk about communication skills or family skills. There was never family therapy with me and my mom and dad present. In fact, while I was going to the therapist, my mom didn't even know that I knew about dad.

Connectivity: Does it help when kids of trans parents talk to other kids of trans parents?

Cicotello: The kids tend to go into hiding. It's really difficult for me to find other kids of trans parents. I feel very connected to the parents; that's whom I've mostly seen at the conferences. But I feel very disconnected from the children. I would love to find more of a community, so we can talk about the issues. So often whom I hear from is the parent: "I just told my daughter about me and she's throwing up. Now what do I do?" or, "I have a three year-old; how do I raise him to accept my transgenderism?"

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Children of Trans Parents (cont.)

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Children of Trans Parents Resources

COLAGE

3543 18th St #1
 San Francisco, CA 94110
 Phone: 1-415-861-KIDS (5437)
 Fax: 1-415-255-8345

E-mail: colage@colage.org
 Kids of Gays --- Despite its name, this group sponsored by COLAGE explicitly welcomes children of transgendered persons. They have an e-mail list, a Web site, and an office in San Francisco. To reach them by e-mail, write KidsofGays@aol.com.

Families Like Mine

1730 New Brighton Blvd., PMB 175
 Minneapolis, MN 55413
 612-362-3389

<http://www.familieslikemine.com>
 General questions:
info@familieslikemine.com
 Abigail Garner:
abigail@familieslikemine.com

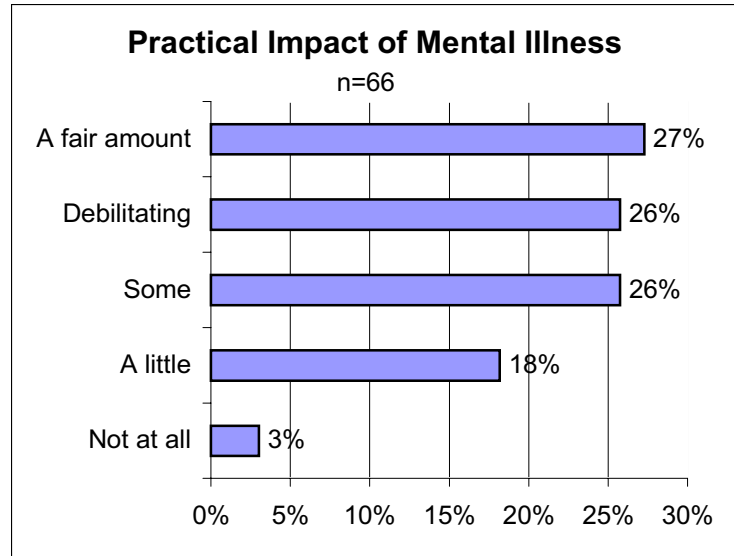
Dial-up and Adult Children of Transgender Parents email groups. For more information, contact julieg@AMNIX.COM

Trans Family Children Discussion List. For children of transitioning parents, including adult children. For information, contact info@transfamily.org, or see www.transfamily.org

Mental Health Survey Results (cont.)

(Continued from page 6)

may have a current mental health condition. Of these, about a quarter each said their condition interferes with their daily function "some." Only two said their condition interfered with their daily functioning "not at all." Eighteen percent (N = 12) said it interfered "a little." An additional 4% (N = 3) said their condition varied, was sometimes debilitating, or varied



between being debilitating and affecting their daily function a fair amount.

Mental Illness Attributed to Being Trans+ /SOFFA

The majority of respondents felt their mental health issues were due at least in part to being trans and/or SOFFA; only 18 (20%) said their trans/SOFFA identity was "not at all related" to their diagnosis, and 14 others (15%) said the question wasn't applicable.

Four respondents (4%) said their mental health issues were 100% (or "totally") related to being trans/SOFFA.

Since transitioning I have had no mental health problems. They were largely the result of denial and fear about being acceptable in the world as the person I am.

My struggles with depression and mental health have been directly related to my queer status and to body image issues generated by living in a culture that pathologizes

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Mental Health Survey Results (cont.)

(Continued from page 19)

any body that is "deviant" – i.e., anything other than thin, white, straight, conventionally attractive, and gender normative. Incidentally, queer communities can exacerbate this as much as the straight/mainstream world. It's surprising that this survey does not address this at all.

The [trans] experience is a very difficult one and it takes an enormous amount of energy to keep safeguarded. There is much sadness and frustration with no release for extended periods of time. Keeping the secret is definitely detrimental to one's health. My wife knows about my Trans issues and it has practically destroyed our relationship, I can't even imagine what it would do to what's left of my life. Thank God I have no children.

About a quarter of the respondents (23%, N = 21) said there was a "significant" correlation between their mental health and being trans+/SOFFA; the same number said there was "a little" correlation. Thirteen respondents said there was "a fair amount" of correlation.

My mood disorder is inherited, it runs in my family and my son has a similar condition. I was not diagnosed until a severe breakdown in my mid-30s but I am certain that without the co-existing gender dysphoria I never would have had that serious a breakdown or the full blown form of the disorder I now have.

Much of the daily abuse I've received in my life has come from how people have perceived me – making them uncomfortable with me. I've survived attempted rapes, been beaten up, and stalked and fetishized for being differently gendered.

On the psychological axis, I think having buried so many issues, the deepest-buried being my desire to be male, that of course I would get depressed recurrently until I had admitted them to myself and others.

Social stigma and expectations about gender, genitalia, and passing have impacted my mental health in negative ways.

It has occurred to me that my reluctance to make/keep/contact/trust friends is partly due to being closeted for so long about being transsexual.

Of course, the relationship between being trans and having a mental illness can be complex, as one person pointed out:

[S]ome of us get so caught up in feeling like something's wrong with us, but we're unable to verbalize it yet. So when a professional tells us we might be this or we might be that, we grab it. "Hey! So THAT'S what's wrong." It makes us feel better to KNOW something finally. Problem is ... most of the time it's just a side effect of the main issue that hardly ever gets delved into without a fight.

The majority of non-trans partners (but not friends and allies) said that being partnered with a trans person was at least a little related to their mental health issues. Although 38% (N = 5) said they weren't related at all and one said the question wasn't applicable to them, 46% (N = 6) said they were related "a little" and one said they were related "a significant amount."

Letter Requests Denied Due to Mental Illness

One of the primary fears of people who have a mental illness and seek medical assistance with a gender transition is that mental health gatekeepers will withhold their hormone and/or surgery approval letter/s because of the mental illness. Our survey showed that while this fear is founded, 91% of the trans respondents (N = 80) said they had never been denied access to hormones or surgery due to a mental health condition.

Seven of the respondents HAD been denied access due to their mental health diagnosis. Three were turned down seemingly out of the provider's

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A Journey For Parents Of Trans

By Mary M. Boenke, MSSA, MS
<MaryBoenke@aol.com>

Chair, PFLAG's Transgender Network, Mid-Atlantic Regional Director, National Board of Directors, frequent speaker and author of "Trans Forming Families: Real Stories About Transgendered Loved Ones"

Probably most parents of trans have a challenging emotional experience when their child, young or fully adult, comes out to them as a transgendered person. While "transgender" has become a familiar word to all those who watch TV talk shows or read popular magazines, we parents tend to assume, unconsciously, that nothing like that could happen in OUR family! And most parents would be right.

So it comes as a shock when one's child comes out as a trans person - female-to-male, male-to-female, cross dresser, or simply wanting to live somewhere in the middle. Shock may be considered the first stage of a common journey, originally identified as the grief process by Elizabeth Kubler-Ross. Parents tend to be numb, unable to talk about it even though they may say some positive things as, "We still love you; it will all work out OK."

The next step may include some denial, often taking the form of, "This is just a stage; surely you will grow out of it," "We'll find you a good therapist who can cure you," or even "How dare that therapist tell our child that s/he is transsexual!" Anger often creeps in here, too. Parents may feel that their child is doing this just to hurt them, to embarrass them, to get even for some long ago disagreement. Fear and hurt are both closely related to anger, i.e. we often fear and/or hate that which hurts us. Guilt is another feeling many parents experience. "What did I do wrong?" Or "I should have recognized this earlier and done something about it sooner," or more positively, "I should have been there for him/her sooner."

When parents realize this condition is not going away they often begin to grieve for the child they believe they are losing. A long loved son or daughter whom they fear they will never see again. Although this is a painful experience, it means parents are beginning to accept the permanence and seriousness of their child's condition. Grief and the accompanying tears are often necessary before a person can begin to accept the situation. If they were loving and caring before transition, most parents will eventually return to this kind of positive relationship. Some will get to acceptance more quickly; others may take several years. Full acceptance does NOT mean "I love you, I just don't want to talk about it." True acceptance means "I have many questions; let's talk about this; I want to understand. What can I read, who else can I talk with, I want to meet your new friends."

So what might help parents get to acceptance more quickly and easily? The most important factor, of course, is the parents themselves. If they have had happy nurturing relationships with all their children and hold family values in high regard, they will be eager to return to this. If they are outgoing, somewhat adventurous people with a variety of life experiences and friends and if they are not immersed in a church that preaches against sexual minorities, they will find this issue less troublesome.

Is psychotherapy necessary? Probably not, but those special therapists who are both knowledgeable about, and accepting of, sexual minorities can be very helpful. Such a person can provide support, perspective and reliable information. An uninformed therapist, or one with negative opinions, can make the journey even more prolonged and painful. One mother said she quit therapy when she realized she was paying for the privilege of educating the therapist!

Do children in the life of the trans person need therapy? Again, probably not. What they really

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Bodywork as Therapy

Both of Connectivity's editors see the same bodyworker, Kathy Morales of Milwaukee, to address their mental health, spiritual, and physical wellness needs. Because of Kathy's extraordinary ease with trans+ and SOFFA issues, we asked her to discuss with us what she's learned about and from trans/SOFFA clients, and how bodywork (also known as energy work) can support good mental health.

Connectivity: How would you describe the work that you do?

Kathy Morales: I listen. I listen deeply, slowly, carefully. Energy doesn't lie. I can "hear" what strand it comes from in the DNA. Is it learned? Inherited? Is it from the original teachings of mother and father?

By placing my hands on a person, I complete a circuit. We complete a circuit whenever we touch one another. Then I can hear what their body is broadcasting. All of us have this capacity; it's a matter of development.

We have this great illusion that what we do doesn't matter, but it does. It influences every other relationship we're in.

Connectivity: We've experienced first hand that you are able to sense many things about someone by simply being in the same space with them or putting your hands on them. What can you tell about someone who is trans?

Morales: My first "hit" from you, michael, was, "he's not what he seems on the outside." I immediately picked up gender questioning. You came out to me immediately, whereas most people wait to test me first before they share that kind of information. But I could tell when I touched your feet that you had female organs, ovaries. I could also feel the presence of hormones and other medications.

It was a refreshing experience for me. Although I'm familiar with the energy field of Lesbians and Gay men, this was a completely new configuration for me to feel. It added to my vocabulary.

You had a masculine outside, but a masculine/feminine force balance inside. Everyone has masculine and feminine forces or energy in their bodies. They are different aspects of a vital force that's present in every person. Those forces don't have to be about gender; they might be about power dynamics, or how the person presents his or her power to the world. There's an energetic imprint from DNA, which is inherited, learned, and a synthesis of the two.

What I found most remarkable was how harmonic you felt to me. Here was a model of someone who has a unique agreement of existing and added hormones. In fact, you have one of the most harmonic reproductive energies I've ever felt, more so than any other person I've worked with. It surprised me to find such a functional, optimal harmony among hormones and body in a trans person. It actually got me to stop blaming my ovaries for my own pain. You are so at peace with what you've created, it helped me focus more on what creates disharmonies in people.

Connectivity: What does create disharmonies?

Morales: A lot of distress that people feel comes from not being synchronized with their body and their energy. The mind races much faster than the physical. People often spend a lot of time on their projections, on how they want to be seen by others. We can get fixated on what we are and how other people think of us. When I'm working with someone, we slow down enough to listen together to what the body is saying.

Humans have an innate propensity to self-correct, but free will can interfere with that. Many people are so in their minds, their body just goes along.

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*Bodywork as Therapy (cont.)**(Continued from page 22)*

When I say I'm "listening" to them through my hands, it means much more than the word usually implies. I get permission from that person's body energy to work with it. Then I acknowledge the information I'm getting, which induces congruence. The body somehow recognizes it is being heard and, as a result, sometimes the person feels heard. Even if the person doesn't feel heard, focusing on its own experience allows the body to self-correct. It's not about me "fixing" things.

We don't expect to be heard, and we don't trust our own reality. That stems from most of us not being listened to as kids. Energy work then becomes empowering, a return to the natural instinct of registering emotions and life experiences through the body.

Connectivity: So is that "all" you do, help the body listen to itself?

Morales: Our bodies are always broadcasting who we are, where we've been, and where we're heading. Part of what I listen for is obstacles or resistances to getting where someone wants to go. Then, if the client is willing, we work on those obstacles or resistances.

But not everyone is willing. For instance, I worked with one man who was very, very invested in being recognized as an abuse victim. I couldn't find abuse in his body. But he maintained he was an abuse victim and would not let that go. He chose not to heal.

But choosing not to heal has implications, too. He became an abuser of his sister. We have this great illusion that what we do doesn't matter, but it does. It influences every other relationship we're in. I can read something about the people you're close to from your energy. For instance, kids can feel what's going on with adults, and act out in response.

If you do accept responsibility for your choices,

you can get really efficient about where you want to go and make radical changes, including in the people around you. Being ruthlessly honest with yourself is the hardest thing for people to do, but bodywork can help, because the energy doesn't lie. I can help people feel the truth through their body.

Connectivity: Depression is a big issue not just in the trans+/SOFFA community, but in the wider community, as well. What can bodywork do for depression?

Morales: There are different ways that depression expresses itself. It is a chemical experience, but stress can change a person's chemistry, particularly over a long period of time. Stress can build up and reach a critical mass. Very rarely does it just suddenly occur. Your mental health state is a function of how you've been living your life. Addictions, for instance, are often wedded to depression.

There is a difference between depression and mood changes. It is important to honor the cycles and patterns that individuals experience and continually go through throughout their lives. Often we are encouraged to not go through our natural cycles, which can be healing. Because our culture promotes mono-emotional states, some people end up living full time in their depression and use it as a way to be a victim, and to not state their truth. In living in this depression, they also disavow responsibility and the ability to choose another way to live differently - not as a victim.

Energy doesn't go away. Information takes up space in the body; it sits in the body until it is acknowledged. When that stored memory is not transacted -- dealt with -- it can really logjam the whole process. It backs up in our bodies. It can cause depletion of energy. We can adapt to these things mentally, but if we do that, it's at the expense of the body, which houses it all. The whole system runs better when the information is

(Continued on page 40)

Coping with Autoimmune Hypothyroid Disease

By Jan

Depression is part of autoimmune hypothyroid disease. In this condition, the body incorrectly turns the thyroid gland off before the thyroid can work fully. It is a self-allergy, perpetuated by a body whose immune system is working "better" than it should, overtime.

In a healthy person, the thyroid--located in the neck--helps keep the body running up to speed. This disease turns off the thyroid and causes all the body's internal organs to slow down. The slowness and cold are easily felt as depression. The slow sensation can be coupled with panic overtones, due to the body's attempt to keep moving by raising adrenaline levels. The depression, when combined with normally unhappy events, such as the end of a relationship or loss of a job, can become dangerously serious.

Even people with normal-sized thyroids, showing normal thyroid blood levels, can have the disease; especially those people showing as "low normal." The medical term for this is "subclinical" disease.

Most endocrinologists know nothing of the few studies done on women with this disease. Commonly, doctors know only of what has been discovered about men with this disease. As with many other conditions, the person with the problem must do the research and inform the physician.

Autoimmune thyroid disease can worsen--and become more apparent--at puberty, after pregnancy, and at ovulation. It is a problem sometimes seen in people who have a lot of other allergies. Full symptom lists can be found online.

There is no cure for autoimmune thyroid disease. Over years, it can cause damage to the body in many ways, even as basic as the cellular level. It may lead to other chronic autoimmune illnesses and increased risk for some cancers. There is no known way to prevent what may happen, but there are ways to mitigate subsequent illnesses.

Synthroid medication is a basic way to daily artificially replace the thyroid's function. Synthroid doesn't cure the disease but can retard its damage. It is important to find the right dosage; too much synthroid can be seriously harmful. There are also additional medical and mental ways to live with the disease without missing out on life. Various options can be used in combination, to see what works.

People with thyroid disease should learn what foods and medicines can agitate thyroid problems and iodine allergies.

For example, iodine is a common component of many medical imaging tests using internal dye, so if sometime you need these tests, you could get a benedryl IV drip, or receive the dye without iodine.

Iodine is also readily found in seafood.

Before taking any medicine, injection, or IV, know what it is in it--including its transport medium and preservative--and how these ingredients might affect you. Let your physician know why you need to know. Even if your doctor has told you what he or she thinks is in it, do the research yourself again on the internet to learn what the cautions are about your medication. Look for the word "thyroid" in the section about possible complications.

Autoimmune thyroid disease is often hereditary. But even in healthy people, it can develop permanently with the use of cocaine. The depression of the hereditary disease is chemically similar to cocaine withdrawal. Healthy people can also develop the disease by radiation overexposure or not receiving enough dietary iodine. That is why most people buy iodized salt.

Sometimes people with hereditary thyroid problems can additionally have other concurrent hormone problems, such as autoimmune pituitary. Closely related is hyperthyroid disease, in which

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Medical Strategies for People with Autoimmune Hypothyroid Disease

By Jan

1. You don't have to get through bad times by yourself. Set up routine counseling sessions, at least every three to four months, so that your therapist will know you in both good times and bad. Friends and family are also good sources of support. Go to them if you are having trouble hanging on; it's just not possible to hang on by yourself. If you are traveling and don't know anyone, hang out for awhile in a mall or another place where there are other people.
2. Seek out community support systems, such as local mental health center groups and faith organizations. Use skin moisturizers for dry skin, and brush your hair gently to lessen loss and avoid tying it back tightly.
3. Knowledge is power. Learn all you can by searching online resources such as Medline. Keep up with new studies. Print them off for your doctor. Get some control over what is happening to you by becoming informed.
4. Be sensitive to how other medications interfere with your well-being. I personally find that I get worse depression-wise on anticonvulsants, lithium, and megace. There are always alternative options.
5. Medications that are helpful to me are:
 - a. Synthroid, for thyroid hormone replacement.
 - b. Paxil; it makes cell walls more permeable and

can lessen cell damage. In me, it also keeps down the incidence of fainting, arthritis pain, and hot flashes. I believe it depresses the body's ability to overproduce damaging adrenaline. In some people, it also helps with depression.

- c. Crinone, a vaginal gel, allows me to ovulate normally (instead of just 3 times per year). Routine ovulation cuts down on the risk of uterine and ovarian cancer. [Editor's note: FTMs or people who are post-menopausal may be unable to ovulate regularly, and/or may not wish to.]
- d. I have uterine biopsies once a year, and uterine and ovarian internal ultrasounds once a year. Soon there will be a simple blood test as an additional check for ovarian cancer!
- e. I personally find no aid in antidepressant medications that are based on the principle of serotonin reuptake inhibitors (such as Prozac and Paxil). However, the historically older tricyclics work great for me, particularly nortriptylene. Tricyclics work because they "rev up" your slowed system.

Remember that nortriptylene can cancel out the benefits of Paxil. But even a small amount of nortriptylene, for as little as three to four months, can be helpful. For the normally bad events that happen a couple of times a decade, a few months on this tricyclic really helps give the footing from which to get some traction going on your own.

Side effects include difficulty reading, dry mouth, and dizziness; use Metadent peroxide mouthwash to combat dry mouth.

- f. Nizoral, prescription strength, for external use on chronic fungus infections.

Thyroid..... (cont.)

(Continued from page 24)

the gland is overactive rather than underactive.

All individuals, whether they have thyroid disease or not, should once a year have the thyroid felt by a physician. Many gynecologists routinely do this at a woman's yearly pap test. This yearly exam, accomplished just by the doctor feeling the person's throat, can help catch enlarged thyroids and thyroid tumors.

For more techniques for coping with autoimmune hypothyroid disease, see "Cognitive Restructuring Techniques" on page 42.

Dancing Through All of It

By Alan Giffith <Birdman@Inwave.com>

I consider myself lucky to have encountered mental health professionals who could treat me for a major mental illness while respecting my gender issues.

By respect, I mean they did not interfere with my process of change, did not discourage that process, yet they remained aware of the stresses that arose and helped me handle those. I am diagnosed with bipolar disorder, previously known as manic-depressive syndrome, and have experienced decades of mood swings that included periods with symptoms of psychosis, some of these periods lasting years. The serious episodes resulted in unemployment and disability, and poverty. I feel doubly lucky that I found excellent mental health care without insurance or money. This help primarily came from local agencies designed to help low-income people. I even feel lucky I was "crazy" enough and poor enough to qualify for such help.

Those care givers without background in gender issues never presumed to be even knowledgeable. I provided them with literature and contacts to introduce them to gender issues and they readily accepted this information. Likewise, physicians had to be informed about the basics of hormone therapy as I moved from treatment by a doctor living in another state to local health care. Developing local resources is a journey in itself and anyone who has gone through it knows the value of finding someone who has already taken this path. Finding a supportive counselor, or a gender self-help group, is crucial because that inevitably leads to referrals. A sensitive and open-minded counselor will know other professionals likely to be accepting.

One of my counselors attended, at my invitation, a transgender conference and workshop for FTMs. She later treated others undergoing gender reassignment. Finding such willing professionals has been a matter of luck and a matter of educating those who are open minded. Educating

those who are supposed to help you can be awkward and difficult, especially in times of depression, but it is, more often than not, necessary. That there are health care professionals willing to be educated about gender treatment is what's important until society reaches the day of greater consciousness.

I was already well underway in transition as I developed local resources. I do not know how already appearing male and sounding male affected my ability to find care givers. I did explore local possibilities asking specifically for counselors who could work with someone transgendered. I did not experience rejection. I was following through on referrals from professionals already involved in my health care. I stayed with professionals in the gender field through the early stages of transition and this part of the process was slowed by financial limitations. I did receive discounts from some gender specialists.

I even feel lucky I was "crazy" enough and poor enough to qualify for such help.

The biggest limitation on my gender transition due to

bipolarity was my own choice to delay making a decision to transition while I was experiencing psychotic symptoms. I did not trust my own mind; I did not feel well enough to proceed. I waited two years for my symptoms to subside and to be able to work again and have financial resources. When I finally was able to work again, I found a job in a mental health field, readily open about the bipolar disorder. About nine months into the job, I was ready for hormone therapy and informed my supervisors of my upcoming transition. Four months later I was fired. It was impossible to document that my gender transition was why I was fired. I did file a workers' compensation action which dragged on for five years and which I let fall by the wayside. By the time a hearing was actually scheduled, I had greater concern about publicity and notoriety than

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Dancing Through All of It (cont.)

(Continued from page 26)

about the slim to nothing chance of actually being found injured on the job.

I have been fired from the last three jobs I have held. In each of these instances, the gender issues played the primary role, each firing occurring within two-four months of people on the job finding out about my gender history. Again, in each instance, I was without recourse legally. In each case, my being fired was followed by onset of psychosis. It is my observation that a main ingredient in my breaks with reality was having to confront yet again the exposure of gender identity issues. To me, these issues are private and medical.

Each time I made significant strides in stabilizing, both financially and emotionally, I lost employment, then subsequently lost my savings. In my transition process this also meant delaying chest surgery due to the financial losses. This entailed another two-year wait while regaining the mental well-being to be able to work and to save money for surgery. Those years I learned the meaning of anguish.

It is not the gender issues themselves which have proved debilitating but the societal prejudice and discrimination resulting from the gender issues becoming known. I find it hard to blame people because of their ignorance, even an ignorance that is institutionalized. I believe that without bipolar disorder, I may have been able to handle differently the situations in which I was fired from jobs. I don't believe that legal action would have probably been successful but I do believe it may have helped pave the way to help others in the future in similar circumstances.

For me there has been a dynamic interplay between gender issues and bipolar disorder. Transition timelines were changed due to bipolar experiences involving thought disorder, due to reasoning in a time of unreason. Bipolar swings got a push from the terrible stress that resulted from major losses arising in the ignorance and

prejudice surrounding gender issues.

Likewise, my life is characterized by simultaneously learning to cope with bipolar disorder, with anxiety, with paranoia, with voices, and learning to fully actualize my identity. These challenges cannot be legislated away, medicated out of existence, or resolved once and for all.

I like to imagine a day when someone will be able to describe how a mental illness affected gender reassignment, when gender reassignment itself is seen as something rather ordinary. When people think, "Oh, yeah. There are some people like that."

For others who face multiple psychological issues, I say ask for help sooner rather than later. Keep asking until the answers fit. Be willing to try medications. They can perform miracles. Forget suicide; I think the anguish continues anyway. Learn stress reduction and use it always. And, you may think I'm kidding on this one, but I'm not: Dance. Every day. Dance through all of it.

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See page 38 for more details!

Sexuality Survey

The Trick with Self-Esteem is Having Some

by J.H.Ponce

Self-esteem, I wish I had some.

One is not born with self-esteem; it is nurtured. As we grow from childhood into adulthood, self-esteem, if we have cultivated enough through our lives, gives us the strength to be the best people we can be, it gives us the best chance to succeed and it keeps us from self-destruction, from becoming our worst enemies.

Just being alive is enough self-esteem to gain more, knowing that you want to love, to feel, to dream, and to be somebody to yourself, not necessarily to others, is self-esteem. Knowing that you have none is enough to start looking for some.

To pamper yourself is to nurture self-esteem; to do everything that makes you feel better about yourself is self-esteem. Others will not appreciate you if you don't appreciate yourself first, in other words, why would anyone think that what you are doing for them is important or special when you are always doing for others rather than for yourself? It loses importance because it's your routine; it's what is normal behavior from you. Now if you are always taking care of yourself first and for a change you do something for somebody else—Wow! People will appreciate the fact that you actually took the time and effort to do it. You make them feel special because what you did for them is special.

I found out not too long ago that depression was just anger turned against oneself. I believe this to be true. I am angry and I am angry at myself and at the world. Angry at the fact that I have not stood up for my decisions or myself. Angry because I have not been honest enough to gain my own trust; angry because I consistently allow others to dictate what I do or don't do; angry because I'm afraid; angry because I've depended on other people rather than myself; angry because I've been hurt and disappointed. Angry because I've let my

Self-esteem is the "Golden Egg". It makes giants out of us. Self-esteem keeps us honest and allows us to love freely without contempt, envy or fear.

dreams slip away; angry because I have not allowed myself to be myself. Angry because I can't stop feeling angry. Angry at the fact that I've lost all my self-esteem. Angry because I'm always depressed even when I think I'm not.

A little self-esteem would have kept me from making so many mistakes and not regret the ones that I have made and a little self-esteem would have kept me from feeling and thinking this way.

Self-esteem is the "Golden Egg". It makes giants out of us. Self-esteem keeps us honest and allows us to love freely without contempt, envy or fear. It helps us understand and accept responsibility for ourselves and our actions. It helps us make the right decisions and it helps us do the right thing. It makes loving ourselves and others if not easy, easier.

- Can I remember when it was I felt full of self-esteem? Yes.
- Can I remember what that felt like? Yes.
- Do you know what self-esteem feels like?
- Can you remember?

- Self-esteem allows you to accept yourself for who and what you are.
- So, what is the trick with self-esteem? Having some, that's right.

It doesn't matter how much or how little you think you have, all you need is some. If you can say to yourself "I don't have any" then you have enough to realize that you don't have any and that is enough to get some more and more becomes more. It's sometimes not easy but it is simple.

Start with doing a little something for yourself everyday, even when you don't feel like it, do something that you enjoy, it doesn't matter what it is as long as the outcome makes you feel better. It could be fixing something broken or simply taking a hot bath, it's your choice.

That's the trick.

Not Your Choice

By ~Mel <SelectivelySane@aol.com>

You can't move.
 You can barely breathe.
 Each day makes you withdraw worse from reality.
 At least what they call reality.
 With its restrictions and judgements,
 And false rules that contradict each other.

They suppress and disapprove
 And shake their empty heads
 They talk but never act...
 Scream but never move.

You want to get out...
 But it's all that there is.
 You want to walk proudly
 But you're not what they want.

You don't fit into their mold,
 You don't walk that straight path.
 You never do what you're told,
 You don't wear the right clothes,
 Or say everything they want to hear.

They don't understand why you need to be
 "different." Why you feel you need to act this way.
 You say and repeat it...that it's not your choice.
 They can't hear the words you say,
 It's like you don't have a voice.

paranoia

Alan Giffith <Birdman@Inwave.com>

when the invisible psychic cops came for me i pre-
 tended i was going to the laundrymat and fled the
 state with a load of dark


how do you keep a secret
 when THEY can read your mind?
 head south reading no road signs

follow the crows to another world
 where angels drive the car while terror shakes you
 like a rag doll

you stand in two realities, one shared
 one with delusion's privacy,
 and try to make sense

you sleep the first good sleep
 on your mother's couch;
 she kissed the ouch

and everything you think
 becomes a suspect
 you interrogate



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By Loree Cook-Daniels

They kept coming, mostly by email, for months. Each was stated in emphatic terms, brooking no argument, asking no questions. They were the reasons why my life-partner had killed himself. I heard:

- He realized his transition was a mistake he couldn't fix.
- Being a Black FTM was too hard.
- He couldn't handle being in an interracial relationship.
- He had been devastated by an "affair" I had.
- He was selfish.
- He was married to a bitch.
- He was trying to signal he needed help, and I missed the signals.

At first, each missive had me crying uncontrollably for days; what was it that Marcelle had said to these people that he hadn't said to me? I even once sent out a widely-broadcast email asking people to tell me what they had heard from Marcelle. After all, a crucial stage survivors of a suicide go through is trying to figure out exactly what happened, and it seemed clear from the tone of these emails that their authors knew something I needed to know.

Eventually, as I began to regain a grip on reality, things began to occur to me. I realized that most of the people who were saying these things *had never talked to Marcelle about what was going on*. A couple had never even met him! *None* had talked to me about what was happening immediately preceding his death (or, for that matter, about our 17 years together and what I knew of his history and state of mind), *none* had been present at any of our dozens and dozens of therapy appointments, and *not one person* had read his suicide notes. Upon what, then, were they basing these pronouncements of what had been going on in my life-partner's head

during his last, fatal, dance with alcohol and pills?

As I continued to try to make sense of where these people were getting their information, it began to dawn on me that some of them – take as an example the anonymous lesbian who charged me with causing Marcelle's death by "allowing" him to transition – HAD no information about who we really were. Where her information came from was, quite simply, her own head. For her, transitioning F-to-M was so horrible that she believed it would lead to suicide. The woman who said Marcelle couldn't handle being in an interracial relationship (which we'd had for 17 years!) turned out to have a failed interracial marriage herself.

I began to think that what was going on was scriptwriting. People were taking pieces of reality – Marcelle had committed suicide – and making sense of the "why" using their own experience and beliefs. What they were telling me was what was in *their* heads, not what was in Marcelle's.

There wasn't (and isn't) anything wrong with these people using snippets of Marcelle's life to work through their own thoughts. The problems came when they (and for awhile, I) couldn't recognize the difference between the stories they'd made up and Marcelle's actual experiences, thoughts, and beliefs. They wouldn't accept what *really* had happened and what Marcelle had *actually* said; when I tried to tell them these things, they told me I was mistaken, deluded, deflecting blame, or didn't have all the pieces.

Who, exactly, were the crazy ones here: the scriptwriters or me? As I wrestled with this question, I began to realize the answer was none of us. In scriptwriting, there are two realities. The scriptwriters' stories are as real as mine;

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Coping With Others' Scripts (cont.)

(Continued from page 30)

they are based on things that have actually happened to them and that they actually believe. The problem is, they have named the people in their stories after people in my life, and then forgotten there is a distinction between the two. The Marcelle in the scriptwriters' stories is, to them, the same person as the Marcelle who actually lived and died. It's like the people who get mad at actors who have played evil characters; they've SEEN this man kill people; of course he's dangerous!

Once I began thinking that what people were doing around Marcelle's death was scriptwriting, I began recognizing scriptwriting in many places. I recognized it in the therapist who said I'd moved Kai and myself across country "too fast," and in my father's statement that my parents taking Kai on a vacation couldn't "be a permanent

solution." I began recognizing past scripts, such as my mother telling me my aunt "had to be unhappy because of what her kids do to her" even though my aunt said she was fine with their

behavior, and in her telling me that it was my fault my best friend left me when I came out to her. Then I realized that the phenomenon happens to trans people and SOFFAs all the time: "You just want heterosexual privilege." "You're doing this because you're not willing to look at your internalized homophobia [sexism, hatred of men, etc.]." "Your parents must have done something *really* wrong for you to be so mixed up." Indeed, scriptwriting is rampant everywhere: "If you'd only stayed in school like I told you, you'd be happy." "Anyone who doesn't want children is selfish and immature." "How can you live [eat, watch so much TV, have so

Then I realized that the phenomenon happens to trans people and SOFFAs all the time: "You just want heterosexual privilege." "You're doing this because you're not willing to look at your internalized homophobia [sexism, hatred of men, etc.]." "Your parents must have done something really wrong for you to be so mixed up."

many piercings, etc.] like that? It's so unhealthy!"

I've learned that scripts can be dangerous. Once a script with a character named after you is written, it keeps running. (Think never-ending soap operas.) When you take an action that seems out of step with what the character in the script would do, the scriptwriter may object. For example, at the 2001 True Spirit Conference, several people saw me with my partner Michael in a "sex workshop" and decided we were being too affectionate with each other. They felt we were "disrespecting" Marcelle. The reality of what happened is that I was being triggered by what the presenters were saying into flashbacks about some very positive and negative experiences Marcelle and I had had together in the months before he died. Michael, who recognized what was happening, was trying to

give me some privacy and dignity by curling his arm around me and having me cry into his shoulder. But the observers had written a script about me, Marcelle, and Michael, and interpreted what

they saw based on that script. Their resulting outrage at what they termed "inappropriate affection" led a group of them to take off their name badges, wait until they could get Michael alone, and verbally assault him.

On another occasion, one anonymous woman who, as far as I could understand, had never spoken to me or Marcelle about what was happening before his suicide, was so convinced of the reality of her script that she thought she could use it for blackmail. Angry about a criticism of Alix Dobkin that I'd posted on an

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Many Genders, Many Butterflies, Mary Poppins

By D. R. Yonkin, CSW

"From... the recent discovery inspired by the Hubble telescope that there are at least 50 billion galaxies, our traditional ways of seeing and existing are being challenged.... And just as chaos theory in the nineteenth century disrupted reductionistic and mechanistic views of the universe, transgender theory as we near the twenty-first century is shaking up reductionistic and mechanistic ideas of the 'known' body we live in. Fixed ideas of gender bipolarism are wavering, forging a revolution on bodies and consciousness that embraces their complexity. From this new vantage the emergence of at least 50 billion galaxies of gender becomes a distinct possibility."

Gordene O. Mackenzie, *50 Billion Galaxies of Gender: Transgendering the Millennium*. In *Reclaiming Genders: Transsexual Grammars at the Fin de Siècle* (Kate More and Stephen Whittle, Editors).

A most beautiful quote, the above, written in 1999. Besides beauty, it conveys the truth of greater glories to come, in ways that can't really quite be grasped—although there are fingertips near or upon realities that modern technology and society are able to slightly open windows and doors upon. The Universe is no longer a windup machine of some inhuman master deity, intent on punishment for failure to find the key that will keep it running—it never was that kind of toy, but that was how people came to see and believe and become somewhat stubbornly fixated in. Now, the Universe is experienced as Consciousness, and the more Consciousness, the more Universe there is to experience.

The trans experience can be perceived as a living art experience, far ahead of its time, like Picasso, or Pollack, or Bob Dylan, or the Lescaux Cave Artists, and far ahead of socio-technology's own tentative grasp. Until the new godling, "MedTechSci", learns to relax a bit, loosen its tie, let go, the butterfly of trans experience will

continue to be battered and bruised at great expense—by a science that thinks it can make butterflies out of caterpillars, the same science that would have us believe that some people are caterpillars to begin with.

As I'm a transpositive therapist, a number of people who believe they are caterpillars have gifted me with their time, presence, courage and stories—and pain, lots of it, every colour of the rainbow, if pain can be a rainbow—seeking answers, support, a way out of the frozen hell the Organizers code as "depression". Most people wear multiple masks, usually every second of their lives, layers of them, blurring and shielding the never-ending child beneath. Yet there's that one expression always there, evolved over a lifetime of pain from an interrupted metamorphosis, and showing through all these "caterpillar" visages. This expression is not a mask—it's Truth. This Truth, which has no voice at that point, conveys in its expression all the words a child knows before it can speak: "See me, accept me, understand me, and love me." I don't know how much it matters that I'm a "therapist"—another label, really, but I do know how much it matters that my own face reflects back their Truth.

There are people who view a Pollack painting as anything but art, rather as unfinished, incomplete, a mess, to be ridiculed, perhaps destroyed. The Organizers labeled it as a form of "abstract expressionism", and because they could make a profit, turned Jackson's best efforts at trying to convey the expressions of an exquisite pain, quite beyond their ken, into something to objectify and collect. These reductionists and mechanists, whom Citizen Mackenzie refers to in the above quote, cannot or will not understand, much less accept, the reality of intense pain that so many persons experience when their inner gender experience runs contrariwise to their outer sense of body and space. These scientists, these tinkerers, are the same ones who prefer to dissect a butterfly in order to add to their collections of

(Continued on page 33)

*Many Genders, Many Butterflies, Mary Poppins, (cont.)**(Continued from page 32)*

organized conceptualizations about how it got that way, rather than just seeing it, accepting it, understanding it and loving it.

This organizing, conceptualizing, theorizing, *labeling*, of trans-truths and trans-beauty disturbs me; this method takes, rather than gives. There is no law that the Ten Thousand Things of the Universe must be named, must have a label. Labeling is a rudeness that refuses to simply ask, "How might I greet you?"

Contrary to popular myth, Adama and Evian *didn't* get to name all the new beings arriving into existence around them, hence getting to be in charge of them—It was much more exciting, loving, authentic, to simply ask, "Besides Beauty, what other names might you have?". The asking allows more beauty to arrive, and in this way, *labels*, when self-expressed, become the bearers of infinite galaxies of expression and being, but only if there is complete freedom. Where there is complete freedom, infinite labels can come and go as they please. The Universe loves to be asked, to be thanked, to be given gifts and to gift back.

While recently completing a practical contribution to academia—the "trans chapter" in a text book for graduate social work students—it seemed at first to be cosmically significant, even an honour, that I could present contemporary, non-pathologizing words, terms and phrases to contemporary, helping-minded people, thus contributing to "forge a revolution on bodies and consciousness". Then, after labouring away for mind-numbing weeks trying to find a way to continue that thought in the section on "theories", I realized two things. One, that I'm rather a non-theorist. And two, that if you keep saying the word "label" quickly and over and over again, it starts coming out sounding exactly like "blah, blah, blah". Try it and see. The label is not the thing itself.

Somehow, I've reached a personal realization,

probably helped along by an otherwise useless but fun degree in art history obtained many years ago, and a more useful, fun one in painting, that theories about trans attempt to accomplish the same thing theories about painting try to do: cover them up; obfuscate them while remaining convinced they've been "explained". Theories are ideas, not the paintings. Theories accomplish nothing after the fact that the painting accomplished *everything*. Theories can be lots of fun, even if taken seriously, since there's always

someone around to make fun of them. They provide a lot of entertainment for many people, and on many levels. I'm just not a very good candidate for being drawn into the kinds of academic ankle-biting that goes on in "transgender

identity development" circles, unless perhaps I get to wear an impressive hat.

When a human creature in pain is sitting across from me, and I see the one or more masks, usually on top, the expressions of which intimate, "Why am I the way I am?" or "What's wrong with me?", or "How did this happen?", I cannot offer a theory, nor a label, or hand them another mask, to cover up the pain. I get asked those kinds of questions a lot, and I'm always reminded of the scene from the film "Mary Poppins" that made a worlds-shattering impression on me at the age of eight. After Mary's big, exuberant, magical dance with the chimney sweeps all over the neighbourhood roofs, down the stairs, through the parlour and out into the street, Mr. Banks, the head of the house, demands, "Will you be good enough to explain all this?", to which she replies, "First of all, I would like to make one thing perfectly clear. I never explain anything."

And interestingly, mysteriously, I find that repeating "supercalifragilisticexpialidocious" over and over quickly never comes out "blah, blah, blah." It is what it is.

Where there is complete freedom, infinite labels can come and go as they please. The Universe loves to be asked, to be thanked, to be given gifts and to gift back.

What Are You Searching For? The Real Work of Gender Therapy

By Zantui Rose <zantui@juno.com>

Fifteen years of providing therapy service to hundreds of people, with a variety of presenting issues including gender, has convinced me that answers for the concerns of the physical world can only be found in a deep experience of Spirit. This truth is crucial for people who are doing gender expansion work. To explore one's gender questions without looking deeply into one's spiritual path is to have tap shoes on without knowing how to tap dance. Simply owning the shoes does not deliver a performance.

The matter of Spirit is sorely lacking in the transgender community as in the culture at large.

Most often when someone enters into a therapeutic relationship for any issue (questions of gender being one of them) they are looking to solve their problems in a tangible concrete fashion that can be measured. They want answers, skills, ways of reasoning and a body of knowledge that will give them the illusion that they are in control of the happenings of their lives. They want order in a chaotic and toxic environment. At a foundational level, this exploration is important. However, if one stops here in their process, they will revisit their confusion.

If a gender-variant person bases therapy on questions and answers about hormones, bi-polar gender choices, surgery, living full time and coming out to the world, they are acquiring only the shoes. One still does not know how to dance. Learning, teaching, talking about and accepting gender expansion as part of our Spiritual awakening is to begin the dance. This, I believe, is the heart of the work of the caregiver who is administering to the transgendered person. However, a large percentage of gender explorers are not interested in opening themselves to the work of awakening Spirit. What they want is to

Therapeutic work about transcending gender is the work of a Spiritual movement.

know they are not "sick" and, most important, they want their referral letter moving them along the tracks of gender duality shifting. Stopping the train long enough to look at the bigger picture is time consuming. I believe the bigger concern is that Spiritual awakening just might derail the train, causing them to question their direction entirely.

Therapeutic work about transcending gender, is the work of a Spiritual movement. It is learning to live in a rainbow of personal expression, a continuum that holds no division lines, a movement of personal energy that expresses itself in many directions. It is coming to an energetic vibration that has the freedom to go anywhere, to swing, to twist, and turn creatively. It invites us

to let go of the restrictive notion of the divisive male-female polarity, which is merely based on conditions constructed by the present-day science of our system. I'm not talking about androgyny or homogeny. I'm talking about movement - now here, now there... all, some, none - a spiral of continuance of expression. Nothing is closed, and nothing is out of bounds, because there are no boundaries to trespass.

When we question the separation of humanity into two genders, we challenge the primary tenet of a fear-based system that teaches us to divide and conquer. Learning to judge racial, cultural and class variations divides us further. Authorities to which our fear-based mentalities have given power - medical practitioners, psychologists, politicians, religious leaders - have insisted on the present-day separation of women and men because these dynamics are part of the scaffolding of the system that sustains their authority. The division of humanity into two genders is the most long standing and rigidly enforced of all stereotypes, and it persists in the therapist's office. We are obsessed with gender division, as it has become our cultural glue. The entire perception of this illusion must be challenged and eventually transcended. We must commit ourselves to the

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What Are You Searching For? The Real Work of Gender Therapy (cont.)

(Continued from page 34)

dismantling of gender in order to move further toward Spiritual Truth, which should be the work of the caregiver.

When any one of us unplugs from even one aspect of the conditioned illusion, in this case gender duality, it pulls out one piece of the energy that has helped to create it. Eventually, there is no longer enough energy to keep creating the illusion, and it dissipates. In this moment of dissipation, we have an opening, an opportunity to find Spiritual Truth.

In the world of pure Spirit energy, sublime relationships exist and there are no static opposites. All is one, and everything progresses from one to the other in a never-ending circle. Can we evolve from a species that created the concept of gross relationships of gender opposites, to having the wisdom of sublime relationships – all of us parts of the same whole – a continuum of the immutable Truth? Aren't we all, each of us, a piece of the Divine Creation? When one steps into the greater world of pure energy, this package we call our "individual energy frequency" takes on a new wholesome perspective.

Life in form, is Spirit's giant sandbox and we are here to play. To play is to be spontaneous. Play helps us observe and accept that life is about change, process, growth. If we think of ourselves as a gender, we become an "end result", we become a stagnant "product". The body has been given to us as a gift to experience all the gifts around us. Bi-polar gender has given us rules to live by that restrict our breath, restrict our play, restrict our Spirit.

There is an ache in all of us to actualize our Full Self. Some are more conscious of this ache than others. We feel there is something missing, we feel the void, the hole, the loneliness of the lost Self. This hole is deeper than gender, and to let go of the belief that your thoughts, your body-form, and your assigned gender are the total substance of you, is to touch fear. It is the fear of

being truly whole that keeps us stuck in gender duality.

I believe it is the caregiver's job to invite a vision of no gender, a world without gender, to imagine everyone around you free to play, to express, to freely adorn themselves, to love whomever, to create over and over, every moment – a new expression of Spirit in form. Everyone must give themselves the permission to shapeshift into ALL the possibilities. This is what life in form was meant to be - a creation with no boundaries, with no end to the creation.

If we can come to the game of gender with a consciousness of the play, it opens up a whole new field of expression. It allows us to finally completely face the void, to realize the loneliness of shutting away part of oneself, and to bring to the experience of life all of oneself - to create ourselves as the Creator intended. There are no gender rules here, not in the Spirit's playground.

What an honor it is to have the privilege of helping people to wake up on their evolutionary gender path. To stretch beyond gender is to have fun. Hafiz, a 14th century Persian poet, wrote: "I view gender as a beautiful animal that people often take out for a walk on a leash and might enter in some odd contest to try to win strange prizes."

If a 14th century poet can view gender this freely, isn't it time we wake up? If, when involved in the therapeutic relationship people are not pursuing the deeper matter of Spirit that their gender expansion is pointing to, they are only buying the shoes, and I will miss them on the dance floor.

Transgender Aging Network's Primer
now online

This paper covers definitions, the social implications of transition, issues specific to transitioning in later life, the role mental and physical health professionals play in transition, SOFFA issues, health care, legal and financial issues in later life, social concerns, and implications for service providers and advocates, including a discussion of the challenges involved in integrating heterosexual trans people and SOFFAs into groups traditionally focused on lesbians and gay men.

www.forge-forward.org/TAN/

Gender Variant Persons and Trauma (cont.)

(Continued from page 13)

employment protections exist; and are there particular threats to safety or the existence of positive support in hir work environment from specific persons. For those who are unemployed, considering employment issues may include asking questions like what work environments match hir skills, interests, and abilities; how might ze best go about gaining employment as a trans person; will ze be out on the job; how has ze been generating income without formal employment; and what fears does ze have about possible homelessness.

Appraisal of family and other relationships may include such matters as what is the status of hir primary relationship; is ze out in hir primary relationship; is ze out to all or part of hir family; does ze have children; do child custody disputes exist with hir partner or other family members; what local legal precedents or statutes, if any, exist regarding a trans parent's child custody; and what is the status of hir available personal support structure. Community considerations might include such questions as what is the status of the local trans community; how are trans persons recognized within the local sexual minority community; how does local law enforcement view trans persons; and is ze aware of the frequency of assaults and murders of trans persons. The review of these issues and others more applicable to particular individuals will help identify which areas are of greatest possible threat.

Sherman's second goal, overcoming avoidance of the cues and reminders of trauma, can be especially difficult for gender variant persons. Trans persons cannot remove themselves from our transphobic culture which informs each of us in a variety of ways and through a variety of persons and institutions that the expression of gender variance is shameful, sinful, evil, immoral, disordered, illegal, profane, and wrong. These cues and reminders of trauma are prevalent in so many and in such seemingly innocuous places even from out of nowhere that they can be overwhelming. In addition, persons may have internalized society's transphobia. Helping the

trans persons with whom we work to have a healthy or at least non-pathological perspective regarding gender variance is important and can be facilitated through the person's greater immersion in trans culture and the recognition of or identification with other seemingly more successful trans persons. Suggesting readings or web sites of trans persons which document a positive history of gender variant expression and spending time considering cultural myths of a rigid, genital-based bi-polar gender order may aid in overcoming avoidance. Also helpful for many trans persons is gaining a greater awareness of one's own gender-role expectations by explicit discussion of definitions and expectations of concepts like woman, man, husband, wife, daughter, son, transition, sex-change, and gender variance. By identifying individualized constructs and goals in a supported and safe environment, persons can begin to create positive change in their lives. As progress is made toward gender goals, greater resilience and lesser avoidance can result.

This sort of meaning-making can also be helpful in gaining greater control over particular traumatic experiences, which is Sherman's third goal. Engaging in the process of becoming more aware of the (gender) water in which we swim as a culture and as individuals can allow for new vantage points for viewing situations and experiences to be found. These changes in perspective may help lead to new ways of seeing old things. Additionally, greater control can be gained by participating more actively in local trans communities. This participation might include advocating for changes in statutes and policies, sharing personal experiences with gender variant persons and others, or doing outreach education in more marginalized groups within the trans community, such as working with sex workers around issues of sexually transmitted diseases. Active participation can be empowering; helping to generate concrete, external, and generalizable differences can be a powerful elixir for personal healing.

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Gender Variant Persons and Trauma (cont.)

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Working through trauma via re-exposure and subsequent reinterpretation, Sherman's fourth goal, is potentially complicated for gender variant persons who live in a transphobic culture. Unlike trauma victims whose struggles result from singular events, trans persons may not be able to remove themselves from the experiences of trauma in their everyday lives. Re-exposure can be a regular occurrence and often happens outside the safety and structure of counseling. As a result, ongoing reinterpretation of traumatic events is often a part of the healing process as traumatic events reoccur in the lives of trans persons. In addition, a trans person's interpretations are likely to change as well in response to hir changing experiences in expressing hir personal sense of gender identity more openly. Counselor sensitivity about and awareness of these processes can create safer places for trans persons to occupy during counseling and can keep counselors from additional victim-blaming when clients continue to report traumatic events.

Affirmative Counseling with Gender Variant Persons

In considering the available professional discussions regarding diagnosis and treatment of gender variant persons, therapeutic goals for Gender Identity Disorder would include elimination of gender variant behavior, thoughts, and feelings. Treatments to reach these goals have typically included induction into a process of gender transition of physical and hormonal modification with the goal of living as an unambiguous member of the opposite gender with a heterosexual orientation in that gender role. Additionally, treatment of trans persons has often included counsel for the client to expunge hir gendered past in order to complete the elimination of gender variance. Treatments have assumed that the culture, roles, and values of stable and unchanging bipolar gender constructs are inherently superior. As a result, research regarding trans persons has focused on the efficacy of hormonal regimens and surgical procedures and has invisibilized the existence of

trans persons who do not fit the expected constructed outcomes in relation to stable gendered identities, sexual orientation, medical procedures, or desire for passability.

When working with disadvantaged minority persons, it is important to recognize that helping professionals have a choice either to promote the reigning social discourse or to empower persons to tell their own story. Empowerment involves interventions designed to reduce clients' powerlessness stemming from the experience of negative valuation and discrimination. By acknowledging environmental, social, economic, and political factors which can cause and maintain a person's problems, affirmative counseling can reduce blaming the victim in counseling. Specifically in relation to gender variance, affirmative helping professionals accept a person's gender identity and do not work to change a person's gender expression. They abstain from reinforcing the less-than messages which emanate from our heterosexist society and refrain from labeling a person's gender variant expression as a pathology in and of itself. The work may proceed in identifying difficulties related to gender variance, even as there is an effort to distinguish between a person's inner struggle and the culture-bound oppression which may be its source. Affirming helping professionals must work to recognize the complex layers of cultural expectations which may be present for any one person. They need also to attend to a person's support networks, which can function as sanctuaries in an oppressive society, by exploring a person's level of engagement with similar others and by helping them to identify more fully, engage more actively, and develop sources of support with these others.

Connectivity on the Web

See *Connectivity* (and much more) in full color on the web at

www.forge-forward.org

Connectivity's Sexuality Survey

Connectivity conducts topic-specific surveys for every issue of its newsletter. The next survey focuses on sexuality!

Please participate in the sexuality survey via the web (www.forge-forward.org/newsletters/surveys/sexuality-survey.html) or by requesting a snailmail copy (from PO Box 1272, Milwaukee, WI 53201).

Survey results will appear in the correspondingly themed issue of *Connectivity*. Each issue of *Connectivity* is always available on the web at www.forge-forward.org.

If you would like to be notified by email about survey results, calls for submissions for future *Connectivity* issues, and when the latest issue of *Connectivity* is online, please contact with your email address:

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We aim to provide valuable information to a wide spectrum of individuals, including trans+folk, significant others, friends, family, allies, professionals, and many more. Although our focus is typically geared towards FTM+/SOFFA experiences, we

welcome and encourage all to respond to our surveys. This survey, for example, has many body-specific questions that were written with an FTM+/SO focus. People who identify as MTF+ or another gender identity should feel free to alter questions or options as appropriate.

For weeks we've tried to write one survey that can be answered by both trans and non-trans people, by individuals who are and aren't in a relationship, by people who are partnered with trans and non-trans partners, and by people who have one or more partners. Ultimately, we need you to help us. Skip questions and/or add comments to your answers to make them fit your situation. Because some questions seem to presume you are part of a couple that has one trans and one non-trans partner, we particularly ask those in trans-trans relationships and/or polyamorous relationships to help us accurately reflect your experience by commenting on your answers.

Surveys can be found online at:
www.forge-forward.org/newsletters/surveys/sexuality-survey.html;
or email editor@forge-forward.org with any questions.

Thank you for your participation!

REID VANDERBURGH, MA HOLISTIC PSYCHOTHERAPY

- gender identity and transitions (including couples and partner issues)
- life transformations
- loss and grief
- sexual orientation



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A Journey For Parents Of Trans (cont.)

(Continued from page 21)

need most is for the adults in their lives to “get it together”, to answer questions truthfully, to take the transition or unusual traits a little casually, and to reassure the children frequently that they are loved and safe and always will be. Older children may need to be reassured that transgender is not known to be inherited.

Children may also need some help in handling questions or some harassment from others. If a child shows persistent signs of grief or anger or is withdrawn, having someone “in their corner” may be helpful. If the adults decide the child should see a therapist, they should first make it clear it has nothing to do with ANYone being sick, but only to get some expert help in how to feel and understand better and maybe how to better handle the rest of the world.

True acceptance means “I have many questions; let’s talk about this; I want to understand. What can I read, who else can I talk with, I want to meet your new friends.”

The trans person can do much to help parents sail these troubled waters more easily. Coming out to them in a comfortable setting, and not at a holiday gathering, or better yet - writing a letter they can read and reread and answer when they are ready, reassuring them they are loved and appreciated and this is NOT about THEM, being willing to talk and answer any questions, offering books and other parents or groups they could talk with may all be helpful, at least eventually. Being patient, giving them time, especially if they must start grappling with a new name or, far more difficult, new pronouns. Gentle prodding and appreciation for their struggle often brings the most hard-core parents “around” eventually.

In PFLAG (Parents, Families and Friends of Lesbians and Gays, now also bisexual and transgender inclusive) we often say there is another stage - Celebration! This is the wonderful time when parents begin to appreciate fully who their child is, why life was so difficult before transition, the great courage it must have taken for their child to come out to him/herself and to


others, maybe to undergo some medical interventions. This is the time when parents love to talk to others about their special child, their recent learnings, have pride in themselves and the whole family for handling this experience so well, maybe even marching in Pride Parades, and like to write and speak about social injustices to their

child and other who are similar.

For some parents, having a sexual minority child opens up a whole new life view of this minority group, an expanded

world view, and great personal growth. Some, like my husband and myself, will tell you - we wouldn’t have missed this journey for ANYthing! We are enormously proud of our “new” son and are busy working hard to make the world a better place for him.

For further information, contact Karen Gross at kittengr@aol.com or Mary Boenke at maryboenke@aol.com or 540/890-3957. Karen provides support for PFLAG’s Transgender Network and runs a number of email lists for parents. Mary chairs this national Network. Both are proud mothers of adult female-to-male transsexual sons and are trans activists.

 **Do you want to be notified when *Connectivity* is available on the web?**

Send us an email at editor@forge-forward.org and we’ll add you to the list. This low-volume list will tell you when a new issue is available, inform you of upcoming calls for submission for *Connectivity*, and when new surveys for *Connectivity* are available. Please take a moment to sign up now!

Bodywork as Therapy (cont.)

(Continued from page 23)
in its proper place.

Connectivity: How can people work with this built up or depleted energy?

Morales: The build up or depletion of energy can create major life obstacles and resistance to shifting. Through energywork, we can jointly move the energy, hone it, creating better flow and less resistance. For some people, they may only need "check ins" or "tune ups", or assistance in augmenting the flow of energy in their body.

Connectivity: What are some key elements or tools within the work you do?

Morales: Breathing is really key. When we don't breathe, it suspends the energy. When we do breathe, it can move things through our bodies. We don't always have to talk about things, or therapize -- just breathing can help move things through.

Another important concept is awareness work. Awareness can be a very "simple" internal process of listening to one's internal state or their body.

A third key element of the work I do is encouraging radical honesty, since it is essential for moving energy and healing. I attempt to create a safe container for truth telling. By allowing people to speak their truth, frequently individuals can self-correct without much intervention on my part. Clients can practice radical honesty in my office and reinforce the principles of how healing the truth is.

Connectivity: Do you think talk therapy and bodywork work together?

Morales: They definitely can. I get a lot of referrals from therapists. We don't have to do it all through talk therapy. Body awareness can do a lot, and it doesn't need to be long term. In fact, sometimes traditional therapy can be coddling. I

won't work with people who aren't willing to be honest with themselves, because radical honesty is critical.

Bodywork slows people down enough to listen to themselves. Our distress comes from not being synchronized with one's self, and not being willing to let things go. We fixate on what we are and how to continue being that way. What matters most, though, is what the person thinks, not what others think. People are slowed down on the table, where I can help augment the energy flow in their body, change its amplitude. I build a holding container so they can hear themselves and learn to do that listening on their own, without me. I help them confront their habit patterns, what they tend to think of as normal, and help show them they can be changed.

In particular, I work to depotentiate trauma memories. It's like what EMDR (Eye Movement Desensitization and Reprocessing) does: it gets into the nervous system and shifts things.

Connectivity: If someone were interested in finding a bodyworker, what would you suggest?

Morales: There are many ways of approaching finding a qualified and competent body- or energy-worker. Most cities have many local resources or alternative care directories which list practitioners. The important thing is to remember to ask as many questions as you feel necessary so that you feel comfortable with the practitioner you select. Give them your laundry list and see if they have a problem with it before you first meet with them.

Connectivity: Although you haven't had extensive experience working with trans/SOFFA clients, you've had contact with other trans+ and genderqueer people in your personal life. Can you talk about that a bit?

Morales: As an artist, I've worked and collaborated with so many people within the LGBT

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Bodywork as Therapy (cont.)

(Continued from page 40)

community. While I always approach everyone by acknowledging their uniqueness, there is such an incredible level of creativity within the queer community. For example, when I first met Holly Brown [ed note: a talented female impersonator and artist who lived and performed in Milwaukee, Wisconsin prior to her death] it was a startling introduction! She had such a unique set of information that expressed itself through every pore in her body. When my daughter met her, she was just as captivated by Holly's intense, unique energetic nature.

One thing that I'm so pleased about is that my daughter is so accepting of lesbian, gay, bisexual and transgender people. She simply sees sexual orientation or gender as just a difference, no different than the length of someone's hair, or how they like their coffee.

Connectivity: It seems like you really enjoy working with trans clients; do you?

Morales: Working with trans people is way more interesting. It feels like it opens up possibilities and creativity. So many trans people go through a lot to be who they really are.

Ask Gearhead (cont.)

(Continued from page 7)

abuse. One of the best books, in my opinion, is *The Courage to Heal*, by Ellen Bass and Laura Davis. Try going to your local bookstore and page through some of the books until one strikes you as potentially beneficial.

There is also a relatively new online email list for trans and SOFFA survivors of sexual assault called trans_survivors. This may serve as an excellent place for both you and your partner to connect with others who have many things in common. You can join the list by going to www.queernet.org and following the subscription instructions for trans_survivors.

Sometimes professional help is essential to get over these types of hurdles. There are many strategies that can now be used to work with trauma, including Eye Movement Desensitization and Reprocessing (EMDR), somatoemotional release, debriefing, TFT (Thought Field Therapy), medication, and much more.

There are no easy answers but a loving partnership can work miracles.

Sexuality
Call for Submissions

The next issue of Connectivity will focus on Sexuality. The submission deadline for this issue is April 15, 2003. Please submit your article, letters, poetry, etc by email to editor@forge-forward.org or by snail mail to PO Box 1272, Milwaukee, WI 53201

Sexuality is a core component of many adults' (and teens') lives. Whether we choose abstinence/celibacy or being sexual only with ourselves, or seek relationships with others (committed long term relationships, anonymous interactions, flirtations, long or short term "tricks"/"fuck-buddies", monogamous or polyamorous relationships), FTM+s/ SOFFAs may approach sexuality differently than those who have no trans-involvement.

Issues we hope to cover in this issue include:

- exploring our bodies - self love and sexuality
- cruising and flirting
- trans+ erotica
- evolving and/or shifting sexual orientation(s)
- changes in libido and/or sexual interest(s)
- culture clashes of mixed orientation "expectations" (what people expect based on previous orientation experiences)
- SM as a tool for expanding and exploring gender/roles
- BDSM as a component of or full sexual identity
- learning about non-trans male bodies
- tools and tips for greater sexual satisfaction
- negotiation with partner(s) - discussion of comfortable erogenous zones and mutual pleasure
- sex clubs, segregated bars/ organizations, and navigating only spaces
- safer sex techniques and negotiation

By Jan

[Ed Note: Although this article was submitted with the articles on pages 24 & 25 on coping with auto-immune disorders, the techniques outlined below can be effective for anyone.]

There are some cognitive restructuring methods that are helpful. With these methods, you deliberately alter your thought patterns-- "brainwash" yourself!-- so that you can live through depression without taking an emotional nose-dive. It's not a cure, but cognitive restructuring can put you back in the driver's seat.

When you get really tired of what is happening to you, this method will give you some relief. The idea is, that you have beliefs that keep leading you to the same old behavior and the same old outcomes. Only you can change your beliefs, try new things, and see better outcomes. You can't learn how to do anything new if you keep doing what you know.

- a. Buy a whistle. Wear it. You know when you are starting to think those debilitating thoughts. They can come really fast. When you start to think these thoughts, reach for the whistle and blow. Say out loud: "Stop!" Immediately go to one of five thoughts that you have planned for just such an occasion. These are five thoughts that are pleasant for you, that you keep stored in a list in your heart. Think about what you are doing: "I am choosing something different."
- b. You know when you are starting to think those thoughts that spiral downwards. The ones that begin with A and just keep getting worse until you finally get down to Z. You've been running through them maybe your whole life and

these thoughts may feel like facts. The thoughts that start out with a small hurt and end up irrationally that everything in the whole world is bad. On your way down the alphabet, stop to ask yourself this question:

"What is the worst that could happen?"

Now answer that question. Figure out what the worst would be. Figure out what your options would be, should the worst happen. Figure out more than one option. Brainstorm a short list of how you could deal with the worst and get out of it. Ask yourself, "Is this becoming more clear?"

- c. Depression can cause irrational thoughts. Examine these thoughts and replace them with rational ones. Make a list for yourself (when you are not depressed), of reasonable thoughts that you can exchange for unreasonable ones when you are depressed. Ask yourself, "Is this making more sense?"
- d. Are you starting to think that you have no options? Are you thinking that a situation absolutely will never change? That life is not fair to you? Do you feel that there is only one way to achieve a goal, and that this one way is finally and forever blocked? When you begin to see things as having no options and no change, it is time to talk with someone else who has fresh ideas. There are always other options and "final, perfect, fair, always within the rules" doesn't happen very often in real life. Ask five people what they would do.
- e. Spiraling thoughts have these things in

(Continued on page 43)

*Cognitive Restructuring Techniques (cont.)**(Continued from page 42)*

- common. Learn to recognize these factors as the depression talking, not you: catastrophic thinking, thinking all or none, seeing only black and white, finding solace only in blaming yourself or others, jumping to one huge conclusion about life over just one event. Say to yourself, "I am feeling sad. But my feelings could be different tomorrow." You can also say: "Because I'm not always depressed, this won't last."
- f. What language are you using to talk to yourself and others? Make a list of the name-calling words you wish you could use. Make another list of only accurate words, and switch what you say to yourself and others. When you start to feel you are not as capable as someone else, say out loud back to yourself, "So what!"
 - g. When you feel that you are sure about what will happen in the future, say back to yourself, "No one knows what will happen in the future. I'm not a fortune teller! I refuse to take up any more of my time speculating on this."
 - h. Is your self-worth based on anything external? Do you feel that others run your feelings? That's not very controllable, is it? What do you truly like about yourself? Make a list. When you start to focus on the external thing, deliberately move your thoughts to the items on your own list.
 - i. Do you find yourself thinking that you are messed up because of your past, and as such, things can never be different for you? Stop that thought, right there. Say, "My past doesn't have the power to ruin me."
 - j. Have you been spending more than five minutes thinking about how bad everything is? Aren't you tired of it? Tap yourself on the wrist, saying, "I don't have any more energy for this kind of thinking."
 - k. Maybe you made a mistake that you've made amends for, but that you can't stop thinking about. Keep a five-year calendar on hand. Take it out and look at the last month of the fifth year. Say, "Five years from now, this mistake won't matter anymore."
 - l. "I have had good times before. This isn't such a good week, but I know good times always come back again."
 - m. On a day when you are doing well, make a tape for yourself. Play it on another day, when you need assurance from yourself that bad times don't last forever.
 - n. Is there someone you need to get out of your mind? Call yourself on it. Notice, as you are driving down the road, all the people driving by or waiting on traffic jams. Or imagine you are sitting in your spacesuit on the moon, looking at the populace of the entire earth. Say, "There are lots of interesting people out there to meet." Alternately say, "The only thing that comes delivered is pizza."

Mental Health Directors' LGBT Training Manual

By Loree Cook-Daniels

A growing number of "mainstream" groups are training their constituents about "LGBT" needs. One such training document is "Meeting the Mental Health Needs of Gay, Lesbian, Bisexual and Transgender Persons," a publication of the National Technical Assistance Center for State Mental Health Planning (which they abbreviate as NTAC).

NTAC is a joint project of the National Association of State Mental Health Program Directors -- i.e., the people in every state charged with creating public mental health programs -- and the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration -- i.e., a primary federal agency concerned with mental health. Thus, what NTAC says is going to have an impact on public policies that, in turn, will impact us.

The good news is that this document includes trans content well beyond the title. At one point, they even caution that "[T]reatment or self-help settings that are lesbian or gay affirmative are not necessarily transgender affirmative." The authors separate out sexual orientation and gender identity consistently, and note when the needs of trans people differ from the needs of non-trans LGBs. Unfortunately, they don't always have the **data** they need to do this.

They also include a full chapter devoted to "transgender concerns." This chapter begins with a description of the Tyra Hunter case, in which a non-op MTF was refused services by the Washington, D.C. fire department responding to her auto accident and who subsequently died. It then moves into terminology and prevalence -- always contested in trans contexts -- but one statement in particular surprised me: "Transsexuals may be male or female, heterosexual, homosexual or bisexual; they typically report...low libido." This chapter mentions "the lifelong persecution and suffering"

trans people experience, and lists a number of reasons why transgender persons may seek therapy (unfortunately, this list does not reiterate that LGBTs may seek mental health care for reasons unrelated to their sexual orientation and/or gender identity). Although the section on the role of the mental health service provider says, "group therapy has been recommended with all sexual minorities to combat isolation and provide a safe atmosphere in which to grapple with issues related to sexual orientation and gender identity," it does not offer any advice for suburban and rural settings in which such groups would be difficult to form. The chapter also notes that "many [emphasis added] people may attempt to pursue sex reassignment surgery who do not have a gender identity disorder." Despite these drawbacks, however, the majority of this chapter is respectful and at least provides a baseline of information for providers who may have had no previous contact with trans people or issues.

Some of the basics the publication misses include:

- A discussion of "transphobia" (a word they never use despite several discussions of homophobia);
- The special mental health concerns and needs of SOFFAs;
- Sex work and its connection to some trans people; and
- The high rate of HIV infection among trans people.

This NTAC series includes descriptions of "several mental health programs that have successfully tailored their services to meet the needs of diverse consumers." In this case, there are three.

Seattle Counseling Service for Sexual Minorities reports that in 1998 it served 2 FTMs and 32 MTFs, equaling approximately 5% of their clientele. The description of their spousal support program refers only to spouses from a heterosexual relationship where one partner is coming out as gay or lesbian, and their domestic

(Continued on page 55)

Coping With Others' Scripts (cont.)

(Continued from page 31)

email support list, she threatened to publicize "the *truth* of why Marcelle killed himself" if I didn't post the response she wanted.

How far will people go in defense of their scripts? Think about it: How far were the September 11 hijackers willing to pursue their script that all Americans are evil?

Even when people won't defend their scripts to the death (ours or theirs), these scripts can be problematic. I'm one of those people who lose my place when singing rounds and when I'm counting and someone near me is verbally playing with numbers. At best, I've found that a concurrently running alternate story of my life is a distraction. At worse, such scripts have led me to doubt my reality and make choices that weren't in my best interest.

To help myself figure out what to do when someone has a script where a character has my name, I've developed a three-step plan. I offer it here in the hope that others will try it and give feedback on what works for them and what doesn't, what the plan still needs to address, and what additional ideas they have. Write me at LoreeCD@aol.com.

Coping with Others' Scripts: The Plan

1. Recognize there is a script.

Clues to the existence of a script starring someone with your name include:

- Someone telling you what you think.
- Someone "explaining" your behavior or decisions.
- Someone judging the appropriateness of an action you've taken or a decision you've made without asking you for your motivations, reasons, and considerations.
- Someone treating you like you're crazy, that what you've done makes no sense at

all.

- Someone getting angry at you for something you didn't do.

Remember that you may hear about others' scripts through third parties, or have to intuit them from others' actions. For example, my sister accused me of being abusive to my parents for telling them that one of the ways I coped with feeling suicidal myself after Marcelle's death was to promise myself I only had to live until Kai turned 18. From that I could guess that the "Loree" who lives in her head differs from her real-life namesake by never actually being suicidal, never talking about such a subject with family members, or being so vicious she'd make up such a topic simply to torment others.

2. Judge how wedded the scriptwriter is to hir script.

Once you realize that someone seems to be using your name in a story that doesn't jive with your experience, step two is to assess how wedded sie is to hir script. Some of the questions to consider are:

- When you say, "what you just said doesn't match my experience," or "that's not how I see it," does sie look eager to hear what you have to say next? Or does sie interrupt you with an explanation of why sie's right?
- When you talk about your experience, does sie ask follow-up questions? If sie does, does sie listen to the answers?
- Have you ever heard hir say, "Oh! I didn't know that." Or, "Well, that changes my whole viewpoint!" Or, "Gee, I'd never thought of it that way"?
- Does sie ever start sentences about your life with phrases like, "What you don't understand is..." or "What you haven't considered is..." or "That's not true...."?
- What are hir sources of information about your life? Is sie asking you questions

(Continued on page 46)

Coping With Others' Scripts (cont.)

(Continued from page 45)

- directly or getting hir information about you from somewhere (or nowhere!) else?
- Does sie ever come back after a conversation has ended and ask more questions (which indicates a willingness to think about what you've said)? Does sie ever ask for referrals to other people or publications that share your experience or viewpoint?
 - Do you know of any occasions when sie has sought out people to articulate viewpoints sie doesn't understand?

Generally, if the person isn't interested in hearing about your experience, tells you why you're wrong about yourself, and generally resists learning about others' viewpoints, be wary! This person may well be far more interested in defending the "rightness" of hir script than being helpful to -- or accurate about -- you.

If sie does seem open to revising hir script, then by all means, talk about your actual experience and feelings!

3. Be willing and able to leave the game.

If, on the other hand, the person isn't open to having hir script "about" you rewritten, step three is being willing and able to leave the game. You are engaging in a battle of wills when you want to correct someone's script. It may be obvious to you that since it's your life, you should have the last word. Unfortunately, as we've seen, people will go to great lengths to defend their scripts from any and all challenges. Engaging in a battle like this diverts your energy from the very thing you're trying to defend: your right to define and live your own truth. Take back that energy. Walk away and get on with living your truth.

If you can't bring yourself to walk away (or if circumstances prevent it, like the stubborn

scriptwriter is your boss and you're not in a position to change jobs), make a safety plan. It's always hard to *not* think about the pink elephant; the best way to redirect your thoughts and emotions is to focus on something else. Perhaps you can automatically begin mentally listing your good qualities whenever someone starts telling you about your life (particularly useful if they're bent on telling you what you're doing wrong!). Or maybe you can use the trigger of discovering someone's written a script starring a character with your name to think about whom in your life *you've* been writing scripts about. Perhaps you can resolve to use such occasions as opportunities to figure out some concrete step you can take to better live out your values. Or, look at each event as an opportunity to learn something new about the way others think.

On that note, I dedicate this essay to the many people who've written (and sometimes felt compelled to share with me) scripts "starring" me, Marcelle, and/or michael. I applaud you for your creativity and convictions, and invite you to focus those skills on finding ways to make life better for yourself and others.

History Quiz

Take the online FTM+/SOFFA focused history quiz.

www.forge-forward.org/newsletters/surveys/historyquiz.html

It's challenging and will get you thinking about tough issues that affect the trans+/SOFFA community. The respondent with the most correct answers will win a year's subscription to *Connectivity*. Test your knowledge today!

Watch upcoming *Connectivities* to learn the correct answers.

*Mental Health Survey Results (cont.)**(Continued from page 20)*

unwillingness to accept the legitimacy of transsexualism, or because the provider had a view of transsexualism that was incompatible with the person's reality:

[The reason given was] that I was crazy and not TS; that there is no such thing as TSism.

Endo[crinologist] in my home area refused to see me for hormone therapy. While she never knew anything about me and my situation specifically, her stated attitude towards TG people was, "That is a problem population" and I was specifically told, "she no longer sees patients with your kind of endocrine problem." Again, she never saw me to assess my endocrine problem in the first place! So, my reading is that she sees all TG people as having a mental health condition that she doesn't want to deal with.

Back when I first explored transition (age 21) the psychiatrist tested me and because in his opinion I would be gay after transition, he wouldn't take me into his program. His view was that transition should be a cure for homosexuality. This was when homosexuality was still considered an illness.

One was turned down because professionals believed the person's desire to transition was related to having been abused: *They thought I was only "GID" because I had been sexually abused as a kid.*

The other three were given a variety of reasons.

Well, just today the therapist I have seen for the past 2-1/2 years stated she has too many reservations about my mental illnesses to give me a hormone letter. I have been taking T [testosterone] without a script for 3-1/2 years. She stated that there were too many "other" factors, like my husband is also FTM (she thinks I am copying him), my abuse history, the fact that I am unable to hold a job, to give me the letter. She said it wasn't personal and that she

has to protect her license. Oh...another reason for not giving me a letter was I didn't bind. I am a size H cup with Chronic Obstructive Pulmonary Disease. I can't bind.

He thought I was having too many problems, i. e., with health and mental health, and that unless I was well enough to work and stable he wouldn't recommend hormones or surgery. Also I don't think he believed I was transsexual. He thought I was [a] traumatized woman who was tired of being seen and harassed by men because I wasn't masculine appearing before hormones.

[The professional turned me down, saying] that I need to "know myself better" first.

Of the seven who were turned down, four sought a second opinion. One who didn't explained, *No, [I] haven't gotten a second opinion because [I am] "too young, too scared."*

Although we did not ask about this, two respondents volunteered that having a mental illness can also be problematic in the trans community:

I wish the trans community was more supportive of each other. I know that I am barely tolerated because of having a mental illness. Everything is supposed to be so smooth with transition and mine hasn't been, so I get a lot of flack from other transmen.

I have minimal support within [the] TS community and [am] pretty isolated.

Experiences with Mental Health Professionals

We did not ask how satisfied people were with their therapy experiences, but many volunteered their opinions. The negative stories ranged from outright abuse to ineffectiveness.

Two doctors have also done inappropriate

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Mental Health Survey Results (cont.)

(Continued from page 47)

sexual things to me in the context of examinations: one doctor laid on top of me and asked why I was a lesbian, and another put a hand up my shirt to see how large my bound breasts were.

I have had nothing but bad experiences with so called "gender specialists," social workers, psychs, etc. They either want to focus only on gender-specific stuff without looking at me as a whole person, or they think I'm butch just because of abuse in my past. Most therapists have tried to box me into the "FTM" category because they can't wrap their heads around the idea of a Butch who doesn't ID as a woman, a masculine female who passes as a man in the world but still identifies with their femaleness, etc.

I went to a day treatment program at [name withheld] from April 1996 to February 1997 and in April 1996 I had just started living as a woman. They didn't know me as a man, but my ID said "male" at the time and had my male name on it, so the therapists were trying to get me not to wear makeup. And once, in front of a group of mentally ill patients at a therapy session, one of the therapists said, "you're really a guy." ... There was also a patient there who was very religious and refused to call me [by my female name] and "she" and it seemed like my music therapist was protecting her instead of educating her about trans issues, or even gay issues.

As a teen I saw a therapist after leaving an unhealthy relationship and was, in my opinion, carelessly overmedicated (and addicted) for six months until I became noncompliant and refused to take any more.

I have found it difficult to find a therapist with experience, expertise, or competence in both trans stuff and other issues.

On the other hand, some respondents were deeply grateful for the care they'd received.

My psychiatrist was the greatest. I was referred to him after I admitted for the first time why I drink myself into oblivion, end up in detox facilities, and attempt suicide. He had seen transgendered people before but I was his first "FTM". First he sorted out my depression/grief/anxiety/alcohol abuse issues by reassuring me he would help with my GID once I was stable enough to process everything clearly and make informed decisions... I am forever grateful to my psychiatrist for helping me get to the point I am today. I am living and working as a guy and am the happiest I have ever been.

I've been very lucky with the mental health services I have received since "coming out" as trans. I mention this because it seems that most people have very much the opposite experience.

I get excellent care from the Veterans Administration (VA) Hospital.

Most providers of the nine different ones I have seen were either helpful or admitted they were not equipped to deal with gender. Finding the ones who were capable was key to my improvement and successful transition.

Most of the mental health services I have received have been excellent and primarily from private psychotherapists; the majority of them have not been for my gender identity issues but for my childhood trauma issues.

PTSD from family/relationship trauma superseded GID for most of my life in terms of levels of distress. But this is mostly worked through, and I am transitioned, so I am fine on both accounts. Luckily I never had to fight with my care providers to see these two as separate issues.

Involuntary Mental Treatment

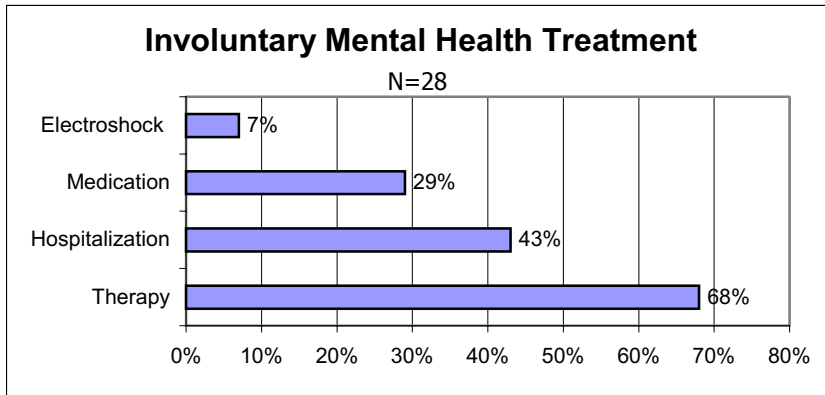
Ninety-four people answered the question, "have

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Mental Health Survey Results (cont.)

(Continued from page 48)

you ever *involuntarily* received mental health services?" Of those, two-thirds (N = 62) had never been involuntarily treated, and four did not believe they had ever been involuntarily treated. But 30%, or 28 respondents, had received involuntary



treatment.

I had to go [to an abusive outpatient clinic] so that I wouldn't get kicked out of the homeless shelter that I was staying at. As long as I was going there, I wouldn't get kicked out of the shelter....it also got me into the [Department of Vocational Rehabilitation] so that I could receive job training.

Involuntary treatment can have many ramifications, as some of our respondents pointed out:

I became much worse when I was put in that hospital (as a teenager). Because of that experience, I have not talked to my family in 16 years. I also did not receive medical attention for my real problems for many years because I was afraid of being hospitalized or made to take meds.

At age 17 my mother found out that my boyfriend was born a woman, after reading a journal of mine which was delving into my inner conflicts regarding sexuality (previously lesbian). A combination of my age, and his age (then 22), and her conservatism led her to believe I had been "converted, brainwashed"...something. So

she took me for a needs assessment at a local conservative suburban mental institution/chemical dependency rehab. I believe she told them I had attempted suicide, because most of my treatment seemed to be centered around that. I had never felt suicidal up until then. When I turned 18, I left home as fast as I could. I have no relationship with either of my parents.

The types of services respondents had had forced on them were therapy (68%, N = 19); hospitalization (43%, N = 12); medication (29%, N = 8); and electroshock therapy (7%, N = 2). Five persons – 5% of our total sample – had had forced

"treatment" to address their gender identity.

Yes, my fucked up parents put me in therapy from when I was a toddler for acting "gender wrong" (sic), or so I since found out. They did everything possible to make me conform, I mean everything. Six years ago I left home. And I'm still in therapy to get over the so-called "therapy" I was subjected to by my parents and the medical establishment. I was called pervert, evil, etc. and a servant of satan. I was exorcised. I was hit and worse. My sister became a religious far right and choice evangelical fundamentalist because of me and then she had a mental breakdown at university, she tripped out and was institutionalized and medicated. She in fact is the only one in the immediate family to be diagnosed as having a mental illness. Now my parents are in therapy too because of my ts-ism and they say it's all my fault...

Currently seeing a therapist as a condition of my mother's continued financial support (college tuition), although I don't believe I need therapy. My therapist agrees, but is

Mental Health Survey Results (cont.)

(Continued from page 49)

willing to help me deal with my mother. [The therapist] is supportive of my transition.

Although the numbers are too small to draw conclusions from, involuntary treatment did differ some by age: both of the respondents under 18 had been involuntarily treated, and 39% of those 25-34 had had forced treatment. The percentages of the other age groupings were all around a quarter.

Both of the minors were struggling.

They won't let me get hormones until I'm 18, but then they have to ASK why I'm depressed.

I have had insomnia since the age of six. I am now sixteen. Nobody knows I am transsexual. My father would be violently outraged if he knew. I...cut myself up in secret. I will not let myself be treated. I have had schizophrenia experiences no one knows about. I abuse my body to make myself stop menstruating and to hinder breast growth. I cannot function in school and often do not go. My friends make fun of me every day, as do enemies. I cannot get help. I cannot talk to anybody. I cannot get hormones, and it is very hard and ... [unclear] to cross-dress. There are no support groups, online or real. And there is nobody like me. Everybody hates me and I am very unhappy. I animate. I draw comics about my transsexuality and nobody understands. They get scared when I talk about sexuality. I need help please. I cannot give you my address because my parents may read a return letter if they suspect it.

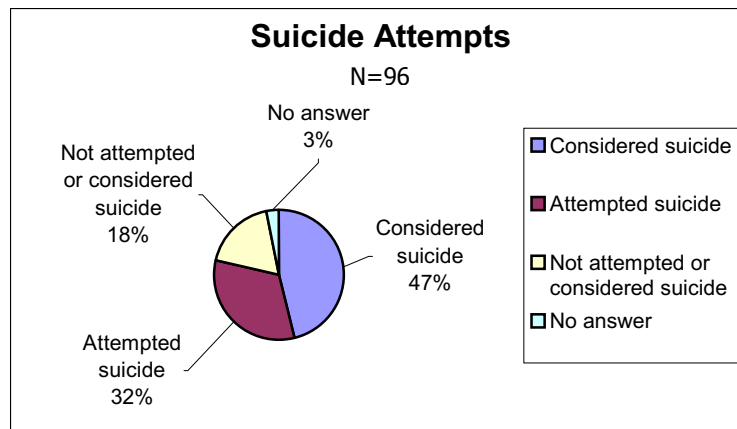
[Editor's note: We attempted to contact this person to provide hir with free, online and in

person support alternatives.]

Suicide Attempts

The vast majority of respondents had at least considered suicide: 47% (N = 44) had "considered" it, and 33% (N = 31) had attempted it. Only 18 had not attempted or considered suicide, and three declined to answer the question. One respondent cautioned that dividing those who had attempted from those who had "considered" it might lead to false assumptions:

To elaborate...I think about it all the time, I've wished I was dead since I was 5 or 6. My suicide is years overdue, but I've been taking care of people and animals who rely on me. I can't leave til they're safe or have died of natural causes. I want my life to end soon, but I need to wait until my passing won't harm anyone. I've never attempted suicide even though my suicidal preoccupation is intense and nearly constant. I hope this isn't too much information, but I wanted to clarify that my answer of "no, but I've considered it" doesn't imply that my suicidal thoughts are rare and fleeting intrusions into an otherwise satisfying life. My daily life experience is deeply unhappy and painful. I've learned to cope and survive, but it's still not worth living. I hope this isn't too depressing to read. It seemed important to tell the truth.



Of those who had attempted suicide, most made multiple attempts; only 29% (N = 9) had attempted only once. The number of additional attempts went up to 75 and "lost count."

The question of suicidal feelings was one of the few in which answers differed significantly based on

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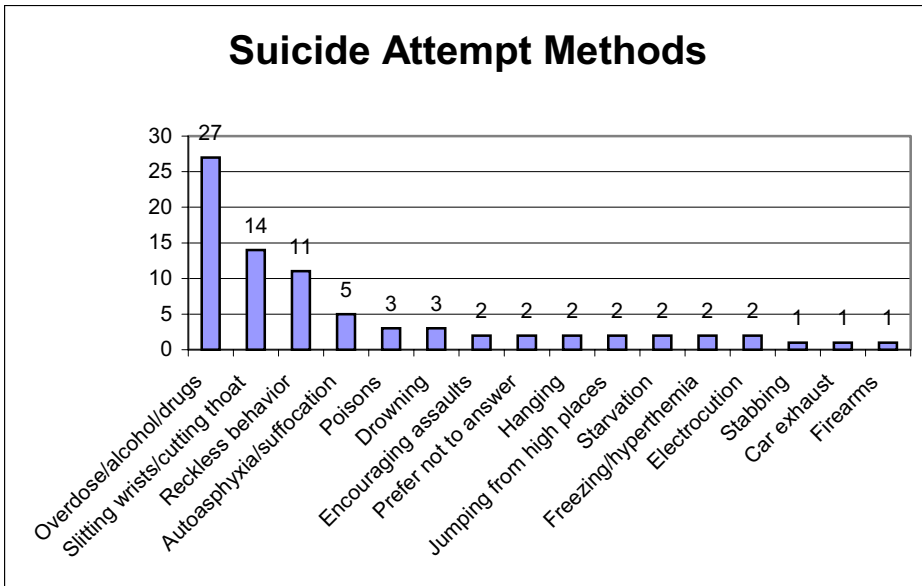
Mental Health Survey Results (cont.)

(Continued from page 50)

whether the respondent was a trans person, a non-trans partner, or a non-trans friend or ally. While only 16% (N = 12) of trans persons had not considered suicide, 31% (N = 4) of non-trans partners had never been suicidal, and 50% (N = 2)

"If you have a long term mental health condition and are on any form of hormones (testosterone, estrogen, progesterone or other – for reasons of birth control, HRT after menopause, same/dominant hormone enhancements, or "cross-gender" hormones), have you noticed if the hormones have had any effect on your mental health condition (s)?" Thirty-seven (42%) said the question was not applicable to them, and two said they were on hormones before the onset of their mental illness.

Therefore, 47 (54%) said they had a mental illness that might have been affected by hormone use. Of these, the vast majority (70%, N = 33) felt that their mental health had *improved* when they started hormones. Some of these transformations were dramatic.



of non-trans friends/allies had not considered suicide.

Age did not make a significant difference in suicide attempts. With the exception of the under 18 respondents (where one of the two had attempted, resulting in a 50% rate), all of the other age ranges fell within 31-34%. Note that this question did not ask when the suicide attempt(s) took place, and some respondents volunteered that their attempts took place when they were much younger.

The vast majority of those who had attempted suicide had a diagnosis of depression (with or without other diagnoses): 77% (N = 24). Three of the attempters (10%) had a single diagnosis of GID. Three of the attempters (10%) had diagnoses of GID and PTSD. One person had not claimed any mental illness or GID diagnosis.

Mental Health and Hormones

Eighty-seven respondents answered the question,

Within 12 hours of my first testosterone shot, my depression was lifted like a black cloud. Even now, when I'm late on my shots, I feel it seeping back in. As long as I get my hormones, I'm fine and have no mental health issues. So I don't know if this counts as anything more than a hormone disorder.

I cannot begin to explain how much more functional I am in every way since beginning hormones. It is incredible. But I don't expect it to "cure" my mood disorder, only make it very manageable.

Yes!! Surprisingly to me, I feel that taking hormones has really helped me see whom I really am! I always knew that I was different, but not till taking them did my outlook on "everything life" improve. My complete outlook on how I am part of a human race feels "right – correct." As the other, I was never happy or never not

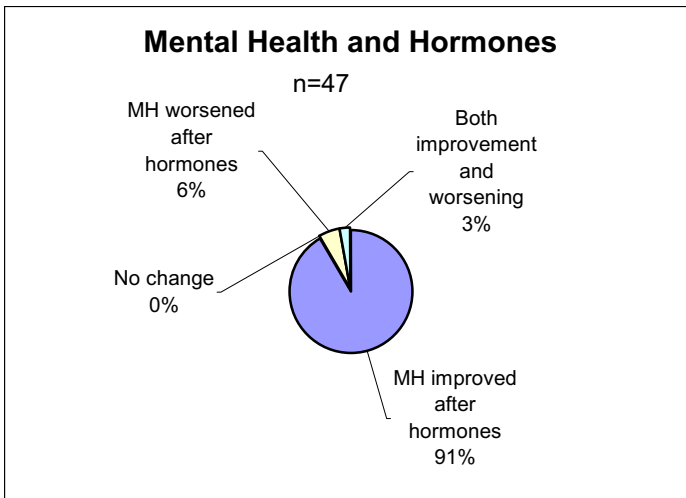
Mental Health Survey Results (cont.)

(Continued from page 51)

confused as to my place in this world. I feel right!

Others reported they developed a general sense of calmness and well-being once they started on hormones.

T[estosterone] seems to have settled my mind



and my emotions to a comfortable level.

Depression runs in the family and waxes and wanes, but T[estosterone] has been very helpful and stabilizing.

The effects of T[estosterone] were immediately felt as a sense of calm and a certain peacefulness.

I feel a general sense of "better" and "good" since starting on T[estosterone]. I've had six shots now, and some kind of calm/peace has set in. I don't know if this is physical, mental, emotional or spiritual, but it feels good.

[A]ll of my friends reported that I have become more mellow since I started testosterone.

I am somewhat moody/depressed when not on testosterone, but it only affects my enthusiasm, not my functioning.

T[estosterone] adds a significant stabilizing factor and I am able to keep my psych meds (depakote) at the lower end of the therapeutic range or just below.

I have improved steadily since starting HRT, 9 months ago. I am beginning to enjoy a productive, fulfilling existence, for the first time in my life.

After beginning hormones and getting my transition underway, I went off anti-depressants and haven't had what I considered any "serious" depression problems since (over two years).

A quarter of the respondents had noticed no change in their mental condition once they started hormones. Two (4%) said using hormones worsened their mental condition.

Anxiety bouts that I have had post-T[estosterone] have been pretty much the same as pre-T[estosterone]. I have checked out if there is a relationship and I don't think there is. I had been hoping T[estosterone] would help alleviate my anxiety, but that hasn't happened either.

One person said he had experienced both improvement and a worsening after beginning hormones.

Since starting on testosterone, my depression got better overall, but when I had another episode – relapse? – it was worse than any of my previous episodes. I cannot say if this was due to the testosterone or just the documented pattern of later episodes being more severe than earlier episodes for most people.... The parts of my depression that were related to PMS went away entirely, which is not surprising.

All three of those who said their conditions had worsened with hormone use had multiple diagnoses.

Two respondents volunteered that they had hoped

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Mental Health Survey Results (cont.)

(Continued from page 52)

hormones, surgery, and/or transitioning would help with their social discomfort:

My depression has eased since starting on testosterone, but my willingness to be social has not increased as I thought it would. Perhaps after I've had top surgery. Perhaps after I have decent facial hair. Perhaps I'm just an introvert and will never feel comfortable around very many people.

I've never been diagnosed with any kind of social phobia but I am painfully introverted and people often say I come across as retarded or autistic. I am intelligent, University educated, capable etc. but just find it near impossible to open my mouth most of the time. I am curious if going on hormones and passing as male will change that. Makes sense that if the world saw me right then I'd be more able/interested in interacting with this world.

Mental Health Techniques

With five exceptions, all respondents had at least one technique they used to maintain or improve their mental health, and most used multiple tools. In order of their use, the tools respondents used were: exercise (77%); therapy (72%); journaling (58%); vitamins or supplements (52%); meditation (52%); medication (45%); body work (36%); prayer (36%); diet (36%); herbal supplements (34%); energy work (26%) and crystals or rocks (15%).

Thirty respondents wrote in other techniques. Talking to friends and family was mentioned most often (N = 8).

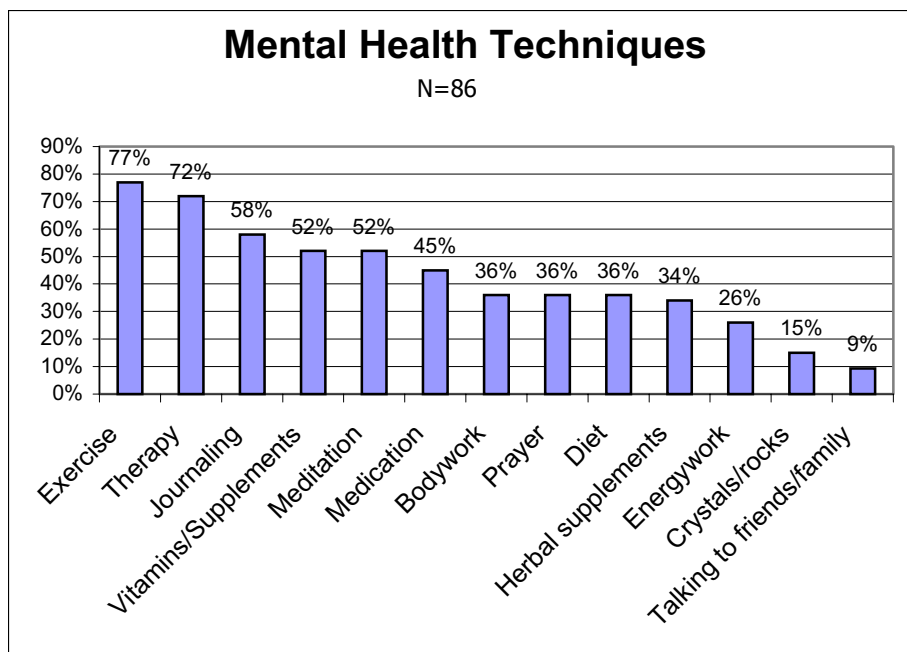
Having friends to talk to has always been more effective than therapy.

Other volunteered techniques were art, music and sex (used by four respondents each); reading and rituals (three each); and activism/ community-building, dancing, yoga, going out, cognitive restructuring, and optimism (two each). Other mentioned techniques included traveling, having fun, making revolution, writing for publication, driving, Bach remedies, burning incense, using marijuana, being in water, regular sleeping patterns, magick, looking at pictures of self and other transmen, and isolation. One found solace in Buddhism: *[It] has a long history of understanding and addressing mental health.*

Some people said transitioning or surgery was crucial to their mental health:

My mental health is good since surgery and I believe I lead a normal hetero life.

It has taken a REALLY long time, but working on my depression, relationships with people, and actually transitioning has gotten me to a mental place that I really feel that I am doing very well.



(Continued on page 54)

Mental Health Survey Results (cont.)

Insurance Coverage

A significant influence on how accessible are mental health services is whether one has health insurance, and specifically health insurance that covers mental health services. About 45% (N = 43) of the survey respondents had mental health coverage. Twenty-two percent (N = 21) had no health insurance at all. Ten had health insurance that excludes mental health, and eleven respondents didn't know if they had insurance that covered mental health care.

Most of those with mental health coverage had some limitation on that coverage: more than half (N = 25) have a cap on the number of visits or sessions they can have, and nearly half (N = 21) must choose a therapist from a limited list of providers. However, nine could see any therapist they wanted, and 11 had no cap on the number of sessions their insurance would cover.

Related to insurance coverage is poverty, which is in turn related to other issues:

[I] cannot afford chest surgery and have attempted and failed to remove breasts 2X.

It has only been in the last couple of years that I have been able to get help from competent counselors (for sexuality and identity issues) and that I have had ANY access to healthcare. Poverty has been a big problem.

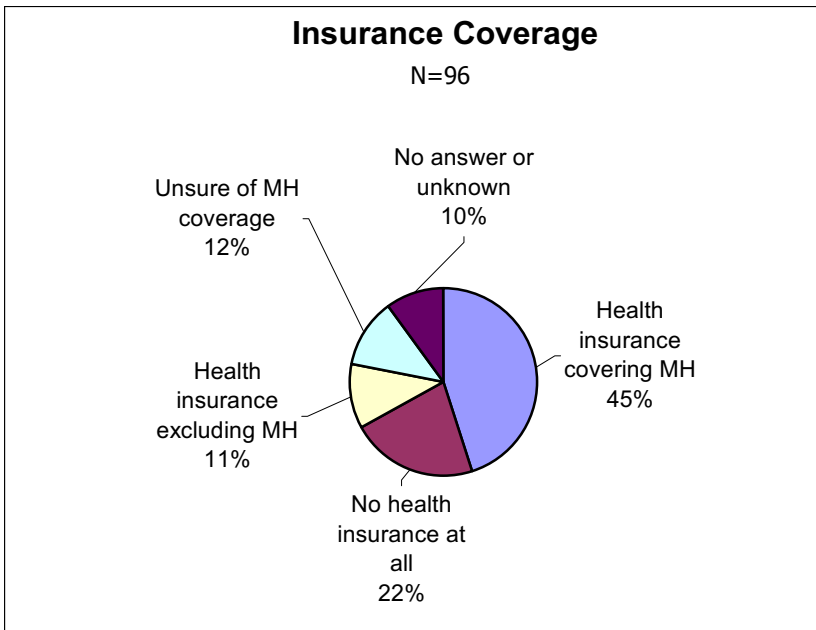
Conclusions

The trans+/SOFFA community has a complex, ongoing relationship with mental health issues and the mental health service community. Although it is frequently pointed out that one cannot be "officially" trans without at least some contact with the mental health system, our survey found that many members of our community seek mental health services because of conditions outside of their gender identity.

These other mental health conditions may or may not be linked to gender identity (and, in particular, to transphobia against those whose gender identity violates the strict binary norms), although the majority of respondents felt that for them, there was a link. For some people, resolving their gender identity -- often by transitioning -- helped lessen or end their other mental health concerns. For many others, hormone use by itself seemed to have a very welcome side effect of improving their other mental health conditions. This finding, in particular, deserves far more exploration and rigorous research.

It is no surprise that the trans+/SOFFA community's relationship with mental health providers is complex and ambivalent, because of mental health providers' unique role of gatekeeper to the medical and, sometimes, social means through which trans+ people communicate their identity. What is, perhaps, surprising, is how many of our respondents have positive stories to tell about how their therapists respectfully and competently helped them resolve even very complicated clusters of conditions and issues. Unfortunately, a few have also found the opposite: mental health

(Continued on page 55)



*Mental Health Survey Results (cont.)**(Continued from page 54)*

professionals who used co-existing diagnoses or even just their own ignorance and prejudice to create even more trauma and pain in the lives of their trans+/SOFFA clients.

One finding that we particularly need to pay attention to is how much impact non-GID mental health conditions have on our community and its members. Two-thirds of our respondents have an ongoing mental health condition, and three quarters of these say their condition affects their daily functioning at least "some," with a quarter characterizing their condition as "debilitating." Perhaps more so even than the incidence of suicidal feelings in our community -- 80% of the respondents had at least considered suicide -- the implications of this level of daily functioning impairment need to be discussed far more deeply. How can we organize our community to provide better supports for those with mental health issues? Are there organizing implications of these findings -- i.e., do we need to think about how we go about planning conferences, support groups, etc. to better accommodate the levels of mental health "disabilities" of our members? Do we need to do a better job of talking about the overlaps between GID and other mental health conditions when we train and/or screen therapists? What else should these findings be making us think about?

Send your ideas to editor@forge-forward.org.

Next *Connectivity* Survey

Remember to participate in the next *Connectivity* survey on sexuality. For more details, see page 38 or check online at www.forge-forward.org

*Review of Mental Health Training Manual (cont.)**(Continued from page 44)*

violence program seems only open to victims of same-sex violence. Their transgender/transsexual services are for "people exploring gender identity or who are in the process of meeting the Benjamin Standards to prepare for sex reassignment surgery." On the other hand, their commitment to "culturally competent services" says that "any client that identifies as a minority -- racial/ethnic, older adult, child, deaf/hard of hearing, developmentally disabled or other -- must have their treatment plan reviewed by a minority specialist representing these other identifications, in addition to the sexual minority specialist."

The South Beach (New York) Psychiatric Center's Outpatient Department formed its LesBiGay and Transgender Affirmative Program in February 1996. At the (unspecified) point the report was written, they had served 60 individuals, 90% of them men. This program offers weekly support groups, cultural awareness groups, and a "reading room"; a monthly coffee klatch; and advisory boards and outreach efforts within the clinic environment.

Pride Institute, founded in 1986, with facilities in Minnesota, New York City/New Jersey, Chicago, Dallas and Ft. Lauderdale, offers "a full continuum of care for the entire spectrum of psychiatric and addictive disorders." It was unclear from the description how much trans-related content this "LGBT" program actually has.

The 76-page NTAC report is available for \$10.00 from:

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Next Issue:
Sexuality

