EXPERT REPORT OF WALTER O. BOCKTING, PHD

Schroer v. Billington

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Qualifications and Background

1. I am an Associate Professor with tenure in the Department of Family Medicine and Community Health, University of Minnesota Medical School. In my position of Coordinator of Transgender Health Services, I am responsible for patient care, research, and the training of health professionals in the area of transgender health. In addition, I am involved in the treatment of a range of sexual disorders and am affiliated with the University's Center for CAH (Congenital Adrenal Hyperplasia) and Intersexuality, Division of Pediatric Endocrinology, Department of Pediatrics.

2. I have been licensed by the State of Minnesota Board of Psychology as a Licensed Psychologist (LP2505) since 1991.

3. I serve on the Board of Directors of the Harry Benjamin International Gender Dysphoria Association, an interdisciplinary professional organization dedicated to the advancement of scientific knowledge, training, treatment, and advocacy in the area of gender identity disorders and transgender health; this is the association that sets forth the Standards of Care for the Treatment of Gender Identity Disorder. In addition, I am a member of the International Academy of Sex Research and the American Association of Sex Educators, Counselors, and Therapists. I am currently Past President of the Society for the Scientific Study of Sexuality and Vice President of the North American

Federation of Sexuality Organizations. Finally, I am a member of the American Psychological Association and serve on its Task Force on Gender Identity, Gender Variance, and Intersex Conditions.

4. I received my bachelor degree in Psychology (1985), doctorate degree in Clinical Psychology (equivalent to an All But Dissertation; 1988), and PhD in Medical Psychology (1998) from the Vrije Universiteit, Amsterdam, The Netherlands. I moved to the United States in 1988 to complete a Post-Doctoral Clinical/Research Fellowship in Human Sexuality at the University of Minnesota and have been at the University of Minnesota ever since. Subsequent continuing education has included numerous conferences in psychology, gender, and human sexuality, and a recent sabbatical leave project (January-August, 2006) on gender identity disorders in children and adolescents at the Vrije Universiteit Medical Center, Amsterdam, The Netherlands.

5. My research interests include sex and gender, transgenderism and intersexuality, sexuality and the Internet, HIV prevention, and the promotion of sexual health. I have been awarded grants for my research from the American Foundation for AIDS Research, the Minnesota Department of Health, and the National Institutes of Health. In addition, I have served as a co-investigator on grant-funded studies from the Centers for Disease Control and Prevention.

6. I have published 46 papers in my areas of research, of which 32 are in peer-reviewed journals. I have edited five books, four of those in the area of transgender health. *See* Exhibit 1 (curriculum vitae).

7. I teach medical students, residents, and psychologists in postdoctoral training at the University of Minnesota Medical School in transgender and sexual health.

In addition, I am a frequent presenter at local, regional, national, and international scientific and continuing education conferences.

8. Among other consultations in the area of gender identity and human sexuality, I have assisted companies and organizations to successfully accommodate transgender employees. *See* Exhibit 1. For example, in 2001, I assisted the U.S. Department of Agriculture with a gender role transition in the workplace of one of its inspectors.

9. More detailed information about my background and experience can be found in my curriculum vitae, which is attached as Exhibit 1. Exhibit 1 includes a list of the other cases in which I have provided an expert opinion, have been deposed, and/or have served as an expert witness in the last 4 years.

10. My consulting fee is $300 per hour.

Opinions

11. In this litigation, I have been asked to render expert opinions on (1) What is sex/gender? What factors make up a person's sex/gender, and which factor(s) is/are the most important; (2) What is gender identity? How is it determined, when is it established, and can it be changed?; (3) What is transsexuality and what is its prevalence?; (4) What is gender identity disorder? What is the proper course of treatment for gender identity disorder, and how has this protocol been developed?

12. In forming my opinions, I have relied on my scientific education and training, my research experience, my knowledge of the scientific literature in the pertinent fields, and my extensive clinical experience in treating sexual and gender

identity disorders. I also have reviewed the complaint in *Schroer v. Billington* dated 6/2/2005, the memorandum order of Judge Robertson dated 3/31/2006, and an article cited in this memorandum order from the Harvard Journal of Law and Gender by Noa Ben-Asher entitled "The Necessity of Sex Change: A Struggle for Intersex and Transsex Liberties.".

Based on my review of the foregoing, and for reasons set forth in more detail below, my opinions are the following:

I. SEX, GENDER, GENDER IDENTITY, AND SEXUAL IDENTITY

13. Sexual identity has at least four components: (1) natal sex, (2) gender identity, (3) social sex role, and (4) sexual orientation (Bockting, 1999):

(a) The first component, natal sex, is typically assigned at birth as male or female based on the appearance of the external genitalia. Only when the external genitalia appear ambiguous (in the case of intersexuality), the gonads and internal reproductive structures (testes, ovaries, uterus), sex hormones and chromosomes are assessed, and sex is assigned based on the findings. In resolving any remaining ambiguity, the likelihood of the development of a gender identity that is congruent with the sex of assignment is the most important criterion, and the sex of assignment may be provisional pending the outcome of gender identity development which cannot be determined until later (Cohen-Kettenis & Pfaefflin, 2003; Dreger, 1999; Money & Ehrhardt, 1972).

Transsexuals are not born with ambiguous genitalia; at birth, their sex is assigned based on the appearance of their external genitalia as male or female. However, later in life, their gender identity reveals itself to be the opposite of their sex assigned at birth.

(b) The second component, gender identity, refers to a person's basic sense of belonging to one sex or the other (boy or man, girl or woman) (Stoller, 1964). One's core gender identity is believed to be established early in life, by the age of 2-3 years (Money, Hampson, & Hampson, 1957). In most cases, gender identity is congruent with the sex assigned at birth; in the case of gender identity disorder it is not.

(c) The third component, social sex role, refers to characteristics in personality, appearance, and behavior that in a given culture and historical period are designated as masculine or feminine, that is, more typical of the male or female social role. Social sex role may reflect gender identity, however, the two components should not be confused with one another. Both men and women typically have masculine as well as feminine sex role characteristics to varying degrees. Therefore, masculine characteristics in women and feminine characteristics in men should not bring into question the integrity of their core gender identity. For example, a woman (transsexual or not) who does not conform to society's sex role expectations and is perceived by others as masculine, typically has

an unambiguous female core gender identity (Bockting, 1999). Therefore, even though people may perceive a male-to-female transsexual as masculine based on sex role stereotypes, her core gender identity is typically female and sex reassignment would be an appropriate course of treatment.

(d) The fourth component, sexual orientation, refers to sexual attraction toward men, women, or both. Sexual orientation is about one's sexual attractions, behavior, fantasies, and emotional attachments towards others, whereas gender identity is about one's experience of self as male or female. Sexual orientation is only one aspect (one of at least four components) of an individual's overall sexual identity (Coleman, 1987).

II. TRANSSEXUALITY AND ITS PREVALENCE

14. Transsexuals are individuals whose sex assigned at birth is incongruent with their gender identity (who have a core crossgender identity), and who desire or have had hormone therapy and/or sex reassignment surgery to feminize or masculinize their bodies. Prior to surgery, they transition to living full time in the crossgender role.

15. Transsexuals should not be confused with individuals with other transgender identities. Transgender individuals are a diverse group of individuals who cross or transcend culturally-defined categories of gender (Bockting, 1999). They include transsexuals, but also transgenderists and crossdressers/transvestites. Transgenderists live full-time in the crossgender role, may take hormones, but do not desire sex reassignment surgery. Crossdressers or transvestites wear clothing and adopt

behaviors associated with the other sex for emotional or sexual gratification, may live part-time in the crossgender role, but do not have a core crossgender identity and do not seek sex reassignment surgery.

16. Definitive prevalence data on the transsexual population are lacking, particularly in the U.S., which has no national database of transsexual individuals. Data from other nations indicate that the prevalence of transsexuality, based on those who had sex reassignment, is 1:11,900 for male-to-female transsexuals and 1:30,400 for female-to-male transsexuals (Bakker, van Kesteren, Gooren, & Bezemer, 1993).

III. GENDER IDENTITY DISORDER AND TREATMENT

17. Gender identity disorder is a mental disorder classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM), Fourth Edition, Text Revision (American Psychiatric Association, 2000, pp. 576-582). *See* Exhibit 2. The criteria one needs to meet to receive such a diagnosis can be summarized as follows:

(a) A strong and persistent cross-gender identification, manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex;

(b) Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex, manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual

characteristics to simulate the other sex) or belief that he or she was born the wrong sex.;

(c) The disturbance is not concurrent with a physical intersex condition; and

(d) The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

18. That gender identity disorder is classified as a mental disorder in the DSM has become increasingly controversial (Bockting & Ehrbar, 2005). Indeed, not all individuals whose gender identity varies from their sex assigned at birth experience clinically significant distress, particularly after they have resolved any incongruence they may have experienced. Opponents of gender identity disorder being a classified mental disorder have argued that the distress that transsexuals may experience is primarily a result of a conflict between the individual and society (because they do not conform to society's gender expectations), a type of distress specifically excluded in the DSM from the definition of mental disorder (American Psychiatric Association, 2000, p. xxxi). Moreover, they argue that a diagnosis of Gender Identity Disorder perpetuates the social stigma associated with gender variance. On the other hand, consistent with my clinical experience, the diagnosis of Gender Identity Disorder does validate the inherent distress that leads individuals to seek sex reassignment and therefore, in my opinion, belongs in the DSM. In addition, having such a diagnosis facilitates access to appropriate treatment (Bockting & Ehrbar, 2005).

19. What causes gender identity disorder remains unknown. Biological factors (hormonal, genetic, brain structure) and psychosocial factors (culture, upbringing)

most likely interact, but research is still in its infancy and findings to date are inconclusive (Cohen-Kettenis & Gooren, 1999). No solid empirical support has been found for the influence of family or origin dynamics (Zucker & Bradley, 1995). Current research on the etiology of gender identity disorder primarily focuses on biological factors, such as the role of prenatal and perinatal androgen exposure in sexual differentiation of the brain. A discrepancy between genital differentiation and brain sexual differentiation has been invoked as an explanation for transsexualism (Cohen-Kettenis & Gooren, 1999), an explanation which has been supported by findings of a female brain structure in male-to-female transsexuals (Zhou, Hoffman, Gooren, & Swaab, 1995).

20. The treatment of gender identity disorders is guided by standards of care (SOC) set forth by the Harry Benjamin International Gender Dysphoria Association since 1979, now in its 6th revision (Meyer et al., 2001). *See* Exhibit 3. These guidelines are widely accepted and respected, and reflect the professional consensus about the psychiatric, psychological, medical, and surgical management of gender identity disorders. Based on an assessment by a mental health professional with expertise in the treatment of gender identity disorders, an individualized treatment plan is developed that typically consists of psychotherapy and—in case of a strong cross-gender identity—hormonal sex reassignment, real-life experience (living full time in the cross-gender role), and surgical sex reassignment. In case the mental health assessment reveals that, in addition to gender identity di: order, the individual suffers from other mental disorders such as anxiety or depression, personality disorders, or, rarely, schizophrenia, treatment of these concerns is incorporated into the treatment plan and satisfactorily addressed prior

to the initiation of sex reassignment (Bockting, 1997). Many transsexual individuals, however, do not suffer from any other mental disorders (Cohen-Kettenis & Gooren, 1999; Cole, O'Boyle, Emory, & Meyer, 1997). Gender identity disorder is a condition in and of itself that does not imply any other mental distress. Patients may have additional mental health concerns, but these are not part of a diagnosis of Gender Identity Disorder and would have to be assessed separately and reflected in an additional diagnosis.

21. The role of the mental health professional in the treatment of gender identity disorders includes assisting the patient to make a fully informed decision with regard to a change in gender role and sex assignment. While it is the client's decision whether or not to undergo any sex reassignment procedures, the mental health professional's responsibility is to determine the patient's eligibility and readiness for such procedures. This includes ascertaining that the patient is stable psychologically and emotionally, and, if concerns arise, assisting the patient in achieving such stability prior to the initiation of hormonal or surgical sex reassignment. In practice, this means that the mental health professional is available before, during, and after reassignment to assist the patient to achieve optimal adjustment in the crossgender role and maintain good mental health. According to the SOC, a recommendation from one or two mental health professionals is required to access sex reassignment procedures (one for hormone therapy or breast/chest surgery, two for genital reconstructive surgery).

22. The SOC are clinical guidelines; individual professionals and organized programs may modify them because of a patient's unique anatomic, social, or psychological situation, an experienced professional's evolving method of handling a common situation, or a research protocol.

23. The Standards of Care for Gender Identity Disorders (SOC) define the following eligibility criteria for hormonal sex reassignment:

(1) Age 18 years;

(2) Demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks;

(3) Either (a) a documented real-life experience of at least three months prior to the administration of hormones; or (b) a period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months).

24. The SOC stipulate that breast/chest surgery as part of sex reassignment should be considered with the same reservations as beginning hormone therapy. A mastectomy for female-to-male patients is usually the first surgery performed for success in gender presentation as a man. Female-to-male patients may have surgery at the same time as they begin hormone therapy. For male-to-female patients, augmentation mammoplasty may be performed if the physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormonal treatment for 18 months is not sufficient for comfort in the social gender role.

25. The SOC define the following eligibility criteria for surgical sex reassignment:

(1) Legal age of majority in the patient's nation;

(2) Usually 12 months of continuous hormonal therapy for those without a medical contraindication;

(3) 12 months of successful continuous full time real-life experience.

(4) If required by the mental health professional, regular responsible participation in psychotherapy throughout the real-life experience at a frequency determined jointly by the patient and the mental health professional. Psychotherapy is not an absolute eligibility criterion for surgery;

(5) Demonstrable knowledge of the cost, required length of hospitalizations, likely complications, and post surgical rehabilitation requirements of various surgical approaches;

(6) Awareness of different competent surgeons.

26. The eligibility criteria defined in # 23, 24, and 25 above are minimum requirements. In addition, the SOC define readiness criteria, criteria that are tailored to the individual client based on the outcome of the mental health assessment. The readiness criteria for hormonal reassignment are:

(1) The patient has had further consolidation of gender identity during the real-life experience or psychotherapy (i.e., the patient has begun to bring the private experience of gender identity in congruence with the public expression of gender role and presentation, for example through spending some time in the crossgender role or by informing family members and friends of his or her crossgender identity).

(2) The patient has made some progress in mastering other identified problems leading to improving or continuing stable mental health

(this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis, and suicidality,in case such concerns were identified during the mental health assessment or during subsequent treatment);

(3) The patient is likely to take hormones in a responsible manner.

27. The readiness criteria for surgical sex reassignment are:

(1) Demonstrable progress in consolidating one's gender identity;

(2) Demonstrable progress in dealing with work, family, and interpersonal issues resulting in a significantly better state of mental health; this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis, suicidality, for instance).

28. The SOC define the real life experience as "the act of fully adopting a new or evolving gender role or gender presentation in everyday life." The real-life experience is essential to the transition to the gender role that is congruent with the patient's gender identity. Although mental health professionals may recommend living in the cross-gender role, the decision as to when and how to begin the real-life experience remains the patient's responsibility.

29. When mental health professionals assess the quality of the real-life experience, the following abilities are reviewed:

(1) to maintain full or part-time employment;

(2) to function as a student;

(3) to function in community-based volunteer activity;

(4) to undertake some combination of items 1-3;

(5) to acquire a (legal) gender-identity-appropriate first name;

(6) to provide documentation that persons other than the therapist know that the patient functions in the desired gender role.

30. When a patient is treated in accordance with the SOC, hormone therapy is prescribed and carefully monitored by a competent physician.

31. Male-to-female sex reassignment surgery consists of well-established surgical procedures resulting in high patient satisfaction, improved psychosocial adjustment, and virtually no regrets (Green & Fleming, 1990; Pfaefflin & Junge, 1998). The recovery time of male-to-female genital reconstructive surgery is about two weeks (Bowman & Goldberg, in press).

32. When it comes to sex reassignment, gender identity is the most important component of sexual identity upon which the sex of assignment is based. In this context, gender identity can be viewed as the sex of the brain, which, once established, cannot be changed (Cohen-Kettenis & Gooren, 1999). Treatment attempts aimed at changing gender identity to become congruent with sex assigned at birth have not resulted in long-term change (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). In contrast, treatment in accordance with the SOC aimed at changing the body and gender role to become congruent with gender identity has been shown to be highly effective (Pfaefflin & Junge, 1998).

Scientific Bases for Opinions

33. Shively & DeCecco (1977) first defined the four components of sexual identity, which were then adapted by Coleman (1987) and Bockting & Coleman (1992).

34. The theory that core gender identity is established early in life is in part based on research with children born with ambiguous genitalia (Money & Ehrhardt, 1972; Money, Hampson, & Hampson, 1955, 1957). For example, Money and colleagues (1957) observed that the vast majority of children with an intersex condition whose sex was reassigned prior to the age of 27 months adjusted to the change without complications, whereas a minority of children who were reassigned after the age of 27 months did. They concluded that sex of assignment and gender of rearing, instead of chromosomal, gonadal, or genital sex, were the best predictors of adult gender identity (Meyer-Bahlburg, 1998; Zucker, 1999). At the time, nothing was known about the sexual differentiation of the brain. Since the demonstration of sexual brain differentiation in animals (Phoenix, Goy, Gerall, & Young, 1959), prenatal exposure of the brain to androgens has increasingly been put forward as a critical factor in gender identity development (Diamond & Sigmundson, 1997).

35. Based on such instruments as the Bem Sex Role Inventory (1981), individuals may be classified as predominantly masculine, predominantly feminine, both highly masculine and highly feminine (androgynous), or neither masculine nor feminine (undifferentiated), regardless of their sex or gender identity. Many studies have been conducted with the Bem Sex Role Inventory showing that both men and women report masculine and feminine characteristics to varying degrees, and that what is considered masculine or feminine in a given culture may change with time (e.g., Auster & Ohm, 2000). Transsexuals also typically have both masculine and feminine sex role characteristics; masculinity in a male-to-female transsexual may lead uninformed others to erroneously question the validity of that person's female core gender identity

(Bockting, 1997; 1999). However, many male-to-female transsexuals who have masculine interests and other masculine sex role characteristics have an unambiguous female core gender identity and are appropriate candidates for sex reassignment.

36. Coleman (1987) argued that, in order to assess sexual orientation adequately, all four components of sexual identity need to be assessed. He also argued that in defining the sexual orientation of transsexual individuals, gender identity should be used as the reference point (Coleman & Bockting, 1988). In other words, the sexual orientation of a male-to-female transsexual who lives as a woman and is attracted to men can best be described as heterosexual (instead of homosexual).

37. The prevalence of transsexuality is based on the number of referrals to a national, government-subsidized gender identity clinic in the Netherlands. In the United States, treatment is not centralized and access to sex reassignment services is variable, compromising the ability to adequately estimate the size of the transsexual population.

38. Whether or not mental disorders (other than gender identity disorder) are more common among transsexuals than among the general population is not clear. This question has not been inadequately studied and the evidence that is available is inconclusive (Cohen-Kettenis & Gooren, 1999). My clinical impression and interpretation of the available research findings is that the symptoms of other mental disorders (e.g., anxiety, depression) that transsexuals may present with are a result of the social stigma associated with their gender nonconformity, and are not intrinsically related to their gender identity disorder. These symptoms improve with treatment as individuals learn to effectively manage such social stigma (Bockting, 1997; Pfaefflin & Junge, 1998).

39. Family dynamics, such as symbiosis with the mother, absence of the father, and the maternal wish for a daughter were thought to be responsible for the development of gender identity disorder, but no solid empirical support was found for these hypotheses (Cohen-Kettenis & Gooren, 1999; Green, 1987; Roberts, Green, Williams, & Goodman, 1987; Zucker et al., 1994). Animal research has shown support for the role of testosterone in sexual differentiation of the brain during critical periods of development, however, research findings on the effect of prenatal androgen exposure in humans on gender identity have been inconclusive (Cohen-Kettenis & Gooren, 1999). A sexually dimorphic nucleus of the hypothalamus of male-to-female transsexuals was found to be significantly smaller than in males, but entirely within the size range of females (Zhou et al., 1995; Kruijver et al., 2000).

40. Case reports of attempts to change individuals' crossgender identity to become congruent with their sex assigned at birth do not reveal convincing evidence for complete and long-term reversal of crossgender identity by means of psychotherapy (Cohen-Kettenis & Kuiper, 1984; Pauly, 1964). Once established, a crossgender identity is virtually impossible to influence (Cohen-Kettenis & Gooren, 1999).

41. Many studies have shown that the vast majority of transsexuals are satisfied with the outcome of sex reassignment. Satisfaction rates range from 87% for male-to-female transsexuals to 97% for female-to-males (Green & Fleming, 1990). Factors associated with satisfaction include participation in counseling and psychotherapy (Green & Fleming, 1990), the duration of the real life experience (Doorn, 1997; Lawrence, 2003), hormone therapy (Carroll, 1999), quality of surgical results (Ross & Need, 1989; Lawrence, 2003), and a legal change in name and sex (Pfaefflin &

Junge, 1998). Regrets and reversal to the original gender role are rare, in fact less than 1.0-1.5% (Pfaefflin & Junge, 1998). Sex reassignment has been shown to result in improved mental health, socioeconomic status, relationships, and sexual satisfaction (Fleming, Cohen, Salt, Jones, & Jenkins, 1981; Mate-Kole, Freschi, & Robin, 1990; Pfaefflin & Junge, 1998).

Summary of Opinions/Conclusions

42. Based on the foregoing, my opinions can be summarized as follows:

a. Sexual identity has at least four components: (1) sex assigned at birth; (2) gender identity; (3) social sex role; and (4) sexual orientation;

b. Gender identity (a person's basic sense of belonging to one sex or the other), established early in life (as a result of sexual differentiation of the brain), is the most important and deciding factor in sex assignment. Once established, most likely the result of sexual differentiation of the brain during critical periods in prenatal and perinatal development, gender identity is not amenable to change.

c. Individuals with gender identity disorder, a relatively rare condition, experience a profound incongruence between their sex assigned at birth and their gender identity.

d. Although gender identity is classified as a mental disorder, individuals with this disorder, particularly when receiving treatment, may not show any other mental health symptoms.

Moreover, stable mental health is a prerequisite for access to hormonal and/or surgical sex reassignment.

e. Treatment of gender identity disorder is guided by the widely accepted Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders that reflect a consensus of professionals specializing in this area. For individuals with strong cross-gender feelings, treatment typically consists of psychological evaluation and therapy, hormonal therapy, real-life experience (living full-time in the cross-gender role), and surgical sex reassignment.

f. Treatment attempts to adjust gender identity to become more congruent with sex assigned at birth have failed. Sex reassignment, in accordance with the Benjamin Standards of Care, has been shown to be highly effective in achieving congruence, resulting in high satisfaction rates, very few regrets, and improved mental health and stability.

43. I may wish to supplement these opinions or the bases for them as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise by defendant's expert witnesses, whether in expert reports, or in their depositions or other testimony.

September 14, 2006

Walter O. Bockting, Ph.D.

References

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders*, Fourth Edition, Text Revision. Washington, DC: American Psychiatric Association.

Auster, C.J., & Ohm, S.C. (2000). Masculinity and femininity in contemporary American society: A reevaluation using the Bem Sex Role Inventory. *Sex Roles, 43*(7/8), 499-528.

Bakker, A., van Kesteren, P., Gooren, L.J.G., & Bezemer, P.D. (1993). The prevalence of transsexualism in the Netherlands. *Acta Psychiatrica Scandinavica, 87*, 237-238.

Bem, S.L. (1981). *Bem Sex-Role Inventory*. Palo Alto, CA: Consulting Psychologists Press.

Bockting, W.O. (1997). The assessment and treatment of gender dysphoria. Directions in *Clinical and Counseling Psychology, 7*(11), 1-23.

Bockting, W.O. (1999). From construction to context: Gender through the eyes of the transgendered. *SIECUS Report, 28*(1), 3-7.

Bockting, W.O., & Coleman, E. (1992). A comprehensive approach to the treatment of gender dysphoria. *Journal of Psychology and Human Sexuality, 5*(4), 131-155.

Bockting, W.O., & Ehrbar, R. (2005). Commentary: Gender variance, dissonance, or identity disorder. *Journal of Psychology and Human Sexuality, 17*(3/4), 125-134.

Bowman, C., & Goldberg, J. M. (in press). Care of the patient undergoing sex reassignment surgery. *International Journal of Transgenderism, 9*(3/4).

Carroll, R.A. (1999). Outcomes of treatment for gender dysphoria. *Journal of Sex Education and Therapy, 24*, 128-136.

Cohen-Kettenis, P.T., & Gooren, L.J.G. (1999). Transsexualism: A review of etiology, diagnosis and treatment. *Journal of Psychosomatic research, 46*(4), 315-333.

Cohen-Kettenis, P.T., & Kuiper, A.J. (1984). Transseksualiteit en psychotherapie. *Tijdschrift voor Psychotherapie, 10*, 153-166..

Cohen-Kettenis, P.T., & Pfaefflin, F. (2003). *Transgenderism and intersexuality in childhood and adolescence: Making choices*. Thousand Oaks, CA: Sage.

Cole, C. M., O'Boyle, M., Emory, L. E., & Meyer, W. J., III (1997). Comorbidity of gender dysphoria and other major psychiatric diagnoses. *Archives of Sexual Behavior, 26*, 13-26.

Coleman, E. (1987). Assessment of sexual orientation. *Journal of Homosexuality, 14*(1/2), 9-24.

Coleman, E., & Bockting, W.O. (1988). "Heterosexual" prior to sex reassignment, "homosexual" afterwards: A case study of a female-to-male transsexual. *Journal of Psychology and Human Sexuality, 1*(2), 69-82.

Dreger, A.D. (1999). A history of intersex: From the age of gonads to the age of consent. in A.D. Dreger (Ed.), *Intersex in the age of ethics.* Hagerstown, MD: University Publishing Group.

Diamond, M. & Sigmundson, H.K. (1997). Sex reassignment at birth: Long-term review and clinical implications. *Archives of Pediatrics and Adolescent Medicine, 151*, 298-304.

Doorn, C.D. (1997). *Towards a gender identity theory of transsexualism.* Doctoral Dissertation. Amsterdam, The Netherlands: Vrije Universiteit.

Fleming, M., Cohen, D., Salt, P., Jones, D., & Jenkins, S. (1981). A study of pre- and post-surgical transsexulas; MMPI characteristics. *Archives of Sexual Behavior, 10*, 161-170.

Green, R. (1987). *The "sissy boy syndrome" and the development of homosexuality.* New Haven, Connecticut: Yale University Press.

Green, R., & Fleming, D. (1990). Transsexual surgery follow-up: Status in the 1990s. *Annual Review of Sex Research, 1*, 163-174.

Kruijver, F.P.M., Zhou, J.N., Pool, C.W., Hofman, M.A., Gooren, L.J.G., & Swaab, D.F. (2000). Male-to-female transsexuals have female neuron numbers in a limbic nucleus. *The Journal of Clinical Endocrinology & Metabolism, 85*(5), 2034-2041.

Lawrence, A. (2003). Factors associated with satisfaction or regret following male-to-female sex reassignment surgery. *Archives of Sexual Behavior, 32*(4), 299-315.

Mate-Kole, C., Freschi, M., & Robin, A. (1990). A controlled study of psychological and social challenges after surgical gender reassignment in selected male transsexuals. *British Journal of Psychiatry, 157*, 261-264.

Meyer III , W., Bockting, W., Cohen-Kettenis, P., Coleman, E., DiCeglie, D., Devor, H., Gooren, L., Hage, J., Kirk, S., Kuiper, B., Laub, D., Lawrence, A., Menard, Y., Patton, J., Schaefer, L., Webb, A., Wheeler, C. (2001). The standards of care for gender identity disorders, sixth version. *Journal of Psychology & Human Sexuality, 13*(1), 1-30.

Meyer-Bahlburg, H.F.L. (1998). Gender assignment in intersexuality. *Journal of Psychology and Human Sexuality, 10*, 1-21.

Money, J., & Ehrhardt, A.A. (1972). *Man and woman, boy and girl: The differentiation and dimorphism of gender identity from conception to maturity*. Baltimore, MD: Johns Hopkins University Press.

Money, J., Hampson, J.G., & Hampson, J.L. (1955). An examination of some basic sexual concepts: The evidence of human hermaphroditism. *Bulletin of the Johns Hopkins Hospital, 97*, 301-319.

Money, J., Hampson, J.G., & Hampson, J.L. (1957). Imprinting and the establishment of gender role. *Archives of Neurology and Psychiatry, 77*, 333-336.

Pauly, I.B. (1965). Male psychosexual inversion: Transsexualism: A review of 100 cases. *Archives of General Psychiatry, 13*, 172-181.

Pfaefflin, F., & Junge, A. (1998). *Sex Reassignment. Thirty years of international follow-up studies after sex reassignment surgery: A comprehensive review, 1961-1991.* [Available online at www.symposion.com/ijt]

Phoenix, C.H., Goy, R.W., Gerall, A.A., & Young, W.C. (1959). Organizing asction of prenatally administered testosterone propionate on the tissues mediating behavior in the female guinea pig. *Endocrinology, 65*, 369-382.

Roback, H.B., McKee, E., Webb, W., Abramowitz, C., & Abramowitz, S. (1976). Comparative psychiatric status of male applicants for sexual reassignment surgery, jejunoileal bypass surgery, and psychiatric outpatient treatment. *Journal of Sex Research, 12*, 315-320.

Roberts, C.W., Green, R., Williams, K., & Goodman, M. (1987). Boyhood gender identity development: A statistical contrast between two family groups. *Developmental Psychology, 23*, 544-557.

Ross, M.W., & Need, J.A. (1989). Effects of adequacy of gender reassignment surgery on psychological adjustment: A follow-up of fourteen male-to-female patients. *Archives of Sexual Behavior, 18, 145-153.*

Shively, M.G., & DeCecco, J.P. (1977). Components of sexual identity. *Journal of Homosexuality, 3*(1), 41-48.

Stoller, R. (1964). A contribution to the study of gender identity. *International Journal of Psychoanalysis, 45*, 220-226.

Zhou, J., Hoffman, M.A., Gooren, L.J.G., & Swaab, D.F. (1995). A sex difference in the human brain and its relation to transsexuality. *Nature, 378*, 68-70.

Zucker, K.J. (1999). Intersexuality and gender identity differentiation. *Annual Review of Sex Research, 10*, 1-69.

Zucker, K.J., & Bradley, S.J. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York: Guilford Press.

Zucker, K.J., Green, R., Garofano, C., Bradley, S.J., Williams, K., Rebach, H.M., & Lowry Sullivan, C.B. (1994). Prenatal gender preference of mothers of feminine and masculine boys: Relation to sibling sex composition and birth order. *Journal of Abnormal Child Psychology, 22*, 1-13.