

True Selves

**Understanding Transsexualism—
For Families, Friends, Coworkers,
and Helping Professionals**

**Mildred L. Brown
Chloe Ann Rounsley**

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Medical and Surgical Options

Transsexuals living full-time in the opposite gender role want to look authentic and believable. Toward that end, they often undergo hormone therapy, various facial and scalp surgeries, breast and chest surgeries, and in many cases genital sex reassignment surgery. This chapter discusses the most common medical interventions and how they contribute to the transsexual patient's sense of rightness, completion, and wholeness.

Hormones

The purpose of hormone treatment for transsexuals is twofold. First, physically, hormones reduce the secondary sex characteristics of the original sex and enhance the development of the secondary sex characteristics of the desired sex. Estrogens are given to males to feminize their bodies, and androgens are administered to females to masculinize their bodies. Second, psychologically, hormone treatments result in feelings such as calmness, peacefulness, and a sense of fulfillment and well-being. This could be an effect of the hormones or due to the uplifting feeling that arises from knowing that they are taking a definitive step toward becoming more like the sex that they self-identify as.

According to the Standards of Care (SOC) guidelines, to begin hormone treatment, patients are required to present their physician

with a letter from a therapist confirming that they have been diagnosed as transsexual and have undergone a minimum of three months of therapy. Beginning hormone treatment is an eagerly awaited “rite of passage” for transsexuals. As they develop the secondary sex characteristics of the opposite sex, each new bodily change that occurs is a sign of progress and a cause for celebration.

Female-to-Male Transsexuals

Testosterone, the male hormone, is administered by injection every two to four weeks for FTMs, and generally causes the following changes:

- Growth of facial and body hair
- Thickening of vocal cords so that voice pitch becomes lower
- Increased muscle mass, which results in increased physical strength
- Redistribution of body fat, such as loss of waistline and slimming of hips, although breast size does not decrease
- Coarsening of the skin and possible flare-ups of acne because the skin often becomes oilier
- Thinning of the hair on the head; development, with age, of male-pattern baldness (if part of the person’s heredity)
- Cessation of menstruation and reproductive functioning
- Increased libido
- Enlargement of the clitoris

Male-to-Female Transsexuals

Female hormones, such as estrogen, are administered to MTFs by pill, injection, or skin patches, and generally cause the following changes:

- Growth of breasts
- Softening of the skin
- Redistribution of body fat (typically, waistline becomes smaller, and hips and buttocks become rounder)
- *Diminished ability to achieve erections and to ejaculate*
- Loss of muscle mass, resulting in less physical strength
- Thinning of body hair
- Cessation of scalp hair loss

Reactions to Hormone Treatments

Both FTMs and MTFs generally find themselves more emotionally stable and less angry and depressed than before hormone treatment. In addition, many (but not all) MTFs are less stoic and more sentimental and emotional; they may cry easily for the first time in their lives since childhood.

One MTF patient, expressing a typical sentiment, said: “I’m amazed that things that would have driven me out of my mind a few months ago don’t faze me anymore. People say that I’m calmer and more open.”

An FTM patient made similar comments: “Before I began taking testosterone, I had so many mood swings. Frequently, I would wake up exhausted in the morning and find it difficult to get out of bed. Depression and a ‘sucked-down’ feeling were more typical than not. Intellectually, I could detach from the physical aspects of menstrual cramps and PMS, but emotionally, I could not. I used to cry or go into rages for no reason—anything could trigger it. Now it’s dramatically different. I’m calm, happy, and full of energy.”

“Over the past year, I have been delighted at the changes that have occurred,” another FTM said. “I now have facial and body hair, a deep masculine voice, a strong jawline, and a renewed libido. My deep depressions completely stopped within one week of the first testosterone injection. Simple things, such as the joy of shaving, have become part of a routine that I look forward to each day.

I have changed my name to Donald and have a new driver's license with a picture that I am proud to show off."

Transsexuals who undergo hormone treatment frequently state that the experience is like going through puberty again. And indeed, even though they are adults and have adult bodies, the hormone regimen that transsexuals follow triggers some of the same secondary sex characteristics and mood fluctuations that teens experience.

"I'm experiencing an incredible rejuvenation from the hormones," said an MTF patient. "I'm forty-three years old and feel like I'm in my twenties. It's remarkable. I now have my long-awaited breasts, and my skin gets softer every day. I was pretty clearly on the road to the blahs—but not so now. The hormones provide me with different insights, emotionally and ego-wise."

A Spectrum of Changes

Although hormones allow transsexuals to achieve some of the desired physical changes and to become more masculine or more feminine, some areas of the body will not be affected. Basic bone structure (the skeleton) does not change, so height, the width of the pelvis, and the size of the hands and feet cannot be modified with hormones.

The effects of hormone treatment may appear slowly. Some changes occur after six to eight weeks, whereas others may take six to twenty-four months or even longer. In fact, FTMs may not have facial hair growth until they have had four or five years of hormone treatment. And full breast development for MTFs may require ten or even fifteen years.

Because every individual's genetic makeup and metabolism are different, the same hormone in the same dosage can have vastly different effects, much as in puberty. For example, whereas some MTFs will experience hardly any breast growth, others will show substantial development. And for FTMs, facial hair growth ranges from "peach fuzz" to a heavy beard. Since there is no way to predict the

precise outcome, patients are cautioned against unrealistic expectations; hormones do not produce rapid or “magical” results.

As with all drugs, there are risks involved in taking hormones. Some possible side effects are increased blood pressure, liver disease, heart disease, and blood clots in the legs. Regular visits to the prescribing physician or endocrinologist are essential in order to check general health; monitor hormone levels, blood chemistry, and blood pressure; and check for any adverse side effects.

Patients need to be forewarned of the potential side effects. They must be made aware that they will have to continue hormone treatments for the rest of their lives and that the long-term risk factors are still unknown. So patients are generally requested to sign an informed-consent release with their physician before they begin treatment. If the patient is married at the time, some physicians will request that the spouse sign a release as well.

Not all transsexuals take hormones. Some, usually for health reasons, cross-live and proceed with the real-life test without hormone treatment and may or may not go on to have SRS.

Surgical Options

While hormones can help to bring transsexuals' bodies more in line with their gender identity, some patients seek out nongenital cosmetic surgeries to further enhance their masculinization or feminization.

Cosmetic (Nongenital) Surgery

Transsexuals who undergo cosmetic surgeries report an enhanced self-image, greater self-confidence, and a sense of “congruity” or “rightness” when they look in the mirror and see an image that conforms with their gender identity.

“I had long felt,” one patient said, “that my unattractive, large, and rather masculine ‘Italian nose’ was very much of a problem for me in terms of being able to look like and be socially accepted as a woman, so I spent a lot of time isolated, locked away in my room.

Ever since I had my nose and jawline recontoured, though, I love going out in public. My friends say I've become a social butterfly.”

- A wide variety of nongenital cosmetic surgeries are available, and the list of surgical specialties is constantly expanding. The following are the most common surgeries that transsexuals may choose to undergo in order to look more attractive and more convincing:

- Tracheal shave—a reduction procedure performed on the cartilage of the trachea that MTFs undergo because most believe that a noticeable or prominent Adam's apple is a “dead giveaway” of maleness.
- Rhinoplasty (nose job).
- Baldness corrective procedures—hair plugs or scalp reduction to decrease areas of baldness.
- Face-lift.
- Acid peel (for younger-looking, less blemished, smoother skin).
- Liposuction of fat deposits on various parts of the body.
- Changing the shape of the forehead, especially the brow and mid-forehead (males tend to have fullness over the brow area, whereas female skulls appear smoother).
- Changing or contouring the shape of the chin (females tend to have a narrower, more pointed chin, while males' chins tend to be broader).
- Modifying the angle and sides of the lower jaw.
- Cheek implants—for augmentation or contouring.
- Voice surgery—a procedure that some MTFs undergo to tighten the vocal cords for greater tension. The results can vary depending on the patient's voice pitch, the technique used, and the skill of the surgeon.

Patients who choose to undergo one or more of these surgeries generally do so when they begin full-time cross-living so that they will look more passable.

Sex Reassignment Surgery

Sex reassignment surgery (SRS) is surgery on the genitalia or breasts performed for the purpose of altering them to approximate the physical appearance of the genetically other sex.

Although there are no SOC prerequisites for patients seeking nongenital cosmetic surgeries, patients must meet the following requirements before breast and genital surgeries can be performed:

- They must have been under the care of a therapist for at least one year (six months for breast augmentation or mastectomy).
- They must have been diagnosed as gender dysphoric.
- They must have completed the real-life test by living in the opposite gender role for at least one year.
- They must receive a written referral from their primary therapist and a second referral from a clinician other than the therapist. At least one of the two therapists must hold a Ph.D. or M.D. degree.
- They must be in good physical health.

It should be noted that transsexuals must discontinue hormones at least three weeks prior to SRS (and abstain for two weeks afterward) to prevent potentially life-threatening blood clots.

Male-to-Female Surgeries

The SOC lists two surgeries under the category of genital surgeries—breast augmentation surgery and vaginoplasty.

Breast Augmentation Surgery

Breasts are an external cultural symbol of femininity and female sexuality and are also associated with the female sustenance and nurturing role. For these reasons, most MTFs look forward to breast

development more than any other changes in their body. Breast augmentation is generally sought when hormone treatment does not produce sufficient breast development.

Breast augmentation surgery (also called *augmentation mammoplasty*) is done by inserting saline-filled implants below the breast tissue in order to simulate natural breasts.

As one patient said, "After my breast augmentation surgery, I ran over to the mirror to look at my profile and saw the chest contour that I had always seen in my mind's eye. For the first time in my life, I could look in the mirror and see the woman I always knew I was."

Another patient said, "Why do I feel these feelings, like memories I never had before, that echo through my soul? How could I possibly miss the feeling of lying on my side, one breast laying atop the other, when I never had breasts before? But I did miss that, and now things are right, like they've never been before."

Because breast implants can impair the reading of mammograms, breast augmentation should be carefully considered before surgery is performed.

Vaginoplasty

Vaginoplasty is the construction of the vulva and vagina.

There are two standard methods for creating a vagina. The most common method, *penile inversion*, uses the inverted skin of the penis to create the lining of the vagina. A space is made between the rectum and the urethra. The erectile tissue is removed from the penis and the penile skin is then turned inside out and placed into the new vagina as the lining. When there is not ample penile skin to create adequate depth, a skin graft is taken from the stomach, buttocks, or thigh for that purpose.

The second method, *rectal sigmoid transfer*, uses a segment of the large intestine to create a vaginal lining. The main advantage of this method is that it provides natural lubrication and unlimited vaginal length. Some disadvantages, when compared to the inversion method, are that the rectal sigmoid transfer is more invasive

surgery, costs more, requires a longer hospitalization stay and recuperation period, and sometimes results in prolonged mucoid leakage through the vagina.

In both methods, the scrotum is removed and the leftover scrotal skin is used to create the labia, and part of the glans (head of the penis) is used to create a clitoris. Most MTF patients have a capacity to be orgasmic postsurgically with either method, and when performed by skilled surgeons, both methods produce female genitalia that are indistinguishable from that of a genetic female.

Labiaplasty

The purpose of *labiaplasty* is to form a junction between the inner and outer labia in order to create a vulva that closely resembles the vulva of a genetic female. With certain surgical techniques, the labiaplasty is done at the same time as SRS and is simply an adjunct to the vaginoplasty procedure. With other techniques, a minimum of a three-month wait is required after SRS before labiaplasty can be performed, and it is done on an outpatient basis under local anesthesia.

Reactions

Genital sex reassignment gives MTF transsexuals the body and contours they have always dreamed of having. At long last, they can stand naked in front of a full-length mirror and not be repulsed. They are free to wear bathing suits or form-fitting slacks or jeans without embarrassment. Finally, they have the right genitalia with which to be sexual (if they choose to do so).

Many patients describe SRS as lifesaving or sanity-saving. "Choosing to undergo SRS for me," one patient said, "involved the same kind of lifesaving logic as choosing to *not* jump off a cliff. To choose differently in either case would be a completely irrational act. When transsexualism is viewed from this context, one sees that SRS is no more of a lifestyle decision than elective heart surgery, for

instance. SRS is as important to me as water is to someone dying of thirst.”

Another patient expressed sentiments about SRS like this: “Being rid of my penis made such a difference in my life! I didn’t know how much longer I could go on with that ugly growth dangling there. I would have flown anywhere in the world or given up my career in order to have SRS. I got to the point where even death seemed more palatable than keeping my male genitals. Now I no longer have to worry about telltale bulges and protrusions in places where they don’t belong on my body. My genitals fit, my body fits, my clothes fit—I fit.”

Female-to-Male Surgeries

Whereas most MTFs need only vaginoplasty surgery to create the appearance of a complete female genital anatomy, FTMs need at least three surgeries to create a complete male genital anatomy: mastectomy, hysterectomy, and penis construction. Sometimes all three sites are operated on at once, but for most patients, because of cost factors, they are done separately over a period of time.

Mastectomy

This operation is the first and most common FTM surgery performed. There are two procedures for *mastectomy*, depending on the amount of breast tissue to be removed. For patients with a lot of breast tissue, the breasts are surgically removed and the nipple and areola are repositioned to create a chest that is masculine in appearance. This procedure leaves a rather large scar. For FTMs with small and medium-sized breasts, a small incision is made around the areola, and the excess tissue is removed by liposuction or by a combination of liposuction and surgical removal.

Breasts are visible symbols of femininity and are perceived by FTMs as indisputable evidence of their gender incongruity. Most are repulsed by their breasts and bind them or wear many layers of

clothing to conceal them. After their mastectomy, however, they can for the first time publicly wear T-shirts and tank tops and go shirtless on the beach. It is a freeing and exciting experience.

“I am now very comfortable walking around in the world,” one patient said. “I am no longer wearing multiple layers of clothing or sitting in a way that would hide the outline of my breasts. I now make big arm movements and am louder and more boisterous because I am not afraid to call attention to myself. I can flirt in public and even walk with my chest out.”

One patient used metaphor to express her feelings about her chest and genital surgeries: “Before my surgeries, my life was like a television set that had only the sound but no picture. I could understand what was going on, but I never experienced it as it was intended to be experienced—I only had a glimpse of what life was like. Now everything’s there, picture and sound. It is a spiritual and physical awakening for me.”

Internal Reproductive and Sex Organ Surgeries

Most FTMs have all of their internal reproductive organs—the uterus (*hysterectomy*), ovaries (*oophorectomy*), fallopian tubes (*salpingectomy*), and vagina (*vaginectomy*)—removed because for them these are unwanted, unnecessary organs that don’t belong in a male body. Furthermore, these organs are possible sites for cancer and, if not surgically removed, would necessitate regular gynecological exams and pap smears. FTMs do not want this reminder of their former lives. They are relieved to be rid of these organs.

Penis Construction. There are two surgical methods used to construct a penis—genitoplasty and phalloplasty. *Genitoplasty* (also known as *clitoral release surgery*) is the simplest. In this procedure, the surgeon frees the skin surrounding the hormonally enlarged clitoris and wraps it around the clitoris to form a very small penis (usually thumb-sized or slightly larger) that maintains sensitivity and orgasmic capability but is not generally large enough for intercourse.

In *phalloplasty*, a penis is created from skin transferred from some area of the body, usually the abdomen, groin, thigh, or forearm. This tissue transfer, called a *flap*, requires from two to eight stages of surgery and leaves large scars at the graft sites.

There are two common phalloplasty methods for creating a full-sized penis for the FTM patient—the pedicle flap and the radial forearm flap.

Pedicle flap. In this procedure, a tube of skin is raised up out of the groin or the mid-abdominal area and attached to the pubis, with the end result resembling a suitcase handle. Then, in the course of two to four months, secondary procedures are done to augment the blood supply to this flap, cut it free from its origin, and sculpt it so that it resembles a penis. Although the neophallus may look quite realistic, it is highly risky to attempt to create a urethra with this procedure that would allow the FTM to stand up to urinate. Moreover, it lacks sexual feeling and no orgasm or erection is possible. However, temporary stiffeners (silicone rods that can be placed in the phallus at time of use and then removed) or inflatable penile prostheses can be used for penetration. In the latter method, a manual pump is placed in the scrotum and a fluid reservoir in the abdomen and an erection is obtained by squeezing the scrotum.

Radial forearm flap. During an extensive operation of up to thirteen hours, skin is taken from a significant area of the forearm along with the blood vessels and nerves that supply it and is fashioned into the shape of a penis. Then, using microsurgery, the arteries, veins, and nerves are hooked up to the arteries, veins, and nerves in the pubis.

The principal advantage of this operation is that the penis appears natural, has sensation, and can have the urethra extended and attached so that one can stand to urinate. Because the nerves are intact, orgasm is possible, but ejaculation is not. As with the pedicle flap procedure, stiffening devices or inflatable prostheses can be used to create erections.

Scrotum Construction. The scrotum is formed from the labia majora (outer lips of the vulva). Following the removal of the labia minora

(inner lips of the vulva), the labia majora are sewn together on the midline. Inflatable implants are placed under the skin and slowly inflated by injecting saline. Once the expansion is complete, testicular prostheses may be implanted immediately or at some later time. Scrotum construction is generally done at the same time as the genitoplasty or phalloplasty.

Urethroplasty. *Urethroplasty*—urethral extension to the end of the glans—is an optional surgical procedure that allows patients to urinate standing up and can be done in conjunction with both genitoplasty and radial forearm flap phalloplasty.

From a psychosocial point of view, the ability to stand while urinating is significant to most FTMs. However, this is a costly surgery with a high complication and failure rate. Patients who desire this surgery should explore it carefully with the surgeon before proceeding.

Though most female-to-male patients would prefer to have a full-sized penis, the vast majority find the invasiveness and scarring of phalloplasty overwhelming (not to mention the cost, which can be as high as \$100,000 for the radial forearm flap) and elect not to proceed with it. They may decide to have no genital surgery at all or may postpone the decision in the hope that phalloplasty will be improved in the future. What they are seeking is a technique that is less expensive and causes less scarring, yet provides an organ that is sensitive and aesthetically pleasing as well as functional for both urination and sexual intercourse. For now, the majority of FTMs who do have genital sex reassignment opt for clitoral release and the creation of a scrotum and testicles.

Patients who are planning to have surgery are urged to talk to postoperative transsexuals about their procedures and, if possible, to see the results for themselves. While people don't normally bare their genitals to others, in some cases, postoperative patients are willing to share the benefit of their SRS experiences in order to help others make a responsible, informed decision about proceeding with surgery. Although surgeons have photographs to enable patients to see the results of past operations, it helps to see results firsthand.

Cost of Sex Reassignment Surgery

Prices for SRS vary enormously, depending on the number of procedures, the length of the hospital stay required, the part of the country where the surgery is performed, and the fee the particular surgeon charges. In the United States today, SRS can cost from \$10,000 to \$45,000 for MTFs and from \$25,000 to \$100,000 for FTMs who have a phalloplasty, hysterectomy, vaginectomy, and mastectomy.

In general, costs are higher in major medical centers in the larger cities in the United States. In many European countries, parts of Asia, and Canada, the cost of SRS is approximately one-third to one-half the cost in the United States.

Most insurance companies have exclusion clauses for SRS and related “sex change” procedures and will not pay for them. They consider such procedures “cosmetic, experimental, or elective surgeries.” Therefore, transsexuals must usually assume the burden of the medical and surgical fees themselves.

Surgery Is a Personal Choice

One of the first things people think when they hear the word *transsexual* is “sex change operation,” and this phrase often evokes a strong emotional reaction. Although SRS is something that many transsexuals eventually undergo, not all do. It is an individual choice.

For some transsexuals, as long as they can cross-dress and cross-live as their true gender, they do not feel the need to change their physical body surgically. But for most, SRS is an important and positive event that enhances their body image and self-image and frees them to enjoy a better quality of life. Surgery allows MTFs (and some FTMs) to be sexual with sex organs that look and function like “the real thing.”

Genital sex reassignment is only one of several choices open to transsexuals. Most transsexuals opt for hormone treatment and full genital SRS; others pursue a variety of options. For example, some transsexuals may be content to cross-live in the opposite gender

role with no hormones and no surgery, some may be content with hormonal treatment only, and some FTMs may choose only to have a mastectomy or a hysterectomy and forgo any genital surgeries. Any of these are valid options and can be ends in themselves.

Individual patients must decide which surgical procedures are appropriate for them and how far they want to go. The deciding factor is usually what is affordable and at what point they can stop and still be comfortable with their bodies and themselves.

Because the cost of full SRS can be prohibitively high, some patients have to wait many years between procedures until they save up the money. Some postpone SRS for other reasons, reconsidering it only when they arrive at a different stage or mind-set in their lives and surgery becomes a more viable choice for them.

Whether or not to have sex reassignment surgery is a personal choice. The transsexual journey is unpredictable as to timetable, path, and destination. Like a highway, there are many off-ramps, rest stops, and turnabout points along the way. Transsexuals can always stop, start again, or turn around at any point in the journey. Therapists don't assume that any one step will necessarily lead to the other or that SRS is the end goal of gender therapy. If SRS does occur, most patients no longer consider themselves transsexual because they are hormonally, anatomically, and psychologically the correct sex.

Life After Sex Reassignment Surgery

For most transsexuals, sex reassignment surgery is psychologically uplifting. They experience an enormous sense of pleasure and well-being in finally having the body they have yearned for ever since they first became aware of their gender dysphoria. After SRS, they are generally happier and much more self-confident.

For some, however, these good feelings are not immediate. For a period after SRS, some transsexuals fall into a depression, not unlike a new mother's postpartum blues. This type of depression usually arises from the letdown that occurs when transsexuals are

no longer in the limelight, as is the case for many during transition. It also may be related to unrealistic expectations about life after SRS, which is why it is so important that this be addressed in therapy in advance and that the entire real-life test be completed. For others, the emotional lows after SRS may be attributed to postsurgical complications or poor surgical results—either aesthetic or functional.

Most of those who suffer some post-SRS depression state that they nevertheless feel better than when they were living in the wrong body and gender role. “I may not be ecstatic as Joanne, but I was miserable as Joe,” one patient said. “I’d never want to go back to being male.” In fact, according to a recent study, very few patients—fewer than 1 percent of FTMs and 1.5 percent of MTFs—regret having had SRS.

Even though patients may not end up with the perfect body, most are realistic and philosophical about their surgical outcome. One patient explains: “I knew going into surgery that the doctor wouldn’t be giving me the body of my dreams. He was going to do one thing only—make it impossible for me to ever live as a normal male again. And I wanted that—I wanted it badly. But I couldn’t help noticing that the doctor didn’t have a magic wand in his medicine kit. And even a magic wand couldn’t make anyone into a genetic girl, or rewrite the past.”

Life after sex reassignment surgery is seldom idyllic. SRS does not guarantee happiness, nor does it cause gender-related problems to disappear magically. Some postoperative transsexuals still retain anger and shame. Many continue to be frequently “read” and to face harassment and discrimination. In addition, they also, like everyone else, have day-to-day problems. Postoperative transsexuals still have to earn a living; deal with family, relationship, and health concerns; clean the house; pay taxes; and pay their bills. What is different is that now they can do all this without gender dysphoria and with a body and gender identity that are congruent.