Commonwealth of Massachusetts

Joint Committee on the Judiciary

House Bill 482 relative to a Woman's Right to Know

Testimony of Michael A. Grodin, M.D.

Thank you for affording me the opportunity to testify at the Joint Committee on the Judiciary in opposition to proposed legislation seeking to impose unethical, intrusive and unnecessary legislation on women who seek abortion services. I am here speaking on my own behalf and do not represent any organization or institution.

My name is Dr. Michael A. Grodin. I am a citizen of the Commonwealth and reside in Brookline, Massachusetts. I received my Bachelor of Science degree in life sciences at the Massachusetts Institute of Technology, my medical degree from the Albert Einstein College of Medicine, completed post-doctoral training at the University of California-Los Angeles and Harvard and at the Massachusetts General Hospital, Children's Hospital Medical Center and Boston City Hospital. I am a licensed physician in the Commonwealth, board certified and a fellow of the American Academy of Pediatrics. I have been on the faculty of Boston University for 32 years where I am a full professor of Family Medicine and Psychiatry at the Boston University School of Medicine and Professor of Health Law, Bioethics, and Human Rights at the Boston University School of Public Health. I have served as the medical ethicist for the Department of Health and Hospitals of the City of Boston and am presently the medical ethicist for the Boston Medical Center. I have served for 6 years on the National Committee on Ethics of both the American College of Obstetricians and Gynecologists and American Academy of Pediatrics. I have published 5 books and authored over 200 articles in the field of medical ethics. I have been recognized as an expert in the area of medical ethics and informed consent testifying in state and federal court. I was qualified as an expert witness in federal court for the Casey case, a case which ultimately went to the US Supreme Court.

Good law and good ethics start with good facts.

1. This bill is unnecessary as Massachusetts already requires that every woman receive voluntary informed and understanding consent to any medical procedure. The consent process thus already includes the necessity of providing material information

including the risks, benefits and alternatives medical and surgical procedures.(Encyclopedia of Bioethics, 3rd Edition, Macmillan Reference USA, 2003) Further there is specific Massachusetts law requiring women who seek abortion services to be informed about the type of procedure to be used, possible complications and abortion alternatives. Forcing state-scripted and excessive non-material information has the goal of not ensuring "Rights" or empowerment of women but rather to coerce and restrict "Rights" through inappropriate, insensitive and unethical requirements.

2. This anti-choice proposed legislation directly interferes with the private medical decisions that should be left to a woman and her family in consultation with her doctor. The legislation is inappropriate and unwarranted government interference in the doctor-patient relationship and the practice of medicine.

In summary, this legislation is a violation of the doctrine of informed consent, unethical, and would require physicians to practice negligent medicine,

Michael A. Grodin, M.D.

CHERIE M. FELOS
Attorney
205 Highland Ave.
Attleboro, MA 02703

June 6, 2011

RE: HB 502

To Whom It May Concern:

I am a city councilor in Attleboro, an attorney, and mother of five children. I am very opposed to HB 502 because of the vagueness of the term "gender identity". Because of this vagueness, this bill will cause many more problems that it purports to correct. Not only that but it will be very difficult to enforce because people will be able to claim to be part of a protected class due to something that may or may not be apparent to anyone else. In short, because of the way this bill is worded, a person can merely have something in their minds, act on it, and then claim protection under this bill. It is a potential nightmare for future costs in litigation and further confusion as to what will really help people who fit into this category.

I urge you to use common sense and do what is in the best interest of everyone and oppose this bill.

Sincerely,

Cherie Felos
508-918-0007
205 Highland Ave.
Attleboro, MA 02703

PREVENTIVE MEDICINE

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June 7, 2011

The Honorable Eugene L O'Flaherty
Joint Committee on the Judiciary
State House Room 136
Boston, MA 02133

Dear Representative O'Flaherty: **RE: HB502 of 2011-2112 Session**

The transgendered individual suffers from a gender identity disorder as defined in the diagnostic and statistical manual (DSM-IV-TR) of the American Psychiatric Association. All patients with this disorder should be treated with compassion as should all people with any disorder be treated with compassion. Furthermore the Massachusetts Medical Society strongly supports legal protection for transgendered individuals. However, after investigating this matter, I know that the Massachusetts Medical Society has not backed this specific bill, HB502.

This bill, HB502, places young boys and girls and young men and women at risk of loss of privacy when either using bathrooms or gym facilities. I strongly advise that this bill go back to committee for rewrite, and take into consideration the common good of protecting **all the children** in our schools in Massachusetts.

Sincerely,

Gilbert R. Lavoie, M.D.

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June 5, 2011

House Chair of the Committee,
Representative Eugene L. O'Flaherty
Joint Committee on the Judiciary
State House Room 136
Boston, MA 021333

Re: Bill #H502

Dear Representative O'Flaherty:

I am writing to express my concern regarding the "Transgender Equal Rights Bill" that is due to be heard this coming week on June 8, 2011. As a Licensed Psychologist with nearly 30 years of experience, I am alarmed by the potential harm that could result for children and adults, and even for those who consider themselves to be "transgender." The latter term refers to those whose "gender identity" does not match one's physically-determined sex. In a more general sense, the term refers to anyone who violates conventional gender roles (thus including transvestites, transsexuals, gay, lesbian and bisexual persons). My first objection to such an "equal rights" bill is that all such "unconventional" gender roles are assumed to be conditions that are predetermined by biology and genetics, such as skin color and race. Therefore, to disallow transgendered individuals from using any public restroom they might chose would be discrimination in the same manner as prohibiting African-Americans from using "white only " bathrooms.

The general public, as well as much of my own professional community, has assumed for the last 20 years that homosexuality has been proven by research to be genetically-determined, just as, again, skin or eye color is. This belief is based, however, on two particular research studies conducted in the early 1990's, by homosexual researchers (introducing a bias), which have since been discredited. There were many flaws in these studies, including same bias, and inappropriate statistical methods. In addition, no other researchers have ever been able to replicate the results of either study. The original researches themselves have stated publically that they failed to prove that homosexuality was caused by specific genes. Just one reference that addresses this research is Glenn T. Stanton and Dr. Bill Maier, *Marriage On Trial: The Case Against Same-Sex Marriage and Parenting* (Downers Grove, Ill: Intervarsity Press, 2004), pages 134-135.

Homosexuality is a form of "sexual orientation," which can be defined as one's enduring physical, romantic, emotional/and or spiritual attraction to another person. "Gender Identity," refers to one's personal sense of being a man or a woman. If there is no research proving that homosexuality is genetically determined, than it is not surprising that research has not been produced to assert genetic predetermination for gender identity. Since genetics is not the primary determining factor behind either homosexuality or "gender identity disorder," then environmental factors must be of greater influence. And if that is the case, then transgendered individuals do not have a "right" to have equal access to any public restroom they might choose.

Secondly, we must deal with the obvious contraction that this bill proposes: As a society we, rightly so, take great care in protecting victims of sexual crimes, be they children or adults. Massachusetts, especially, treats sexual offenders as amongst the most dangerous predators in our society, often giving them "day-to-life" civil sentences in addition to whatever criminal time they might serve. I am, amongst thousands of others, a mandated reporter in instances when I might even suspect that a child is at risk for sexual harm. With such concern placed in our Commonwealth on protecting potential victims, why would anyone desire to increase the risk of such harm via this bill? While I am certainly not arguing that transgendered individuals are sexual predators, the bill itself would allow true predators to pose as transgendered, and enter any public restroom they choose. I have known cases where convicted pedophiles, out on parole, have been re-incarcerated for entering restrooms and attempting to converse with young boys. If we have worked so hard to protect potential victims from rapists, pedophiles, etc., then why would we even consider a bill that would increase the risk of harm?

Finally, it has been proposed that this equal-rights bill would help reduce the stigmatization of transgendered individuals and thus improve their over-all mental health. Transgendered persons have been found to have higher levels of anxiety, depression, suicidal ideation and disability status than the general population does. Once again, a false assumption is made that such psychological distress is simply the result of societal discrimination, in the same manner that racial minorities experience rejection by the dominant race in a given culture. No consideration is given to environmental factors such as divorce, fragmented families, poor parenting, neglect, emotional, physical and sexual abuse, which create tremendous confusion for any child's developing sense of self.

A bill such as the one proposed would only serve to enable the development of a "false self" in such individuals who, originally for no fault of their own, were negatively affected by such environmental factors. As such, this bill would only victimize further these individuals who struggle with gender and/or sexual identity issues due to initial victimization earlier in their lives. Our society would only be giving them the false hope that greater acceptance of their struggles would enhance their sense of self, rather than challenging them to receive healing for their more core emotional woundedness.

Thank you for taking these comments under consideration as you and your colleagues address Bill #H502 this week.

Respectfully submitted,

Eric K. Sweitzer, Ph.D.
Licensed Psychologist,
Director, The Charis Counseling Centers of Southeastern and Central Massachusetts and Rhode Island.

June 6, 2011

Representative Eugene L. O'Flaherty
Joint Committee on the Judiciary
State House Room 136
Boston, MA 02133

Dear Representative O'Flaherty,

I and countless multitudes of other concerned Massachusetts citizens are praying for and watching closely the leadership and actions of the Joint Committee on the Judiciary in the matter of HB 502.

In the culture war that seeks to destroy the traditional family and moral values of Western civilization, it is unimaginable to me that any intelligent person would be in favor of such an outrageous and notorious bill that would legally mandate the use of public facilities by whatever gender wants to use them. The use of bathrooms by both sexes is an affront to common sense. From a mental health and psychological point of view, it is also a boundary issue.

The explosion of cyber porn on the internet and on-line services is a disgrace. Children have ready access to explicit sexual material that cannot even be found in so-called adult bookstores. This is just another spiral downward in the destruction of our children and the Republic's moral values.

I think of vast number of people who have suffered assault, child abuse and rape in public facilities. Our highest priority must be the mental, emotional and physical well-being of our children. There is absolutely no justification for the passing of HB 502!

To allow BH 502 become law would be an unprecedented coup for those who already seek to exploit our children. This is not a case of "civil liberties" it is absolute nonsense, and ridicules any ethics of decency.

Like millions of Americans, I stand behind the foundational belief of our Judeo-Christian heritage that has been our nation's motto, "In God We Trust" not in the destruction of decency, self-respect and traditional moral values.

Sincerely,

R. Gary Heikkila, Ph.D.
Board Certified Psychotherapist and Counselor.
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STATE HOUSE TESTIMONY
COMMONWEALTH OF MASSACHUSETTS
JOINT JUDICIARY COMMITTEE

HOUSE BILL: H00502
SENATE BILL: S00764
AN ACT RELATIVE TO TRANSGENDER EQUAL RIGHTS

PUBLIC HEARING ON JUNE 8, 2011

As both an attorney and a citizen interested in an orderly society which respects the rights of all, I testify in opposition to this Act Relative to Transgender Equal Rights.

In law school, I learned about the importance of laws which are both clear and fair. Ambiguity in legislation always leads to litigation. Many of our citizens, and many of the struggling businesses within our Commonwealth, are fed up with litigation and ambiguity. This Act, unfortunately, would foster both. It represents a significant threat to both the peace of mind of our communities and to the strength of our challenged economy.

Section 11 of the proposed Act defines that the term "gender identity or expression" as meaning "a gender-related identity, appearance, expression, or behavior of an individual, regardless of the individual's physiology or assigned sex at birth." This so-called definition is not a definition at all. Its indistinctness makes it no more than a profound legal ambiguity. It is, and can be, no more than a hazy vagueness. There is no requirement of a doctor's certification, participation in hormone therapy, or surgery. There is only the need for subjective assertion, notwithstanding physical characteristics, of a bisexual or transgender identity.

The Act would amend section 92A of chapter 272 of our General Laws to provide that all otherwise lawfully sex-segregated facilities, accommodations, resorts and amusements must grant persons admission to and the full enjoyment of such facilities, accommodations, resorts and amusements consistent with their gender identity or expression. It would have an extraordinarily broad reach, affecting everyone who uses Massachusetts bathrooms, bathhouses, exercise facilities, and other locations. It would give legal power and cover for anyone to enter any of these locations, at any time, subject only to their subjective, and possibly devious, assertion of their gender identity.

The purposely vague definition of gender identity or expression would interfere with parents' attempts to assure the safety of their children, and business owners' attempts to assure a safe environment for their customers.

Above all, Massachusetts parents want their children to be safe. It is important for you to consider the risk of sexual assault upon children, and to take all reasonable precautions to prevent any such risk. You should guard against it at all reasonable costs. We do not want our children to be confused and/or frightened in bathrooms which they need to use. We do not want to be, and we do not want our children to be, in unnecessary apprehension of sexual assault.

Our business owners want to thrive in Massachusetts. By significantly broadening Chapter 151B, which deals with unlawful discrimination because of race, color, religious creed, national origin, ancestry, or sex, it would call upon the business owner to make impossible on-the-spot decisions about the gender-related identity based upon the very broad categories of "appearance ... expression...behavior," or risk litigation. On the front line, how could a proprietor or custodian of facilities subject to this act possibly determine whether or not the person is truly transgender? It would leave our business owners in constantly confusing and necessarily imprecise predicaments. By creating a legal vulnerability, it would hurt businesses in our Commonwealth and present an unnecessary challenge to our already fragile economy.

Our laws already protect those with gender identity and expression concerns from harassment and criminal acts. This Act should be defeated in this Joint Judiciary Committee.

Robert W. Joyce, Esq.
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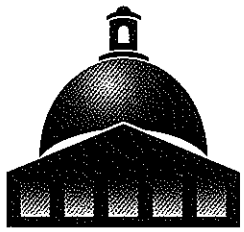

Massachusetts Family Institute℠

Dedicated to Strengthening the Family

June 8, 2011

To: Judiciary Committee members
Re: Transgender Bill HB502 & SB764

For your information I am providing key testimonies from legal & medical professionals testifying against the Bills.

If you have any questions please feel free to contact me.

Regards,

MVacca

Maureen Vacca
Director of Public Policy
MFI

100 Sylvan Road, Suite 625 | Woburn, MA 01801-1800 | 781.569.0400 | www.mafamily.org

The Psychopathology of "Sex Reassignment" Surgery

Assessing Its Medical, Psychological, and Ethical Appropriateness

Richard P. Fitzgibbons, M.D.,
Philip M. Sutton, and Dale O'Leary

Abstract. Is it ethical to perform a surgery whose purpose is to make a male look like a female or a female to appear male? Is it medically appropriate? Sexual reassignment surgery (SRS) violates basic medical and ethical principles and is therefore not ethically or medically appropriate. (1) SRS mutilates a healthy, non-diseased body. To perform surgery on a healthy body involves unnecessary risks; therefore, SRS violates the principle *primum non nocere,* "first, do no harm." (2) Candidates for SRS may believe that they are trapped in the bodies of the wrong sex and therefore desire or, more accurately, demand SRS; however, this belief is generated by a disordered perception of self. Such a fixed, irrational belief is appropriately described as a delusion. SRS, therefore, is a "category mistake"—it offers a surgical solution for psychological problems such as a failure to accept the goodness

Richard P. Fitzgibbons, M.D., a psychiatrist, is the director of Comprehensive Counseling Services outside Philadelphia. Philip M. Sutton, Ph.D., is a psychologist in private practice in South Bend, Indiana; he also works in elementary schools in the Diocese of Fort Wayne–South Bend and at Sacred Heart Major Seminary in Detroit. Dale O'Leary is an author and lecturer. Her most recent book is *One Man One Woman: A Catholic's Guide to Defending Marriage* (Sophia Institute Press, 2007).

of one's masculinity or femininity, lack of secure attachment relationships in childhood with same-sex peers or a parent, self-rejection, untreated gender identity disorder, addiction to masturbation and fantasy, poor body image, excessive anger, and severe psychopathology in a parent. (3) SRS does not accomplish what it claims to accomplish. It does not change a person's sex; therefore, it provides no true benefit. (4) SRS is a "permanent," effectively unchangeable, and often unsatisfying surgical attempt to change what may be only a temporary (i.e., psychotherapeutically changeable) psychological/psychiatric condition. *National Catholic Bioethics Quarterly* 9.1 (Spring 2009): 97–125.

The desire to imitate the other sex or to pass for the other sex is not new, nor is the amputation of healthy body parts. In many cultures, men were castrated for various reasons, in some cases to preserve the prepuberty boy-soprano voice, in others so that they could serve as guards of harems. Such practices are now considered barbaric. Individual women have at various times in history passed as men. Only when surgical skills advanced to the degree that surgeons could construct an artificial vagina and something resembling a penis or scrotum did sex reassignment surgery (SRS) develop as a surgical subspecialty. The materialist ethic of "If we can do something, we may do it" has created a climate where people see nothing wrong with surgeons destroying healthy reproductive organs and creating artificial organs for those who want them. Those who believe in the radically dualistic ethic of "It's my body, so I can manipulate it however I like," are offended if surgeons refuse to grant their demands.

Use of the term "sexual reassignment surgery" is in itself problematic, it implies that the sexual identity is assigned at birth and can actually be surgically reassigned. Sexual identity is observed at birth and, except in rare cases, matches the genetic structure. It is written on every cell of the body and can be determined through DNA testing. It cannot be changed. Calling men who have had SRS "women" does not change their genetic structure. It does not make them genetic women.

The use of "transsexual" is also problematic, since it also implies that a person can move from their true genetic sex to the other sex. At one time, the word "sex" was used to describe everything that was included in being male or female. The word "gender" was used in reference to language; words were masculine, feminine, or neuter in gender. Controversial psychologist, sexologist, and promoter of SRS John Money introduced the idea of "gender identity," defined as a person's own categorization of himself as male, female, or ambivalent. Radical feminists embraced the idea that sex—the biological reality—could be separated from gender, which they viewed as an artificial social construct imposed on male and female bodies. For them, sex may be a biological given, but gender is in the mind and because it is constructed by social interaction, it can be deconstructed.

Those calling themselves transsexuals took the separation of sex and gender in a different direction; for them, gender was natural and sex could be constructed—the body modified to fit the mind. Thus, a person could be male in sex (i.e., biologically, genetically) yet female in gender. This did not mean that a particular man simply had interests, talents, or other traits more likely to be found in women, but that at

the core of his being he was essentially female and had been mis-assigned at birth. Therefore, his desire to be reassigned surgically and hormonally was reasonable and should be accommodated.

Persons seeking SRS experience a disharmony between their bodies and their self-image. The question is, should this disharmony be reconciled by changing the body or changing the mind? Those applying for SRS strongly resist psychological probing into the origins of their feelings, demanding instead a surgical solution to their problem.

Those publicly promoting SRS insist that once SRS procedures are completed, the patient is no longer the sex to which he or she was born, but has been surgically transformed into the other sex. However, SRS procedures create only an imitation of the organs involved in the sexual act which, in the case of women who wish to present themselves as men, are very poor, nonfunctional imitations. Surgery cannot change the DNA or reverse the effect of prenatal hormones on the brain. It can only create the appearance of the other sex. Persons who have undergone these procedures may engage in acts which simulate sexual intercourse between a male and female, but these acts are nonreproductive, since the surgical procedures cannot create fertility. In effect, SRS is the most radical form of sterilization, and according to Catholic moral teaching, it is unethical on that ground alone.

We argue that the desire for SRS generally results from an array of psychological disorders. In defense of this view, we provide information on the background of the SRS movement, a review of the procedures involved, and data on typical psychological problems suffered by these patients. There is a discussion of the three types of people who apply for SRS. We then address the ethical, religious, and other objections to SRS and the effect of general acceptance of SRS on freedom of religion, speech, and thought. We conclude that SRS does not serve the best interests of the patients and is a misuse of the skills of surgeons and psychiatrists.

Background

Johns Hopkins University in Baltimore, Maryland, was once a center for SRS. When Dr. Paul McHugh became psychiatrist-in-chief in 1975, however, he decided to investigate what he "considered to be a misdirection of psychiatry and to demand more information both before and after [the] operations." He asked for a follow-up on patients from psychiatrist and psychoanalyst Jon Meyer. Meyer found that "sex reassignment surgery confers no objective advantage in terms of social rehabilitation."[1] According to McHugh,

> most of the patients [Meyer] tracked down some years after their surgery were contented with what they had done and ... only a few regretted it. But in every other respect, they were little changed in their psychological condition. They had much the same problems with relationships, work, and emotions as before. The hope that they would emerge now from their emotional difficulties to flourish psychologically had not been fulfilled. We saw the results as

[1] Jon Meyer and Donna Reter, "Sex Re-Assignment," *General Psychiatry* 36 (1979): 1010–1015.

> demonstrating that just as these men enjoyed cross-dressing as women before the operation, so they enjoyed cross-living after it. But they were no better in their psychological integration or any easier to live with.[2]

McHugh and others became convinced that SRS involved collaborating in mental disorder rather than treating it, and the SRS program at Johns Hopkins was discontinued.

It is important to distinguish between SRS and procedures designed to restore organs that are deformed, whether from genetic abnormalities, congenital defects, injury, or disease. The techniques currently used for SRS were developed for patients with such deformities, and if no change of sex is intended, they are medically indicated and therefore ethically justifiable.

There are genetic and other abnormalities that can cause discordance between genetic sex, hormone receptivity, and external and internal sexual organs.[3] These disorders of sexual development are very rare. While it is appropriate to test anyone desiring SRS in order to be sure that they do not suffer from one of these rare abnormalities, those who seek SRS are virtually always genetically normal men and women with intact sexual and reproductive organs and hormones levels proper to their sex.

Sexual reassignment surgery requires the destruction of healthy sexual and reproductive organs. One of the surgeons at Johns Hopkins involved in the procedure expressed his feelings about the act of mutilation: "Imagine what it's like to get up at dawn and think about spending the day slashing with a knife at perfectly well-formed organs, because you psychiatrists do not understand what is the problem here but hope surgery may do the wretch some good."[4] In addition, candidates for SRS are administered hormones to create secondary sexual characteristics usually found in the other sex, such as growth of a beard for women and breast enlargement for men. Hormone treatments can cause serious health problems. For women, the effects of male hormones as well as the SRS surgery can be permanent and irreparable.[5]

Reassignment Process for Males

Sexual reassignment surgery is only one step in a long and expensive process. For *men* it involves dressing in public as a woman and undergoing electrolysis to

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[2]Paul R. McHugh, "Surgical Sex," *First Things* 147 (November 2004): 35.

[3]Disorders of sexual development include androgen insensitivity syndrome, congenital adrenal hyperplasia, and mosaicism involving sex chromosomes. It should be noted that substantial controversy exists concerning the classification and treatment of disorders of sexual development.

[4]Paul R. McHugh, "Psychiatric Misadventures," *American Scholar* 61.4 (Autumn 1992): 497–510, available at http://www.lhup.edu/~dsimanek/mchugh.htm.

[5]Anne Lawrence, "Transgender Health Concerns," in *The Health of Sexual Minorities: Public Health Perspectives on Lesbian, Gay, Bisexual and Transgender Populations*, ed. Ilan H. Meyer and Mary E. Northridge (New York: Springer, 2007), 473–505. See also Anne Lawrence, "Patient-Reported Complications and Functional Outcomes of Male-to-Female Sex Reassignment Surgery," *Archives of Sexual Behavior* 35 (2006): 717–727.

remove facial hair, hormone treatment, electrolysis to remove hair on the genitals and prepare the genital tissue to be used to create a pseudo-vagina, removal of the penis and testes, creation of the pseudo-vagina, creation of an opening for the urethra, and cosmetic surgery—to decrease the size of the Adam's apple, insert breast implants, change other features, and insert silicone implants in the hips and buttocks.

Those who begin the process are often dissatisfied with the initial cosmetic results. Some of those seeking SRS not only want to be women, they want to be stunningly attractive women, and thus may become addicted to plastic surgery. Some also seek out back-alley practitioners for silicone injections and other changes, risking infection and even death.[6]

Some men present themselves in public as women but have not yet chosen to have surgery below the waist. These are sometimes referred to as "she-males," since with breast implants and cosmetic surgery above the waist they appear female, but below the waist they are physically male. Some she-males work as showgirls in clubs that specialize in this kind of entertainment or as prostitutes in order to save up the money needed for genital surgery. Certain men seek out the sexual services of she-males.[7]

Reassignment Process for Females

For *women* the reassignment process involves hormone treatments, removal of the breasts (often begun by binding them), total hysterectomy, and the creation of a pseudo-penis and testes. It is noteworthy that increasing testosterone levels in a woman—to stimulate facial hair growth and increase muscle—has the potential to cause a change in personality, including making the woman more aggressive. A hysterectomy is then performed to stop menstruation which, for many, removes the unwanted monthly evidence of womanhood and vulnerability. Relatively few women who undergo SRS, even those with severe gender dysphoria, choose to take the last step: the creation of a pseudo-penis and pseudo-testes. When this is done, the artificial organs are often small and are nonfunctional. A penis may be constructed to enable a mechanical erection and the simulation of sexual intercourse, but ejaculation is not possible. While the surgeons attempt to preserve sexual sensation in the pseudo-organs, they are not always successful.

Recently, there was substantial publicity about a so-called pregnant man. The pregnant person was in fact a woman who had undergone breast removal and was taking hormones to increase facial hair and muscle, but she had not undergone a hysterectomy or surgery to create pseudo-male external genitalia. When she and her female partner wanted to have a child but her partner could not become pregnant, she ceased taking the hormones and was artificially inseminated.[8] Thus, a woman who looked male above the waist—but was, in fact, fully female—became pregnant.

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[6]"Silicone Death Leads to Prison," *Orlando Sentinel,* July 31, 2003.

[7]J. Michael Bailey, *The Man Who Would Be Queen: The Science of Gender-Bending and Transsexualism* (Washington, D.C.: John Henry Press, 2003), 186–188.

[8]Guy Trebay, "He's Pregnant, You're Speechless," *New York Times*, June 22, 2008.

Origins of the Desire for SRS

Ray Blanchard, of Clarke Institute of Psychiatry in Toronto (now part of the Centre for Addiction and Mental Health), has spent years studying and treating transsexuals. He identified two distinct syndromes: homosexual transsexuals (HT) and autogynephilic transsexuals (AT).[9] J. Michael Bailey's book *The Man Who Would Be Queen* explores the difference between the two.[10]

Homosexual Transsexual Males

According to the Blanchard analysis, HT males are men whose appearance, gestures, and speech are perceived as feminine and who are attracted to masculine men rather than other homosexual men. HT males believe that if they can appear to be real women and can "pass" as such, they will be able to attract these men.

Almost all HT males experienced gender identity disorder (GID) as children. They did not fully identify with their fathers, brothers, or peers and either believed that they were really female or wished to be female. They often expressed disgust at their male genitals, may have tried to hide them, refused to urinate standing, insisted on dressing in girls' clothes, and often chose only girls for playmates. These behaviors often resulted in rejection and teasing by male peers. Although some adult men with same-sex attraction (SSA) exhibit some of these symptoms before age five, in later childhood the symptoms commonly disappear. HT males, however, persist in their identification with females, often presenting an exaggerated image of womanhood in their gestures, speech, and dress.

Many HT males at some point become sexually intimate with males with SSA, but they do not find these relationships satisfying. This is in contrast with a boy who moves from GID to SSA and engages in relations with other men with SSA. The HT male wants a relationship with a heterosexual man and believes that by presenting himself as a very attractive woman he can fulfill this desire. It should be noted that in the gay community, masculinity is favored and very feminine males are not considered as desirable.

McHugh characterizes HT males as "conflicted and guilt-ridden homosexual men who [see] a sex-change as a way to resolve their conflicts over homosexuality by allowing them to behave sexually as females with men."[11] While HT males may insist that their only motivation is to become the women they always knew they were, Anne Lawrence, an autogynephile who has undergone SRS, believes that sexual desire plays a bigger part than many HTs are willing to admit:

> Homosexual transsexuals are not exactly devoid of sexual motivations themselves. Colleagues who have spent a lot of time interviewing homosexual transsexuals tell me that they can best be thought of as very effeminate gay men who do not defeminize in adolescence. Nearly all go through a "gay

[9]Ray Blanchard, "Clinical Observations and Systemic Studies of Autogynephilia," *Journal of Sex and Marital Therapy*, 17.4 (Winter 1991): 235–251.

[10]Bailey, *Man Who Would Be Queen*, 157–160

[11]McHugh, "Surgical Sex," 35.

> boy" period; and their decisions about whether or not to transition are often based in large part on whether they expect to be sufficiently passable in female role to attract (straight) male partners. Those who conclude they will not pass usually do not transition, no matter how feminine their behavior may be. Instead, they accept, perhaps grudgingly, a gay male identity, and remain within the gay male culture, where they can realistically expect to find interested partners. This self-selection process explains the intriguing observation that transitioning homosexual transsexuals tend to be physically smaller and lighter than their autogynephilic sisters. The bottom line is that in homosexual transsexuality, too, a sexual calculus is often at work. Transsexualism is largely about sex—no matter what kind of transsexual one is.[12]

Gender Identity Disorder

There is general agreement that HT normally first manifests itself as childhood GID. Because the symptoms of GID (and therefore HT preceded by GID) appear very early in childhood, some assume that the condition is biological in its origin—either genetic or hormonal, and therefore unchangeable. But there is no scientific evidence to support this conclusion.[13]

A baby is conceived genetically male or female. Prenatal brain development is influenced by the same hormones that trigger the development of the reproductive organs. Babies discover there are two sexes, and to which sex they belong. This should lead to a positive self-awareness: "I am a boy. It is good to be a boy. I am like my daddy and brothers. My parents are happy that I am a boy." In the same way, a girl needs to feel that she is safe, accepted, and loved as a girl and that being a girl is a good thing.

Kenneth Zucker and Susan Bradley's book *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents* represents years of work with patients with GID.[14] According to their clinical model for boys with GID, the disorder begins in early childhood with an insecure mother–child relationship and tends to affect boys who are emotionally vulnerable:

> The boy, who is highly sensitive to maternal signals, perceives the mother's feelings of depression and anger. Because of his own insecurity, he is all the more threatened by his mother's anger or hostility, which he perceives as

[12] Anne Lawrence, "Men Trapped in Men's Bodies: An Introduction to the Concept of Autogynephilia," *Transgender Tapestry* 85 (Winter 1998).

[13] J. Michael Bailey, Michael P. Dunne, and Nicholas G. Martin, "Genetic and Environmental Influences on Sexual Orientation and Its Correlates in an Australian Twins Sample," *Journal of Personality and Social Psychology* 78.3 (March 2000): 524–536; John de Cecco and David Parker, eds., *Sex, Cells, and Same-Sex Desire: The Biology of Sexual Preference* (New York: Harrington Park Press, 1995).

[14] New York: Guilford Press, 1995. For an overview of Zucker's work on gender identity disorders, see National Association for Research and Therapy of Homosexuality (NARTH) Scientific Advisory Committee, "Gender Identity Disorders in Children and Adolescence: A Critical Inquiry and Review of the Kenneth Zucker Research," March 2007, http://www.narth.com/docs/GIDReviewKenZucker.pdf.

> directed at him. His worry about the loss of his mother intensifies his conflict over his own anger, resulting in high levels of arousal or anxiety.[15]

When anxiety occurs at such a sensitive developmental period, the child may choose behaviors common to the other sex, because in his mind these will make him more secure or more valued.

In her book *Affect Regulation and the Development of Psychopathology*, Susan Bradley classifies GID with internalizing anxiety disorders:

> What makes GID different from anxiety disorders is that there are factors in the family making gender more salient. Specifically, boys with GID appear to believe that they will be more valued by their families or that they will get in less trouble as girls than as boys. These beliefs are related to parents' experience within their [own] families of origin, especially tendencies on the part of mothers to be frightened by male aggression or to be in need of nurturing, which they perceive as a female characteristic.[16]

The child's first experiments of identifying with the other sex may be subtly or openly rewarded with smiles, particularly by the mother. She or other females in the family may exclaim, "Look how cute he is dressed up in his mother's shoes. He would be a pretty girl," or something similar.

Zucker and Bradley explain a mother's positive reaction to cross-sex behavior in her baby: "The mother's need for nurturance and fear of aggression allow her to tolerate these behaviors, which may also be reinforced by her perception of her son as attractive; her tolerance may actually lead to a positive response to the initial cross-gender behaviors.[17] The mother may be unwilling to make the child "unhappy" by discouraging cross-dressing, while the father may be convinced that his son is going to become homosexual. It is only later, when identifying with the other sex leads to teasing and rejection, that the mother becomes concerned. Zucker and Bradley have found that many parents of these boys when confronted with obvious symptoms of GID "profess a rather marked ambivalence," ignoring the problem until it is impossible to do so.[18] Presumably, those with even more ambivalence never seek help.

Because of their own problems, parents are sometimes unable to meet their child's needs for security, acceptance, love, and a positive image of his or her own sex. In contemporary culture, fathers often bond with their sons through sporting activities and may not know how to help boys to incorporate their special creative, artistic, or other non-athletic talents into their masculinity. Fathers with creative or artistic sons need to learn how to support and affirm these interests as authentically masculine. Parents may also fail to appreciate the importance of helping these boys in early childhood to develop strong male friendships with boys who share their interests.

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[15]Kenneth J. Zucker and Susan J. Bradley, *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents* (New York: Guildford Press, 1995), 262–263.

[16]New York: Guilford Press, 2003, 201.

[17]Zucker and Bradley, *Gender Identity Disorder*, 263.

[18]Ibid., 72–73.

In some cases, a parent may have wanted a child of the opposite sex, and dresses and treats the child as being of the opposite sex. Some parents pressure the school to allow the child to cross-dress in school, and may even take the child to a transgender support group.[19] Family dysfunction leaves the child vulnerable:

> The parents' ongoing difficulties in dealing with the child's cross-gender behaviors may intensify the child's anxiety and insecurity, but also permit the child to develop a fantasized but valued opposite-sex self. With development and the repeated need to use this fantasized other self, the child may be very resistant to relinquishing this defensive solution.[20]

Richard Fitzgibbons has found that children—particularly boys—with GID often experience rejection, teasing, and mistreatment.[21] Boys who lack eye-hand coordination are often isolated or mercilessly teased because they cannot hit a pitch or properly kick a soccer ball. This rejection can cause an insecurely attached boy to believe that other people hate him. This in turn can lead to self-rejection that is focused on sex identity (e.g., "I hate being a boy" or "I hate being a girl") or on particular body parts (e.g., boys may try to hide their genitals).

The experiences of girls with GID commonly differ from those of boys. Many girls with GID are noticeably *more*—not less—talented athletically and more temperamentally suited for competitive ("rough and tumble") sports than their female peers. This does not commonly lead to as much overt, peer rejection as boys who are *less* athletic and boys who are *less* competitive tend to experience. Yet to the extent that girls with GID, for other reasons, experience an inordinate vulnerability or dysphoria about being "female," they also may fear the biological hallmarks of their sex, such as the development of their breasts or the onset of menstruation. (See "Females Seeking SRS" below for further discussion of the causes and effects of a girl's rejection by female peers.)

Overall, Fitzgibbons believes that this rejection of one's natural body, accompanied by self-hatred and masochistic tendencies, can lead to the desire for SRS. According to Fitzgibbons, if psychotherapists would focus on helping children—and adult patients—learn how to resolve their anger with themselves and with those by whom they feel rejected, these children and adults can become happy with their birth sex.[22]

Other therapists have found that children with GID develop habits of self-pity, and self-victimization, complaining about and exaggerating personal suffering—

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[19] Joelle Farrell and John Sullivan, "School Challenge: Transgender Student Is Age 9," *Philadelphia Inquirer*, May 3, 2008; "Brave New Schools 8-Year-Old Boy Returning to Class As *Girl,* Teachers Making Accommodations, Preparing to Counsel Other Students," *WorldNetDaily*, February 8, (2008); and Richard P. Fitzgibbons, "Desire for a Sex Change: Clinical Observations and Advice," *Ethics & Medics* 30.10 (October 2005): 1–2.

[20] Zucker, *Gender Identity Disorder*, 263.

[21] Richard P. Fitzgibbons, "Gender Identity Disorder," from the Institute for Marital Healing Web site, http://www.maritalhealing.com/conflicts/genderidentitydisorder.php.

[22] Ibid.

habits which are extremely difficult to break. Without a positive intervention, the majority of boys with GID develop SSA in adolescence; however, only a small percentage go on to seek SRS.[23]

The failure to identify with the goodness of their own masculinity or femininity can lead to envying those who have the qualities which they perceive themselves to be lacking. One of the differences between persons whose GID is a path to SSA and those who are on a path to transsexuality is that persons moving toward SSA may envy and even covet the characteristics of their *own* sex which they see present in others but lacking in themselves, while those on the path to transsexuality envy or covet the characteristics of the *other* sex. Those developing transsexuality commonly believe that being—and becoming—the other sex would achieve their goal of feeling safe, accepted, and loved.

It should be noted that there is controversy over the classification of childhood GID as a disorder. Some therapists insist that since childhood GID is a common—but not exclusive or invariable—first step to homosexual identification in adolescence and that since homosexuality is no longer considered a psychological disorder, GID in children should not be considered a disorder. Rather, it should be accepted as healthy and normal for that child.[24] Zucker and Bradley reject such an approach and point to the distress children with GID experience and the high levels of psychopathology found among the parents of boys with GID.[25] According to Zucker and Bradley, these are not happy, well-adjusted boys who just happen to think they are girls. They are troubled children from troubled homes. As evidence, Zucker and Bradley presented a review of the families of ten consecutive GID boy patients who attended their clinic. All the families had serious problems. Eight of the mothers had at least one diagnosed psychological disorder. Of the remaining two, one was in long-term psychotherapy for family issues and the other suffered from severe debilitating migraine headaches.[26]

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[23] Madeleine Wallien and Peggy Cohen-Kettenis, "Psychosexual Outcome of Gender-Dysphoric Children," *Journal of the American Academy of Child and Adolescent Psychiatry* 47.12 (December 2008): 1413–1423.

[24] Edgardo J. Menvielle, "Gender Identity Disorder," letter to the editor, *Journal of the American Academy of Child and Adolescent Psychiatry* 37.3 (March 1998): 243–244; Edgardo J. Menvielle and Catherine Tuerk, "A Support Group for Parents of Gender-Nonconforming Boys," *Journal of the American Academy of Child and Adolescent Psychiatry* 41.8 (August 2002): 1010–1013; Miriam Rosenberg, "Children with Gender Identity Issues and Their Parents in Individual and Group Treatment," *Journal of the American Academy of Child and Adolescent Psychiatry* 41.5 (May 2002): 619–621; and Simon D. Pickstone-Taylor, "Children with Gender Nonconformity," *Journal of the American Academy of Child and Adolescent Psychiatry* 42.3 (March 2003): 266.

[25] Susan Bradley and Kenneth J. Zucker, "Drs. Bradley and Zucker Reply," *Journal of the American Academy of Child and Adolescent Psychiatry* 37.3 (1998): 244–245.

[26] Kenneth J. Zucker et al., "Psychopathology in the Parents of Boys with Gender Identity Disorder," *Journal of the American Academy of Child and Adolescent Psychiatry* 42.1(January 2003): 2–4.

Positive interventions are possible for preadolescent children with GID. Zucker and Bradley report, "It has been our experience that a sizeable number of children and their families achieve a great deal of change. In these cases, the gender identity disorder resolves fully."[27] Since the symptoms are obvious to everyone, including pediatricians and teachers, parents should be encouraged to seek help as soon as possible.[28]

Unfortunately, parents are often unwilling to participate in the process. According to Zucker and Bradley, if the condition is left untreated in childhood, it is much more difficult to treat in adolescence, particularly if the adolescent believes that SRS is the solution:

> Adolescents with gender identity disorder have poor anxiety tolerance. Seeking sex reassignment surgery is a defensive solution and a mechanism for control of anxiety. The thought of not having a "solution" for their distress increases their anxiety, thus making it very difficult to achieve a therapeutic alliance. Despite an understanding (at last at a superficial level) of why they have cross-gender wishes, these adolescents are often unable to relinquish their defense, as they feel too overwhelmed to face their anxiety without it. This leads to demanding behavior and impatience with the therapist as he or she tries to help them explore feelings and behaviors. Many adolescents who seek sex reassignment withdraw from therapy because of their inability to tolerate the anxiety connected with exploration of their wish for surgery.[29]

Given the failure to achieve positive results with adolescents suffering from GID, Zucker and Bradley support hormone treatment for adolescents and SRS only when the person has come of age. The availability of SRS certainly encourages these adolescents to believe that their resistance to therapy will be rewarded and their desire for SRS granted.

Autogynephilic Transsexuals

According to Ray Blanchard, who named the syndrome, AT males are men in love with the image of themselves as women. Blanchard writes:

1. All gender-dysphoric biological males who are not homosexual (erotically aroused by other males) are instead autogynephilic (erotically aroused by the thought or image of themselves as females)
2. Autogynephilia does not occur in women, that is, biological females are not sexually aroused by the simple thought of possessing breasts or vulvas.
3. The desire of some autogynephilic males for sex reassignment surgery represents a form of bonding to the love-object (fantasized female self) and is

[27] Zucker, *Gender Identity Disorder*, 282.

[28] In addition to Zuker and Bradley's own writing and the *Review of Kenneth Zucker Research* by the NARTH Scientific Advisory Committee, see Joseph Nicolosi and Linda Ames Nicolosi, *A Parent's Guide to Preventing Homosexuality* (Downer's Grove, IL: InterVarsity, 2002).

[29] Zucker, *Gender Identity Disorder*, 315–316.

analogous to the desire of heterosexual men to marry wives and the desire of homosexual men to establish permanent relationships with male partners.

4. Autogynephilia is a misdirected type of heterosexual impulse, which arises in association with normal heterosexuality but also competes with it.
5. Autogynephilia is simply one example of a larger class of sexual variations that result from developmental errors of erotic target localization.[30]

Autogynephilia is classified with the paraphilia transvestism. Paraphilias are psychological disorders in which sexual excitement becomes obsessively associated with something other than the presence of a real, total person.

Some ATs object to the classification of their problem as a paraphilia because they are not (at least initially) restricted to enacting a single fantasy in order to achieve orgasm. Rather, the heterosexual ATs find that their fantasies compete with their sexual relationship with their partners. According to Anne Lawrence, a post-SRS AT:

> What makes the issue complicated is that autogynephilia does not necessarily preclude attraction to other people. That is why one can say that some transsexuals are autogynephilic, and simultaneously categorize them as heterosexual, bisexual, or anallophilic [not attracted to other people]. (If autogynephilia completely precluded attraction to other people, all autogynephilic persons would be anallophilic.) But autogynephilic arousal often does seem to compete with arousal toward other people. For example, autogynephilic persons who are heterosexual or bisexual often report that when they first become involved with a new sexual partner, their autogynephilic fantasies tend to recede, and they become more focused on the partner. But as the relationship continues, and the novelty of the partner wears off, they more frequently return to autogynephilic fantasies for arousal. (Perhaps for biologic males, novelty is an important factor in determining which of several possible sources of arousal receives attention.)[31]

The power of the fantasy may, however, reduce the sexual partner to an actor in the fantasy. Lawrence continues:

> Another common observation made by autogynephilic persons is that, while they like having partnered sex, there is sometimes a way in which their partner is almost superfluous, or merely acts as a kind of prop in an autogynephilic fantasy script. Blanchard has observed that this is especially characteristic of many autogynephilic fantasies involving male partners: often the male figure is faceless or is quite abstract, and seems to be present primarily to validate the femininity of the person having the fantasy, rather than as a desirable partner in his own right. In part because autogynephilia seems to compete with attraction toward other people, but without precluding it, Blanchard has sometimes preferred to call autogynephilia an "orientation," rather than a paraphilia.[32]

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[30]Ray Blanchard, "The Origins of the Concept of Autogynephilia," February 2004, http://www.autogynephilia.org/origins.htm.

[31]Lawrence, "Men Trapped in Men's Bodies."

[32]Ibid.

The fantasy life of an autogynephilic involves imagining himself being penetrated sexually. The majority of AT males consider themselves to be heterosexual. Many start out as transvestites, some may marry, and some may have children. Only later in life some may decide that they want to live full time as women. Some ATs continue to be attracted to women and insist after the surgery that they are lesbians.

Most heterosexual transvestites remain content to engage in cross-dressing while others desire SRS. According to Bailey, Blanchard hypothesizes that a man who can "satisfy his urges by periodically cross-dressing in private or in the company of other transvestites" probably will not seek surgery, while a man "whose primary fantasy is having a vulva" eventually will.[33] Blanchard writes,

> Autogynephilia takes a variety of forms. Some men are most aroused sexually by the idea of wearing women's clothes, and they are primarily interested in wearing women's clothes. Some men are most aroused sexually by the idea of having a woman's body, and they are most interested in acquiring a woman's body. Viewed in this light, the desire for sex reassignment surgery of the latter group appears as logical as the desire of heterosexual men to marry wives, the desire of homosexual men to establish permanent relationships with male partners, and perhaps the desire of other paraphilic men to bond with their paraphilic objects in ways no one has thought to observe.[34]

AT males commonly have decided to pursue surgery because they, according to McHugh,

> found intense sexual arousal in cross-dressing as females. As they had grown older, they had become eager to add more verisimilitude to their costumes and either sought or had suggested to them a surgical transformation that would include breast implants, penile amputation, and pelvic reconstruction to resemble a woman. Further study of similar subjects in the psychiatric services of the Clark Institute in Toronto identified these men by the auto-arousal they experienced in imitating sexually seductive females. Many of them imagined that their displays might be sexually arousing to onlookers, especially to females.[35]

AT males are generally less convincing as women and less overtly "sexy" than HT males.[36]

AT in males generally begins with transvestic fetishes and masturbatory fantasies in adolescence. AT males, in general, did not suffer from GID as children; rather, during late childhood or early adolescence they began to secretly dress in women's clothing, particularly lingerie, and masturbate while looking at themselves

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[33]Bailey, *Man Who Would Be Queen*, 165.

[34]Blanchard, "Clinical Observations," 245–246, quoted in Lawrence, "Men Trapped in Men's Bodies."

[35]McHugh, "Surgical Sex," 35.

[36]*Sex Change Hospital,* a television series on the Women's Entertainment network, follows men through the procedure. Most of the clients are older men, who even after surgery are obviously not women.

in a mirror. Those seeking SRS are careful to deny their use of masturbation with fantasy. According to post-SRS AT Sandy Stone, "wringing the turkey's neck," the ritual of penile masturbation just before its surgical removal, "was the most secret of secret traditions" practiced by ATs.[37] To admit the habit of masturbation would be to risk being disqualified as a candidate for SRS.

Lawrence acknowledges the erotic aspects of autogynephilia but believes that focusing on the erotic misses other essential elements: "Autogynephilia can more accurately be conceptualized as a type of sexual orientation and as a variety of romantic love, involving both erotic and affectional or attachment-based elements."[38] For Lawrence, the AT desires to become what he loves. Lawrence views this desire as comparable to the heterosexual desire to become one with the beloved. She says that "becoming what one loves usually becomes their first priority, while other elements of life—family, friends, employment—typically assume secondary importance at least temporarily. The sex reassignment process is often given first claim on the transsexual's time, energy and resources."[39] The kind of romantic love described by Lawrence has an unhealthy obsessive aspect even in a relationship between a man and a woman, but far more so when the "beloved" is a fantasy image of womanhood.

Lawrence also recognizes that ATs are "probably at increased risk for the development of narcissistic disorder," because they are "particularly vulnerable to feelings of shame and may be predisposed to exhibit narcissistic rage in response to perceived insult or injury."[40] Lawrence attributes this to the fact that ATs are wounded because many people treat them as "men pretending to be women." Rather than encouraging therapy to deal with the narcissism and accompanying rage, Lawrence suggests that clinicians avoid inflicting narcissistic injury. This may be difficult, since Lawrence admits that many ATs do not present themselves as convincing women. Even if someone expresses acceptance verbally, they will communicate their true feelings through facial expression and body language which may be perceived as rejection.

Females Seeking SRS

Although the desire for SRS was once relatively rare among women, the number of those seeking partial or complete SRS has increased, almost all originally identifying themselves as lesbian.[41] Women with SSA can be divided into two groups:

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[37] Sandy Stone, "The 'Empire' Strikes Back: A Posttranssexual Manifesto," (2004), http://sandystone.com/empire-strikes-back.

[38] Anne Lawrence, "Becoming What We Love," *Perspectives in Biology and Medicine,* 50.4 (2007): 506.

[39] Ibid.

[40] Anne Lawrence, "Shame and Narcissistic Rage in Autogynephilic Transexualism," *Archives of Sexual Behavior* 37.3 (June 2008): 457–461.

[41] "'Gay' Group Sponsors Breast-Removal Workshop: 'Trans' Conference Seeks to Help Females Who Want to Be Men," WorldNetDaily.com, February 16, 2002, http://www.worldnetdaily.com/news/article.asp?ARTICLE_ID=26487; Paul Vitello, "The Trouble when

those with a strong masculine identification ("butch") and those without ("femmes"). The majority of those with a strong masculine identification experienced GID as children. As children, they failed to identify with the goodness and beauty of their femininity and bodies. Like boys with GID, these girls often failed to establish close same-sex friendships. Many have a history of early insecure attachment to their mothers, whom they viewed as weak and vulnerable. They may have come to believe that if they were boys they could please their fathers or at least protect themselves and their mothers from male aggression. GID in girls differs from a more common "tomboyishness" in that GID girls vehemently resist wearing girls clothing or engaging in typical girl play. Tomboyish girls on the other hand might be atypical in their interests, but are more flexible.

According to Zucker and Bradley, the girl who develops GID is a "temperamentally vulnerable child who easily develops high levels of anxiety," with a mother who has difficulty with feelings and who may have been depressed during the first year of the girl's life. There is often family conflict in which the father expresses a lack of respect for the mother or for women in general. The girl "perceives the marital conflict as a situation in which the mother is unable to defend herself." When the girl "tries out cross-gender behaviors in an initial effort to decrease anxiety," her mother reacts positively because the mother believes imitating males will protect her daughter. The father may also encourage cross-gender behavior. "This permits the child the fantasy of being the mother's protector through identification with the aggressor."[42] In some cases women with GID recalled that their fathers constantly demeaned women in general, but in particular their mothers.

Psychological Disorders Associated with the Desire for SRS

Persons who desire SRS typically experience serious emotional conflicts, often complicated by sexual self-rejection and depression. Because many therapists are not skilled in uncovering and addressing these serious conflicts, SRS is put forward as the best available solution—if not the only solution. The very availability of SRS motivates persons who see surgery as *the* answer to their problems to resist therapy. Those who desire SRS know that if they present themselves in a manner that meets the criteria set forth by SRS-affirmative therapists (i.e., if they claim they have always felt like women in men's bodies or vice versa and if they hide their SSA, their homosexual behavior, their compulsive masturbation, and their paraphilias), then they may be allowed to proceed with SRS. This does not encourage an honest therapeutic alliance. The availability of SRS effectively prevents the patient from revealing anything that might lead to nonsurgical (i.e., psychiatric and other psycho-

Jane Becomes Jack," *New York Times*, August 20, 2006; and Yolanda Smith, Stephanie van Goozen, and Peggy Cohen-Kettenis, "Adolescents with Gender Identity Disorder Who Were Accepted or Regected for Sex Reassignment Surgery: A Prospective Follow-Up Study," *Journal of the American Academy of Child and Adolescent Psychiatry* 40.4 (April 2001): 472–481, (of the twenty clients accepted, thirteen were female wanting to be male).

[42] Zucker, *Gender Identity Disorder*, 263–264.

therapeutic) resolution of underlying problems. Some therapists too readily accept a patient's "I feel trapped in the wrong body" explanation and do not probe—let alone help the patient to resolve—the patient's underlying narcissism, anger, and inability to embrace the reality of their sexual identity.

Once the SRS has been completed, treatment of the underlying psychological problems becomes even more difficult. According to psychoanalyst Charles Socarides: "There is no evidence that gender identity confusion—a gender identity contrary to the anatomical structure—is inborn. Therefore any attempt to change this through surgical means forever dooms the individual's chances of overcoming his psychosexual and psychological difficulties."[43] Generally, persons accepted for SRS are diagnosed with GID. According to the Gender Dysphoria Organization, advocates for those seeking SRS, gender identity disorder

> as identified by psychologists and physicians, is a condition in which a person has been assigned one gender, usually on the basis of their sex at birth, but identifies as belonging to another gender, and feels significant discomfort or being unable to deal with this condition. It is a psychiatric classification and describes the problems related to transsexuality, transgender identity and more rarely transvestism. It is the diagnostic classification most commonly applied to transsexuals. The core symptom of gender identity disorders is gender dysphoria, literally being uncomfortable with one's assigned gender.[44]

The implication is that the "assignment" of an infant on the basis of sex was faulty in these cases and needs to be corrected.

Do persons seeking SRS really believe that they have been mis-assigned, or have they learned that saying they are a woman in a man's body (or vice versa) is the only way they can qualify for SRS? Are therapists who evaluate such persons too willing to take these claims at face value? Sander Breiner, in an article titled "Transsexuality Explained," points out such a misperception is in itself a psychological problem:

> When an adult who is normal in appearance and functioning believes there is something ugly or defective in their appearance that needs to be changed, it is clear that there is a psychological problem of some significance. The more pervasive and extensive is this misperception of himself, the more significant is the psychological problem. The more the patient is willing to do extensive surgical intervention (especially when it is destructive), the more serious is the psychological problem. It may not be psychosis. It may not require psychiatric hospitalization. But the significance of the psychological difficulty should not be minimized by a patient's seeming success socially and professionally in other areas.[45]

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[43] Charles W. Socarides, "The Desire for Sexual Transformation: A Psychiatric Evaluation of Transsexualism," *American Journal of Psychiatry* 125.10 (1969): 1419–1425.

[44] "About Gender Dysphoria," Gender Dysphoria Organization's Web site, http://www.genderdysphoria.org/genderdysphoria_medical.html.

[45] Sander Breiner, "Transsexuality Explained," *NARTH Bulletin* (March 27, 2008), http://www.narth.com/docs/transexpl.html.

While those who make these claims may wish to believe that they are really trapped in the body of the wrong sex, it may be that what they actual believe is that if they were the other sex they would be happy, safer, more accepted, and more loved—which is not quite the same thing. The belief that one's problems would be solved if one undergoes SRS can be thought of as an *idée fixe*—an obsession that dominates thinking and resists evidence. For various reasons, rooted in their psychological history, these individuals believe that SRS will make them happy, and they are willing to do whatever is necessary to qualify for the treatment.

The intensity of the desire for change is presented as evidence of the reality of the "wrong-body claim." Some men seeking SRS say, "I will commit suicide if I am not allowed to have surgery," or "I will castrate myself." Some have actually done so.[46] Suicidal ideation and self-mutilation are generally considered symptoms of mental illness. Therapists should explore whether the person seeking SRS is motivated by an irrational disgust directed at sex-specific characteristics or a fantasy-driven desire for the sexual organs of the other sex, or both. Socarides treated a young man who was forced into therapy by his father. The man admitted that he was sexually abused by an older brother from age seven to age fourteen.[47] He expressed a strong desire for a vagina:

> I will sacrifice everything to change. If you have a vagina, you can control people. You can control them sexually. The idea fascinates me and to use this vagina fascinates me. I think I'm scared of anal intercourse. I could do it with a vagina and I would not be harmed physiologically, but I already have been harmed through anal intercourse with men.[48]

GID in children, which may be a precursor to the desire for SRS in HT males, is hardly a benign condition. It is associated with a number of psychological problems, which if left unaddressed affect adolescent and adult adjustment.

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[46]Karen Kane, "Transsexual Convicted in Castration Death Gets Another 21-60 Months in Jail for Threats," *Pittsburgh Post-Gazette,* April 2, 2008.

[47]Charles W. Socarides, "A Psychoanalytic Study of the Desire for Sexual Transformation ('Transsexualism'): The Plaster-of-Paris Man," *International Journal of Psychoanalysis* 51.3 (1970): 341–349.

[48]Ibid., 344.

[49]Lynda Doll et al., "Self-Reported Childhood and Adolescent Sexual Abuse among Adult Homosexual and Bisexual Men," *Child Abuse & Neglect* 16.6 (November–December 1992): 855–864. Over 40 percent of adult homosexual and bisexual men in this study reported a history of sexual abuse. See also R. L. Johnson and D. K. Shrier, "Sexual Victimization of Boys: Experience at an Adolescent Medicine Clinic," *Journal of Adolescent Health Care* 6.5 (September 1985): 372–376; Judith Siegel et al., "The Prevalence of Childhood Sexual Assault: The Los Angeles Epidemiological Catchment Area Project," *American Journal of Epidemiology* 126.6 (December 1987): 1141; Gregory Dickson and Dean Byrd, "An Empirical Study of the Mother-Son Dyad in Relation to the Development of Male Homosexuality: An

Childhood Sexual Abuse

Several studies have found that at least 40 percent of adults, both male and female, with SSA have a history that includes childhood sexual abuse (defined as sexual activity before age fourteen with a person five or more years older).[49] It should be noted that the "abuse" may be regarded as "consensual," with a troubled child accepting whatever kind of affection or attention is offered. Although some people think that SSA is caused by sexual abuse, all persons who are sexually abused do not develop SSA. While such abuse can be a primary or at least a contributing cause, in most instances the foundation for SSA is laid before the abuse. The early initiation into sexual activity, however, may set a pattern for subsequent behavior.

The percentage of HTs with a history of abuse may be even higher than 40 percent. A small study found that 55 percent of the transsexuals experienced unwanted sexual acts before age eighteen.[50] An article by Holly Devor explored the relationship between adult transsexualism and childhood sexual abuse. In one study of forty-five self-defined female-to-male transsexuals, 60 percent of the subjects reported physical, sexual, or emotional abuse:

> While an experience with at least one of the conventional adult psychopathological sequaelae symptomatic of child abuse (e.g. fear, anxiety, depression, compulsive eating disorders, substance abuse, hyperaggression, suicidal behavior) was often cited, the exact source of these behaviors may be a combination of gender dysphoria and a history of child abuse. It is suggested that transsexualism may manifest in adulthood as an adaptive, extreme dissociative survival response in individuals with a past of severe child abuse.[51]

Childhood traumas can cause lasting damage. The extent of permanent damage depends not so much on the severity of the trauma as on the response of the adults around the child. If parents and other adults respond positively, they can help the child understand that whatever has happened (i.e., divorce, death, abuse) is not his or her fault. With positive adult input, a child's understandable sadness, anger, or feelings of guilt can be minimized. Unfortunately, the parents of children with GID are often unable to provide the support that their children need in order to deal with the trauma, forcing the child to develop his or her own strategy for coping.[52]

Whether motivated by a desire to resolve lingering distress resulting from acute trauma or other factors, an adolescent's (let alone a child's) request to be treated

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Object Relations Perspective," *Journal of the Association of Mormon Counselors and Psychotherapists* 30 (2006). The Dickson and Byrd study found that 49 percent of homosexual men (versus 2 percent of heterosexual men) had a history of sexual abuse.

[50]Darlynne Gehring and Gail Knudson, "Prevalence of Childhood Trauma in a Clinical Population of Transsexual People," *International Journal of Transgenderism* 8.1 (2005): 23–30.

[51]Holly Devor, "Transsexualism, Dissociation, and Child Abuse: An Initial Discussion Based on Nonclinical Data," *Journal of Psychology and Human Sexuality* 6. 3 (1994): 49–72.

[52]Jane Middelton-Moz, *Children of Trauma* (Deerfield Beach, FL: Health Communications, 1989).

hormonally and altered surgically to appear more like his or her non-biological sex, needs to be viewed from the perspective of "competence to choose." SRS renders impossible a person's ever (again or initially) being able to function fully sexually or reproductively either as a member of his or her conceived (i.e., genetic) sex or as the sex which she or he would like to resemble. Research shows that brain development is affected by behavior and that areas of the brain critical for decision making, problem solving, and emotional management do not develop fully until persons are in their mid to late twenties.[53] Therefore, any child or teenager—let alone one who is suffering from gender dysphoria—is not mature enough or competent to decide on the use of sexual hormones or permanent SRS.

Humane parents do not support their child's persistent cutting—or other self-mutilating or self-injuring behaviors—even when such behaviors serve as emotion-regulating and distress-relieving activities. Likewise, parents, however well intended, ethically should not consent to a minor child's permanent sterilization or self-mutilation to ameliorate the psychological distress of a child's gender dysphoria. To the extent that parents or other guardians give consent for a minor to receive SRS rather than seek appropriate psychological and psychiatric care, these adults objectively are neglecting to protect their child from physical injury. Failure to protect children from seriously harming themselves or from being harmed by others—let alone enabling this to happen—objectively is abusive. Surgeons and other medical and mental health professionals, however motivated, ethically should not condone, provide, or otherwise cooperate in such disservice to youth.

Consider the case of a thirteen-year-old boy discussed by a panel of doctors in *Pediatric Annals*. The boy wanted to start hormone treatments with the goal of SRS when he came of age:

> His medical history is significant for reported physical abuse warranting placement outside his home. He underwent psychiatric hospitalization one year earlier for suicidal ideation related to anger associated with gender issues. He has been diagnosed as having attention deficit disorder. ... He is sexually active with male partners only and considers himself a heterosexual female. He uses condoms 50 percent of the time for anal sex. He had one HIV test, which was negative approximately one year ago. He reported having few friends because "no one is like him."[54]

The doctors evaluating this boy's request appear to have ignored the obvious: If this boy is not already HIV positive, he probably soon will be. One doctor quoted in the article expressed concern that "our society does not accept sexual ambiguity." It would seem more proper to recognize that this thirteen-year-old is the victim of ongoing sexual abuse and should be protected and treated rather than put on the fast track to SRS.

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[53] J. N. Giedd et al., "Brain Development during Childhood and Adolescence: A Longitudinal MRI Study," *Nature Neuroscience* 2.10 (October 1999): 861–863.

[54] Robert Listernick, "A 13-Year-Old Boy Who Desires Gender Reassignment," *Pediatric Annals* 32.6 (June 2003): 378–382.

Same-Sex Attraction

"Homosexuality" as a separate diagnosis was removed from the *Diagnostic and Statistical Manual of Mental Disorders*[55] in 1973; however, a number of large, recent well-designed studies have found that persons with SSA are far more likely to suffer from a wide range of psychological disorders, such as depression, substance abuse problems, and suicidal ideation, than the general public.[56] For example, a 2003 study, using data from a nationally representative survey of 2,917 adults, compared persons with SSA to those without;[57] results are shown in Table 1.

To the extent that persons with HT are similar to other persons with SSA, one would expect to find similar or even higher levels of psychological maladjustment. Persons with SSA with a history of childhood GID may be more vulnerable than those without. Some claim that these problems are caused by societal rejection; however, if this were the case, one would expect to see significantly fewer problems among those who live in tolerant countries such as the Netherlands and New Zealand, but psychological maladjustment levels are similarly high in these countries.[58]

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[55]Compare the second (1972) and current (2000) editions, both published by the American Psychiatric Association (Washington, D.C.).

[56]Richard Herrell et al., "Sexual Orientation and Suicidality: A Co-Twin Control Study in Adult Men," *Archives of General Psychiatry* 56.10 (October 1999): 867–874; David M. Fergusson, L. J. Horwood, and A. L. Beautrais, "Is Sexual Orientation Related to Mental Health Problems and Suicidality in Young People?" *Archives of General Psychiatry* 56.10 (October 1999): 876–880; Theo Sandfort et al., "Same-Sex Sexual Behavior and Psychiatric Disorders: Findings from the Netherlands Mental Health Survey and Incidence Study (NEMESIS)," *Archives of General Psychiatry* 58.1 (January 2001): 85–91; Stephen E. Gilman et al., "Risk of Psychiatric Disorders among Individuals Reporting Same-Sex Sexual Partners in a National Comorbidity Survey," *American Journal of Public Health* 91.6 (June 2001): 933–939; Susan D. Cochran, J. Greer Sullivan, and Vickie M. Mays, "Prevalence of Mental Disorders, Psychological Distress, and Mental Health Services Use among Lesbian, Gay, and Bisexual Adults in the United States," *Journal of Consulting and Clinical Psychology* 71.1 (February 2003): 53–61; Keren Skegg et al., "Sexual Orientation and Self-Harm in Men and Women," *American Journal of Psychiatry* 160.3 (March 2003): 541–546; Kimberly F. Balsam et al., "Mental Health of Lesbian, Gay, Bisexual and Heterosexual Siblings: Effects of Gender, Sexual Orientation, and Family," *Journal of Abnormal Psychology* 114.3 (August 2005): 471–476; Theo Sandfort et al., "Sexual Orientation and Mental and Physical Health Status," *American Journal of Public Health* 96.6 (June 2006): 1119–1125; Susan D. Cochran and Vickie M. Mays, "Physical Health Complaints among Lesbians, Gay Men, and Bisexual and Homosexually Experienced Heterosexual Individuals: Results from the California Quality of Life Survey," *American Journal of Public Health* 97.11 (November 2007): 2048–2055; and Michael King, "A Systemic Review of Mental Disorder, Suicide, and Deliberate Self Harm in Lesbian, Gay and Homosexual People," *BMC Psychiatry* 8.70 (2008): 1–17. Cochran and her associates state that lesbians, gays, and bisexuals "use mental health services more and are at a higher risk for suicidal ideation, suicide attempts and self-injurious behavior than heterosexual siblings."

[57]Cochran et al., "Prevalence of Mental Disorders."

[58]Sandfort, "Same-Sex Sexual Behaviors," Sandfort "Mental and Physical Health Status," and Fergusson, "Suicidality in Young People."

TABLE 1
Prevalence (%) of Mental Health Disorders by Gender and Sexual Orientation

	Men		Women	
	Heterosexual	Gay/Bisexual	Heterosexual	Lesbian/Bisexual
Major depression	10.2	31.0	16.8	33.5
Panic disorder	3.8	17.9	8.6	17.1
Drug dependence	2.7	9.2	1.5	6.5
At least one disorder	16.7	39.8	24.6	43.7

SOURCE: Cochran et al., "Prevalence of Mental Disorders," 56.

It should be noted that none of these studies include sexual addiction or paraphilias. Were these included, the differences could be even more striking. Domestic violence is a serious problem for same-sex couples.[59] Men with SSA are more likely to have engaged in high-risk activities, sex with strangers, unprotected sex (often while using drugs or alcohol), and sex for money—all this in spite of the knowledge that this behavior could lead to infection with a number of serious diseases including HIV/AIDS. The percentage of men who have sex with men diagnosed as HIV positive continues to be high in spite of decades of prevention education. HTs going through the "gay boy" stage are more likely to engage in receptive anal sex, which is an extremely high-risk sexual activity, particularly for those who are young.[60] It is possible that conscious or unconscious fear of infection might cause some to be attracted to heterosexual males, since the risk of contracting HIV/AIDS or another sexually transmitted infection from a heterosexual male is far less.

A study of clients of HIV prevention centers found that 52 percent of the 107 transgender-identified clients, versus 22 percent of the 2,019 nontransgender-identified clients, were HIV positive. The authors concluded that "transgendered-identified individuals are at high risk for HIV infection because of reuse of needles and (prostitution) being paid for sexual intercourse."[61]

Masochism

Sexual masochism involves experiencing sexual arousal or excitement from receiving pain, suffering, or humiliation. Jon Meyer and John Hoopes, in an article titled "The Gender Dysphoria Syndrome: A Position Statement of So-Called Transsexualism," considered the possibility that masochism may play a part in

[59]Lambda GLBT Community Services, "Domestic Violence in Gay, Lesbian, and Bisexual Relationships," http://www.lambda.org/DV_background.htm.

[60]Anke A. Ehrhardt et al., "Sexual Risk Behavior, Sexual Functioning, and HIV-Disease Progression in Gay Men," *Journal of Sex Research* 28.1 (February 1991): 3–28.

[61]Jordan W. Edwards, Dennis G. Fisher, and Grace L. Reynolds, "Male to Female Transgender and Transsexual Clients of HIV Service Programs in Los Angeles County, CA," *American Journal of Public Health* 97.6 (June 2007): 1030–1033.

the desire for SRS.[62] The masochists find that sexual arousal is facilitated by the experience of pain prior to sexual activity; they look upon the surgical excision of the genitalia (albeit unconsciously) as a form of masochistic adventure with the surgeon. Similarly, Janice Raymond, in her book *The Transsexual Empire: The Rise of the She Male*, suggests that men who desire SRS may be suffering from a form of destructive masochism. She writes,

> What has been scarcely noted in many commentaries on transsexualism is the immense amount of physical pain that surgery entails. Generally, this fact is totally minimized. Most postoperative transsexuals interviewed seldom commented on the amount of physical pain connected with their surgery. Are we to suppose no pain is involved? Anyone who has the slightest degree of medical knowledge knows that penectomies, mastectomies, hysterectomies, vaginoplasties, mammoplasties, and the like cannot be painless for those who undergo them. ... It seems that the silence regarding physical pain, on the part of the transsexual, can be explained only by an attitude of masochism, where one of the key elements of the transsexual order is indeed the denial not only of self but physical pain to the point "where it may actually be subjectively pleasurable, or at least subjectively negligible."[63]

In an article on SRS in Thailand, a Thai surgeon said that he liked to do SRS work because other patients complained about the pain related to surgery, but "the sexual reassignment surgery patients are *always* happy. They don't complain! They say they are born again here in Thailand and they are happy."[64]

This suggests the possibility that some men seeking SRS may be using the process to fulfill masochist desires and to try to resolve self-hatred. On the other hand, SRS patients frequently do complain about the cosmetic effects of the surgery and about the treatment they receive by those who do not, in their opinion, sufficiently accept them as women.

Ethical Objection to SRS

The publicly promoted goal of SRS is to transform a person of one sex into the other sex. It is physiologically impossible to change a person's sex, since the sex of each individual is encoded in the genes—XX if female, XY if male. Surgery can only create the *appearance* of the other sex. George Burou, a Casablancan physician who has operated on over seven hundred American men, explained, "I don't change men into women. I transform male genitals into genitals that have a female aspect. All the rest is in the patient's mind."[65] Therapists may be unwilling to explore the erotic motivation of those seeking SRS: "Most therapists and surgeons would probably find

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[62]Jon K. Meyer and John E. Hoopes, "The Gender Dysphoria Syndrome: A Position Statement of So-Called 'Transsexualism,'" *Plastic and Reconstructive Surgery* 54.4 (October 1974): 448.

[63]Janice Raymond, *The Transsexual Empire: The Making of the She-Male* (New York: Teachers College Press, 1994), 143.

[64]Margaret Talbot, "Nip, Tuck, and Frequent-Flier Miles," *New York Times*, May 6, 2001, 90.

[65]Raymond, *Transsexual Empire*, 10.

it difficult to acknowledge that when they give approval for sex reassignment surgery, or perform it, they are sometimes simply helping a transsexual woman act out her own paraphilic sexual script."[66] Each person seeking SRS is a unique individual with his or her own history and particular psychological disorders and emotional problems.

The suffering of persons who desire SRS cannot be denied. In many cases, it began in early childhood. Many have been victims of various forms of abuse or neglect and of peer or parental rejection. Basic emotional needs for secure attachment relationships to same-sex peers and to the same-sex parent have often not been met. Gender dysphoria is rarely their only diagnosable psychological disorder. They are, however, united by the belief that SRS will solve their problems. They have created an erotic script in which, as persons of the other sex, they are able to overcome all difficulties. They may enlist the support of surgeons to make their fantasy come true, but such fantasies are not reality based. SRS may satisfy a fantasy wish but it cannot (re)create a person as a fully functioning member of the other sex, able to live honestly as the other sex in real-world situations. Such persons always will be living in their fantasy, trying ever harder to make it more perfect. Fantasies may sooth anxiety temporarily, but they cannot heal the wounds of childhood trauma and satisfy unmet early needs. Once persons receive SRS, they may be—and often are—even more reticent to admit that they are still struggling with serious emotional conflicts.

Therapists are often unable to overcome patient resistance and uncover the underlying problems—serious emotional weaknesses of low self-esteem, sadness, and anger associated with the failure to develop secure attachment relationships in childhood and adolescence. Rather than admit this, they may surrender to the patient's self-analysis and disorder-driven demands. Authorizing SRS allows the medical team to feel that they are doing something—their patients are grateful. But the team overlooks the fact that SRS mutilates a healthy human body, results in significant pain and suffering, incurs real, unjustifiable risks to patients, and does not address the real psychological problems.

This is not to deny the very human needs of these persons for acceptance and love. It is one thing to honor each human person's need for acceptance as a being of infinite worth and value. It is quite another to accommodate a person's demand that others—including medical and mental health care professionals—overlook or deny the truth and accept a fantasy as reality. This kind of forced and false acceptance can only make those who demand it feel more insecure, since at some level they know that a forced affirmation is not sincere.

Our society has confused erotic satisfaction with love. This confusion springs from the widespread adoption of a sexual utilitarian ethic, under which pleasure becomes the measure of good; sexual pleasure is seen as the highest pleasure and therefore the highest good. Those who have adopted this ethical viewpoint regard all sexual pleasure—whether alone or with others, so long as no force is used—as good, and anything which inhibits sexual pleasure as wrong. Thus, if HTs desire to have sex with heterosexual men and can achieve that goal through surgery, there is no

[66]Lawrence, "Men Trapped in Men's Bodies."

reason to deny them this pleasure. If ATs want their fantasy love of self as a woman to be more realistic, they should not be denied the medical and surgical means to achieve their wish. If those with transsexual desires find the pain of multiple surgeries sexually exciting, surgeons should oblige them. For sexual utilitarians, no sexual desire, no matter how compulsive or dangerous, should be denied.

In 1960, Pope John Paul II (then Bishop Karol Wojtyła), in his book *Love and Responsibility,* explained how the utilitarian ethic applied to sexuality violated the fundamental law of love by treating the human person as an object. Reading through the autobiographical material and case studies on pre- and post-SRS patients, one sees that, although they insist that they are pleased with their decision to pursue SRS, these individuals also voice a sad dissatisfaction with the quality of their relationships. At some level they know that they are using others and being used and that they long for something more. Bailey found that HTs, either before or after surgery, often engaged in prostitution. According to Bailey, their ability "to enjoy emotionally meaningless sex appears male-typical."[67] As they grow older, many admit living lonely, isolated lives. Fantasies can never meet the human need for authentic human love.

Partners in Deception

Those who undergo SRS want to be accepted as members of the other sex—legally, socially, and sexually—to "pass." Surgery allays the fear of being exposed as a woman with a penis or a man without. The simplest form of passing is going out in public and having people assume that they are a person of the other sex. Some HT males—either before or after SRS—engage in sexual activity with a heterosexual male without informing him of their true sex. There have been tragic incidents in which their partners have reacted violently to the revelation.[68] Some persons who have undergone SRS have married a person of the same sex, in some cases even without informing that person of their SRS. Obviously, this involves a massive deception. Such marriages are illegal in most states even if the partner is informed of the birth sex. Persons who have undergone SRS often try erasing their pre-SRS history by legally changing their names, cutting themselves off from those who knew them before, and creating a fictitious past.[69]

Transsexual activists are working to change laws regarding sexual identity. They want persons who have undergone SRS to be able change their birth certificates and other records. Many states have allowed this. There is a push to allow persons who appear in public as the other sex, but have not had "bottom" surgery, to change their documents as well. Public officials object since this would affect, among other things, the placement in prisons. As one official pointed out, "How can you send a person with a penis to a women's prison?"[70]

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[67]Bailey, *Man Who Would Be Queen,* 185.

[68]Dan Frosch, "Death of a Transgender Woman Is Called a Hate Crime," *New York Times,* August 2, 2008.

[69]David Batty, "Mistaken Identity," *Guardian,* July 31, 2004.

[70]Daniel Trotta, "NY Rejects Transgender Birth Certificate Law," *Reuters,* December 5, 2006.

Is it ethical for physicians to participate in a procedure when the clear purpose of it is to deceive people? Should surgeons perform an operation where the goal is to hide crucial "facts" from innocent third parties? Does a potential sexual partner or, more importantly, a possible marital partner have a right to know that the person with whom he or she is about to become intimate was not born the sex he or she appears to be, requires hormone treatments in order to sustain this appearance, and is not able to have children? The reaction of those who discover this fact *after* initiating a relationship strongly suggests that most people are not comfortable with engaging in what they perceive as a homosexual relationship.[71]

Religious and Other Objections

The Catholic Church has made it clear that, since it is not possible for a person to change their sex, "people who have undergone a sex-change operation cannot enter into a valid marriage, either because they would be marrying someone of the same sex in the eyes of the church or because their mental state casts doubt on their ability to make and uphold their marriage vows."[72] A woman who has undergone SRS cannot become a priest. The Church will not alter baptismal records to reflect the claim of a change of sex. Many other religious institutions also reject the claim of sex change as impossible and contrary to God's plan. In England, the Evangelical Alliance, an organization representing more than a million British Christians, submitted a strongly worded statement to the government opposing changing birth certificates to reflect SRS. It said, "We affirm God's love and concern for all humanity, including transsexual people, but believe that human beings are created by God as either male or female and that change from a given sex is not really possible."[73]

Arthur Goldberg, cofounder and codirector of JONAH (Jews Offering New Alternatives to Homosexuality), carefully documents and explains that the divinely created and revealed nature of humankind, as understood in the Old Testament and over thirty-eight hundred years of authoritative Judaic oral and written tradition, forbids the practice of SRS.[74] In brief, "no published opinion by any Orthodox [Jewish] scholar permits sex change surgery for reasons of gender dysphoria."[75] Also, this prohibition of SRS—as well as the prohibition of other forms of sexual immorality (e.g., fornication, adultery, promiscuity, masturbation, incest, bestiality, and homosexuality)—is understood by authoritative Jewish scholars as applying to all people, not just Jews.[76] In summary, Goldberg writes:

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[71]Bailey, *Man Who Would Be Queen*, 150–151.

[72]John Norton, "Vatican Says Sex Change Operation Does Not Change a Person's Gender," *Catholic News Service,* January 14, 2003.

[73]Jonathan Petre and David Bamber,"Transsexual Weddings Are Condemned," May 14, 2000, http://www.telegraph.co.uk/htmlCotnent.html.

[74]Arthur Goldberg, *Light in the Closet: Torah, Homosexuality and the Power to Change* (Los Angeles: Red Heifer Press, 2008), chapter 8, "Sexual Reassignment Surgery," 262–299.

[75]Ibid., 299.

[76]Ibid., chapter 6, "The Sexual Behavioral Prohibitions of the Torah," 175–233.

> SRS, for purposes of alleviating transsexual anxiety in a physically normal male or female, is forbidden, and no medical justification has yet been shown to exist. From so much as now is known, the procedure is dangerous, potentially harmful, of doubtful value or benefit, and emphatically contrary to medial ethics. Moreover, alternative and less drastic means of providing relief and a cure are available in gender-affirming processes (GAP) which ... offer holistic approaches not only to resolving gender dysphoria but to fully reintegrating the shattered personality of the affected individual.[77]

Resistance to SRS is not limited to religious conservatives. Some lesbian and radical feminists, such as Janice Raymond, feel that men who have undergone SRS, who were not born female and so have never experienced growing up as women, have no right to claim to be women or, as they do in some cases, claim to be lesbian women.[78] Raymond is particularly offended that HT males who have undergone SRS promote demeaning stereotypes of women as sexual objects who exist for men's pleasure.[79] She is also offended that some HT males insist that they are better women than real women.[80] As the number of women with SSA seeking surgery has increased, their feminist and lesbian friends see these women as betraying the cause or going over to the enemy.[81] Some feminist and lesbian events are restricted to women born as women and living as women.[82]

Many women regard the transsexual males' description of what it means to be a woman—weak and dependent, wanting only to be cared for by a man, addicted to gossip and clothes—as insulting. McHugh reports on his impression of men who have undergone SRS:

> Those I met after surgery would tell me that the surgery and hormone treatments that had made them "women" had also made them happy and contented. None of these encounters were persuasive, however. The post-surgical subjects struck me as caricatures of women. They wore high heels, copious makeup, and flamboyant clothing; they spoke about how they found themselves able to give vent to their natural inclinations for peace, domesticity, and gentleness—but their large hands, prominent Adam's apples, and thick facial features were incongruous (and would become more so as they aged). Women psychiatrists whom I sent to talk with them would intuitively see through the disguise and the exaggerated postures. "Gals know gals," one said to me, "and that's a guy."[83]

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[77] Ibid., 298–299.

[78] Raymond, *Transsexual Empire*, 103.

[79] Thomas Kando, *Sex Change: The Achievement of Gender Identity among Feminized Transsexuals* (Springfield, IL: Charles C. Thomas, 1973).

[80] Ibid., 117.

[81] Vitello, "When Jane Becomes Jack."

[82] See, for example, "Womyn-Born-Womyn," http://en.wikipedia.org/wiki/Womyn-born-womyn.

[83] McHugh, "Surgical Sex," 34.

The cable television series *Sex Change Hospital* (2007) follows real patients through the process. Most of the men who insisted that the surgery made them women did, in spite of long hair and make-up, still look very much like men.

Those interviewing male applicants for SRS find that the men do not understand the true nature of womanhood. Frederic Worden and James Marsh felt that these individuals had no conception of the duties and responsibilities entailed in being a woman but were, rather, wrapped in fantasies of being beautifully dressed, embellished with sparkling jewelry, wonderful coiffures, cosmetics etc. Their aim was a narcissistic one rather than a normal adult feminine sexuality.[84]

Testimonies of former transsexuals who underwent either total or partial SRS, and who subsequently chose to treat the underlying psychological bases of their gender dysphoria, document both the common causes of such perceived "needs" for SRS and the possibility of meeting those needs through nonsurgical and non-hormonal means.[85]

Freedom of Speech, Religion, and Thought

Those who believe that it is impossible to change a person's sex do not want to be insensitive to others, but neither should they be forced to lie by calling a man a woman or by calling a woman a man. Transsexual activists hope to force the public to use pronouns and designations of the sex the person wants to be rather than their true sex, even when the person has not undergone SRS. They want those who refuse to accept sex changes to be labeled as "transphobic"—and charged with discrimination. A flyer produced by a student group at the University of Massachusetts Amherst, lists attitudes condemned as transphobic, including

- Assuming that everyone is either male or female
- Continuing to use inappropriate gender pronouns for someone after being corrected or calling someone "it"
- Believing that transgender people cannot be "real women" or "real men"
- Considering transsexuality to be a mental illness or disorder
- Expecting all transgender people to be transsexual and want to transition completely or at all.
- Believing that transgender youths cannot be trusted to make decisions about their gender identities.[86]

[84]Frederic G. Worden and James T. Marsh, "Psychological Factors in Men Seeking Sex Transformation: A Preliminary Report," *Journal of the American Medical Association* 157.15 (April 9, 1955): 1292–1298, quoted in Charles W. Socarides, "The Desire for Sexual Transformation," 1421.

[85]Goldberg, *Light in the Closet*, 210–212, 295–298.

[86]"What Does Transphobia Look Like?" Stonewall Center of the University of Massachusetts Amherst, www.umass.edu/stonewall.

Dignity USA has even issued guidelines for media coverage of transgender persons. They condemn "referring to transgendered persons using pronouns and possessive adjectives appropriate to their birth sex" as "*extremely* offensive."[87]

Colleges, including traditional women's colleges, are accommodating the demands of students who want to be treated as the other sex.[88] Activists are also pressuring schools to allow children with GID as early as kindergarten to cross-dress, change their names, and use the bathroom facilities of the other sex. Parents of these children's classmates often strenuously object to programs which force children—some as young as six or seven—to pretend that a fully biologically male child is a girl.[89]

Although some HTs can deceive others as to their true sex, many people recognize that there is something wrong when they meet a person publicly presenting themselves as the other sex. People may be too polite to say so—they may even publicly say they support the idea that people can change sex—but they often unconsciously may communicate their lack of full acceptance. This unspoken lack of true acceptance cannot but affect the person claiming to be the other sex. It leads to layers of denial, feelings of insecurity, and need to constantly prove oneself.

Collaborating with Madness?

There is no question that SRS destroys healthy sexual organs, creates permanent sterility, and carries health risks. It cannot change sex but only creates the illusion of change. According to Anne Lawrence, "It is widely accepted that transsexualism represents a fundamental disorder in a person's sense of self."[90] SRS does not treat this disorder, it surrenders to it. The desire for SRS is a symptom of a number of psychological disorders. Since these serious problems are difficult to treat in adolescents and adults, first priority should be given to prevention through education and early intervention. For the development of healthy masculinity and femininity, parents need to understand the critical importance of early secure attachment with each parent and siblings, positive support for sexual identity, encouragement for children with atypical talents and interests, and same-sex friendships in early childhood.

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[87] Transgender Nation, "Transgender Persons: A Primer to Better Understanding," Dignity USA, July 2008, http://www.dignityusa.org/transgender/primer (original emphasis).

[88] Fred A. Bernstein, "On Campus Rethinking Biology 101," *New York Times,* March 7, 2004.

[89] Philadelphia Catholic Medical Association, press release, May 16, 2008, www.narth.com/docs/CMApressrelease.pdf.

[90] Anne A. Lawrence, "Shame and Narcissistic Rage in Autogynephilic Transsexualism," *Archives of Sexual Behavior* 37 (April 23, 2008): 458, referencing Allan Beitel, "The Spectrum of Gender Identity Disturbances: An Intrapsychic Model," in Betty W. Steiner, ed., *Gender Dysphoric Development Research Management (Perspectives in Sexuality)*, (NY: Springer, 1985), 189–206; and U. Hartmann and H. Becker, C. Rueffer-Hesse, "Self and Gender: Narcissistic Pathology and Personality Factors in Gender Dysphoric Patients, Preliminary Results of a Prospective Study," *International Journal of Transgenderism* 1.1 (July–September 1997).

While the desire for SRS is presented as a problem of gender identity, there is substantial evidence that the defense mechanism of rationalization serves to cover up serious emotional and personality conflicts and the underlying sexual motivation, namely, the desire by some to live out their sexual fantasies. At the very least, health professionals should evaluate the role that strong anger toward oneself, with self-destructive impulses and intense anger toward others, depression, self-pity, childhood trauma, addiction to masturbation and fantasy, and envy, plays in the development of HT and AT. These persons also should be evaluated for personality disorders, particularly narcissistic and borderline types.

Efforts should be directed toward the development of effective therapy for adolescents and adults. The fact that such therapy is not described extensively in the literature and therefore is not widely available, and that these patients resist therapeutic interventions, does not justify giving in to the demand for surgical mutilation.

If SRS is neither medically nor ethically justifiable for adults, then starting hormone treatments on adolescents with GID in order to suppress puberty, with the promise of later proceeding to SRS, is even less so.[91] Surgeons, mental health professionals, and those dealing with medical ethics would do well to follow the advice of Dr. Paul McHugh: "I concluded that Hopkins was fundamentally cooperating with a mental illness. We psychiatrists, I thought, would do better to concentrate on trying to fix their minds and not their genitalia."[92] He added,

> As for the adults who came to us claiming to have discovered their "true" sexual identity and to have heard about sex-change operations, we psychiatrists have been distracted from studying the causes and natures of their mental misdirections by preparing them for surgery and for a life in the other sex. We have wasted scientific and technical resources and damaged our professional credibility by collaborating with madness rather than trying to study, cure, and ultimately prevent it.[93]

[91] Joost à Campo et al., "Psychiatric Comorbidity of Gender Identity Disorders: A Survey among Dutch Psychiatrists," *American Journal of Psychiatry* 160.7 (2003): 1332–1336; and Peggy T. Cohen-Kettenis and Stephanie H. M. van Goozen, "Sex Reassignment of Adolescent Transsexuals: A Follow-Up Study," *Journal of the American Academy of Child and Adolescent Psychiatry* 36.2 (February 1997): 263–271.

[92] McHugh, "Surgical Sex," 35.

[93] Ibid.

Janet Aldrich
Hearing

Item Bill Number Bill Title Sponsor

1 S00653 By Mr. Berry, petition (accompanied by bill, Senate, No. 653) of [petitioners] for legislation relative to the interception of wire and oral communications [Joint Committee on the Judiciary]. Frederick Berry NO

2 S00753 By Ms. Creem, petition (accompanied by bill, Senate, No. 753) of Fox, Khan and Creem for legislation to provide access to forensic and scientific analysis [Joint Committee on the Judiciary]. Cynthia Creem

3 S00764 By Mr. Downing, a petition (accompanied by bill, Senate, No. 764) of Benjamin B. Downing, Sonia Chang-Diaz, Carl M. Sciortino, Jr., Katherine M. Clark and other members of the General Court for legislation relative to equal rights of transgendered individuals. The Judiciary. Benjamin Downing NO

4 S00869 By Ms. Spilka, petition (accompanied by bill, Senate, No. 869) of Cantwell, Provost, Swan and other members of the General Court for legislation to protect the Commonwealth's residents from identity theft [Joint Committee on the Judiciary]. Karen Spilka

5 H00403 By Mr. Bruce J. Ayers of Quincy, petition (accompanied by bill, House, No. 00403) of Bruce J. Ayers relative to criminal offender record information. Joint Committee on the Judiciary. Bruce Ayers

6 H00406 By Mr. Bruce J. Ayers of Quincy, petition (accompanied by bill, House, No. 00406) of Bruce J. Ayers for legislation to allow local housing authorities access to criminal records of tenants and prospective tenants. Joint Committee on the Judiciary. Bruce Ayers YES

7 H00462 By Mr. David Paul Linsky of Natick, petition (accompanied by bill, House, No. 00462) of David M. Torrisi and others relative to providing special education schools with criminal offender record information. Joint Committee on the Judiciary. David Linsky Yes

8 H00463 By Mr. David Paul Linsky of Natick, petition (accompanied by bill, House, No. 00463) of Cory Atkins and others requiring the inclusion of certain civil rights offense information in the statewide domestic violence record keeping system. Joint Committee on the Judiciary. David Linsky NO

9 H00473 By Mr. Naughton, Jr. of Clinton, petition (accompanied by Bill, House, No. 00473) of Harold P. Naughton, Jr. relative to background checks for utility grid workers. Joint Committee on the Judiciary. Harold Naughton

10 H00478 By Ms. Elizabeth Poirier of North Attleborough, petition (accompanied by bill, House, No. 00478) of George Ross and others for legislation to provide that interstate criminal offender records be made available to certain persons and agencies. Joint Committee on the Judiciary. Elizabeth Poirier YES

11 H00482 By Ms. Elizabeth Poirier of North Attleborough, petition (accompanied by bill, House, No. 00482) of Benjamin Swan and others relative to information provided to women seeking abortions.. Joint Committee on the Judiciary. Elizabeth Poirier

12 H00484 By Ms. Elizabeth Poirier of North Attleborough, petition (accompanied by bill, House, No. 00484) of Joyce A. Spiliotis and others for legislation to prohibit abortions solely on account of the sex of the unborn child. Joint Committee on the Judiciary. Elizabeth Poirier YES

13 H00492 By Mr. Byron Rushing of Boston, petition (accompanied by bill, House, No. 00492) of Denise Provost and others relative to the reform of laws implicating certain private consensual NO

intimate conduct between adults. Joint Committee on the Judiciary. Byron Rushing

14 H00500 By Mr. Scibak of South Hadley, petition (accompanied by Bill, House, No. 00500) of [petitioners] relative to voyeurism and the inappropriate viewing of intimate areas of another person. Joint Committee on the Judiciary. John Scibak ?

15 H00502 By Mr. Carl M. Sciortino of Medford, petition (accompanied by bill, House, No. 00502) of Susan Fargo and others relative to gender based discrimination and hate crimes. Joint Committee on the Judiciary. Carl Sciortino Rushing Byron NO

16 H00505 By Mr. Smola of Palmer, petition (accompanied by Bill, House, No. 00505) of Todd M. Smola relative to the fingerprinting of persons arrested, arraigned or under indictment. Joint Committee on the Judiciary. Todd Smola ?

17 H00523 By Mr. Martin J. Walsh of Boston, petition (accompanied by bill, House, No. 00523) of Jay Kaufman and others relative to national criminal offender record information checks for persons working with individuals served by the Department of Mental Retardation. Joint Committee on the Judiciary. Martin Walsh Yes

18 H00524 By Mr. Martin J. Walsh of Boston, petition (accompanied by bill, House, No. 00524) of Martin J. Walsh relative to increasinh access to information regarding drug overdose deaths. Joint Committee on the Judiciary. Martin Walsh Yes

19 H01331 By Ms. Kay Khan of Newton, petition (accompanied by bill, House, No. 01331) of Timothy J. Toomey and others relative to providing certain information for victims of domestic violence. Joint Committee on the Judiciary. Kay Khan

20 H01336 By Mr. Jason M. Lewis of Winchester, petition (accompanied by bill, House, No. 01336) of Alice K. Wolf and others for legislation to regulate the collection and maintenance of criminal intelligence information. Joint Committee on the Judiciary. Jason Lewis NO

21 H01339 By Mr. David Paul Linsky of Natick, petition (accompanied by bill, House, No. 01339) of Denise Andrews and David Paul Linsky for legislation to require criminal offender record information for persons volunteering at organizations conducting activities and programs for children.. Joint Committee on the Judiciary. David Linsky Yes already

22 H01347 By Mr. Michael J. Moran of Boston, petition (accompanied by bill, House, No. 01347) of Michael J. Moran relative to authorizing the recording of conversations during certain investigations. Joint Committee on the Judiciary. Michael Moran Yes

23 H01353 By Mr. James J. O'Day of West Boylston, petition (accompanied by bill, House, No. 01353) of James J. O'Day to establish a HIV testing procedure in correctional institutions and providing for sentence reductions for inmates participating in the testing. Joint Committee on the Judiciary. James O'Day stupid NO

24 H01374 By Mr. Benjamin Swan of Springfield, petition (accompanied by bill, House, No. 01374) of Linda Dorcena Forry and others relative to requiring the video or digital recording of statements made by all parties participating in the booking process of persons arrested by state police officers. Joint Committee on the Judiciary. Benjamin Swan NO

25 H02165 By Mr. Fernandes of Milford, a petition (accompanied by bill, House, No. 2165) of Lewis and others relative to providing access to scientific and forensic analysis Joint Committee on the Judiciary. John Fernandes Yes

26 H02207 By Mr. Jones of North Reading, a petition (accompanied by bill, House, No. 2207) of Tarr and others relative to identity fraud in the Commonwealth Joint Committee on the Judiciary. Yes

Bradley Jones

27 H02231 By Mr. Kafka of Stoughton (by request), a petition (accompanied by bill, House, No. 2231) of Kafka relative to wiretapping Joint Committee on the Judiciary. Louis Kafka

28 H02239 By Mr. Lombardo of Billerica, a petition (accompanied by bill, House, No. 2239) of Lyons and Lombardo for legislation to repeal the law establishing certain restrictions on persons within eighteen feet of a reproductive health care facility Joint Committee on the Judiciary. Marc Lombardo

29 H02252 By Ms. Peisch of Wellesley, a petition (accompanied by bill, House, No. 2252) of Walsh and others relative to ensuring confidentiality for victims of rape and domestic violence Joint Committee on the Judiciary. Alice Peisch

30 H02278 By Mr. Walsh of Lynn, a petition (accompanied by bill, House, No. 2278) of Walsh relative to a penalty for the unauthorized transmission to, or interference with, a public or commercial radio station Joint Committee on the Judiciary. Steven Walsh

31 H02282 By Mr. Winslow of Norfolk, a petition (accompanied by bill, House, No. 2282) of Winslow for legislation to exempt the recording of emergency 911 telephone calls, so-called, from laws governing the interception of wire and oral communications Joint Committee on the Judiciary. Daniel Winslow

32 H02847 By Mr. O'Flaherty of Chelsea, a petition (accompanied by bill, House, No. 2847) of Provost and others relative to further defining the dissemination of obscene material Joint Committee on the Judiciary. Eugene O'Flaherty

33 H02853 By Mr. Rushing of Boston, a petition (accompanied by bill, House, No. 2853) of Andrews and others for legislation to improve the collection and analysis of data relative to traffic stops Joint Committee on the Judiciary. Byron Rushing

34 H03143 By Mr. Binienda of Worcester, a petition (accompanied by bill, House, No. 3143) of Fresolo and Binienda for legislation to authorize the use of video-conferencing in certain court proceedings involving children and families Joint Committee on the Judiciary. John Binienda

35 H03148 By Mr. Fresolo of Worcester, a petition (accompanied by bill, House, No. 3148) of Fresolo for legislation to regulate the collection of data by police officers issuing citations for violations by operators of motor vehicles Joint Committee on the Judiciary. John Fresolo

all video records should be public records

Testimony in Opposition to HB 502

Sabrina Piedad D'Souza
64 Allston Street #4 | Boston, MA 02135 | 617-319-2690

Good Afternoon ladies and gentlemen my name is Sabrina D'Souza and I live in Allston Massachusetts. I recently graduated from Boston University Academy as Valedictorian and will be attending Wellesley College in the Fall. I am here today to testify about how the "Bathroom Bill" would negatively affect not only myself, but thousands of women in my state.

To be blunt, blurring the gender distinctions would put females in danger, physically, emotionally, spiritually, and morally.

As a young woman, I like to go out and have fun at Park Street and Faneuil Hall, I also love working out in the gym. However if this bill were to pass, I wouldn't feel safe in public bathrooms. Men are biologically different from women. They have different anatomy, strength, and mentalities. I know that most males do not understand the concept of sanitary pads. It would be scarring walking into a bathroom seeing a man using a man use a urinal when I had to take care of something so private and personal.

Something that is also private is taking a shower. Image me, a very petite woman, walking alone into locker room filled with males bathing. I would have to involuntarily expose my body and compromise my safety to strangers.

Most importantly, this bill could even jeopardize my right to the education I choose. I have enrolled in Wellesley College this fall because I want to develop my leadership skills in a community of diverse women.

While on campus I was thrilled to see Muslim women freely participating in many activities such as dancing, sports, and other extra cirriculars. If this bill were passed, how could Wellesley College remain an all female institution? How could it protect religious liberty of these women?

Some people argue that the "Bathroom Bill" is in accordance with the First Amendment—giving rights to transgender individuals. But, really it violates the First Amendment, and are we willing to violate our own constitution?

Does Massachusetts, a pioneer of freedom want to:

- Take away a woman's right to exercise the standards of her religion?

- Take away a woman's right to free speech? Her right to say: "NO. I want to use a bathroom without men!"

Ladies and Gentlemen, today I am here exercising my right to freedom of assembly and petition; and I request that the legislature does not support the Bathroom Bill under the grounds that men are men and women are women. There is no in between.

Massachusetts Family Institute℠

Dedicated to Strengthening the Family

TESTIMONY IN OPPOTITION TO H502/S764

Joint Committee of Judiciary
June 8, 2011

Harassment on the basis of sexual orientation is illegal and should be enforced. Harassment can take many forms and can be committed by anyone, including students, teachers, staff and visitors. Schools have a duty to protect students from harassment by establishing and enforcing anti-harassment policies, educating students and staff in the prevention of harassment, modeling appropriate behavior, monitoring student conduct, and responding quickly to harassment when it occurs.

With respect to bathrooms, locker rooms and showers in our public schools, the Bill proposes that a transgender student be allowed access to all those facilities that correspond to the student's gender identity or expression. Schools should have to accommodate the needs of transgender students but not while risking the legitimate privacy concerns of the great majority of students.

Across the state schools are not ready to manage the practical fallout of HB 502. It does not take into account the realities that face educators and school districts around the state.

One can understand the need to stop discrimination. However this Bill threatens the health and well-being of the students and staff in every school district. The ramifications have not been given adequate thought and study.

Thought must be give to proposed guidance for sexual orientation in public schools and colleges, including access to bathroom, locker rooms and showers, participation on sports teams and student attire. Specifically:

* Input from School Committee Association, Superintendents Association, Interscholastic Athletic Association, etc.
* Concern over safety, modesty and privacy are not addressed or considered.
* Addressing needs of a very few at the expense of the great majority of students is not good policy.
* The Bill presents immediate equal access problems.
* The Bill will immediately impact high school athletes regarding privacy rights.
* In its current state, the Bill has great potential for unintended consequences.
    * Financial and social implications
    * Potential for chaos, especially at the high school level
    * Potential for excessive litigation (discrimination, privacy rights, etc.)

For the above reasons, HB 502 should be sent back for further study.

Respectfully submitted,

M Vacca

Maureen Vacca
Director of Public Policy

100 Sylvan Road, Suite 625 | Woburn, MA 01801-1800 | 781.569.0400 | www.mafamily.org

Testimony of Jeffrey S. Wall, 3 Snowcrest Run, North Reading relating to the proposed "Transgender Bill".

I have invested the past 16 years of my life immersed in the field of education. I am first and foremost a science teacher but have served as a coach for multiple sports during this time period. I fully support the mission statement that governs my high school:

North Reading High School is a community of learners challenged by a rigorous curriculum that fosters both critical and creative thinking. Provided with a safe learning environment, students will demonstrate higher order reasoning skills, service to the school and community, and tolerance toward all individuals. Each student will leave North Reading High School with the tools necessary for a life-long commitment to citizenship, service, and learning.

The North Reading School committee openly supports Title IX and Chapter 622.

The ideals within the mission statement that North Reading High School stands by encompass academic, civic, and social expectations. The North Reading School District does not discriminate in employment, educational programs, and activities based on the basis of race, color, sex, religion, national origin or sexual orientation. Every member on staff holds these ideals to be of great importance and sets forth each year to uphold the integrity of the mission statement. Each year teachers are faced with the task of creating dynamic lessons designed to target learning strands set forth by the Massachusetts Frameworks. Teachers are responsible for meeting the needs of each student in order for him/her to develop their academic, social, cultural, and physical potential. The emergence of multiple intelligences has caused educators to step back and re-evaluate their practices. Each child is now foreseen as having their own style of learning, their own aptitudes, and their own interests. Given the infinite number of ways that lessons can be delivered and the infinite numbers of ways students learn, teaching has become very complex. But educators venture into the field realizing this and embrace differences and encourage students to be themselves. Students are encouraged be break through the previously constructed "set of norms". The status quo is not stagnant but rather ever-changing. It was said many years ago that all men (and women) are created equal. But much like we have found in the classroom, individuals in society are diverse and unique as their own fingerprints. Treating individuals with an assembly line mentality is no longer acceptable. Robots can be designed to be identical with respect to all of their attributes, being devoid of feeling and made for a specific purpose. Legislation has been passed nation wide that embraces people's difference and fights for individual rights. When there is a disparity, masses of people join in to support the "under privileged", or group, people feel are being targeted. Being in education for many years, I am sympathetic to individuals that may be looked on as different or needing special services. I have counseled young people with differences and helped them not only embrace their short-comings but in many instances overcome them or use them as a source of strength to draw from. Uniqueness does not mean you are an outcast. Uniqueness is to be embraced.

Having made the point that all individuals are unique and have specific needs, I am concerned about some recent legislation that has been proposed in an attempt to service individuals that are transgendered. The individuals that are transgendered are unique and in some states are being accommodated for their uniqueness. In California, individual rights were re-examined and it was found that separate but equal is no longer constitutional. Unisex bathrooms are a requirement. It has been recently proposed that unisex bathrooms and unisex locker rooms will become commonplace to accommodate individuals who are transgendered. The effects of this decision will be far reaching and complicate an all ready complex institution. My opposition to this legislation stems from my experiences being a teacher, coach, and father of three girls. All three of these facets factor into my opposition of unisex locker rooms and bathrooms.

One of the duties that teachers are assigned to in my school is bathroom duty. One person sits outside the boy's and girl's lavatory and students are asked to sign in. The teacher assigned to the duty is responsible for making sure that the students sign in, use the facility, and return back to class in an efficient manner. Teachers complain frequently that it is difficult to appropriately supervise the opposite sexes bathroom because of their level of discomfort. Adding a unisex bathroom to the mix will cause much more discomfort to an all ready uncomfortable situation. Supervising the bathrooms adequately will require more staffing at this duty. Having unisex bathrooms will increase the risk of students being sexually harassed. It will also cause students to feel more anxious about using the facilities. There are males in the school that have commented to me when I tell them that they can go in and use the bathroom that they would rather wait until the other student(s) are out. Having a unisex bathroom would now put that young man at risk of being embarrassed by using the facility in front of a member of the opposite sex. To an adolescent, this can be very damaging.

Speaking on behalf of my opposition to unisex locker rooms, I'd like to draw from experiences centered around my 34 years of being involved with the game of football as a player and as a coach. My first few years of coaching were centered around helping athletes achieve their fullest potential on the field as well as in the classroom. The role of the coach has expanded over the years to include fostering the growth of the athletes. This growth includes mental, emotional, and sometimes physical maturity. The role of the coach is more then merely teaching the sport. Stress is placed on supervision in the classroom, locker room, on the field, and within the town. Incidents of hazing and sexual harassment among athletic teams are more wide spread and publicized then ever before. Adding the piece of transgendered locker rooms to the equation is much like opening Pandora's Box. I envision locker room security as being a nightmare. Locker rooms as it is can be a source of anxiety for some athletes anyway. I am not talking about hazing, but rather the emotional and psychological distress that it causes for under-developed individuals. The fragile psyche of the athlete that doesn't want to shower or change in front of the other male athletes will now be forced to undress in front of members of the opposite sex. The damage that this would cause to the adolescent ego would be unfathomable. The stress that this would put on an individual is unconscionable. I can't speak for the female athletes and their anxiety with changing in front of other teammates but I know that there is a body image problem that runs rampant through our society.

The pressures to look a certain way have led to many health issues with regards to bulimia and other eating disorders. If transgendered locker rooms are constructed the problem will continue to rise. It is also worth noting that my daughters will not partake in a sport if they are forced to change in a locker room that males have access to. Privacy is one thing that all people hold dear. No one likes to open himself or herself up to be a public display and when this privacy has been invaded psychological repercussions result.

Another concern of mine is technology. A concern that is on the rise is cyber-bullying. With all the supervision in the world it would not be possible to police every person every time they are in the locker room. Who is to say that someone wouldn't use a cell phone to take a picture of a member of the opposite sex and place that picture on-line or on facebook? Maintaining order in an all male locker room is difficult enough without adding members of the opposite sex to the equation. The burden from a coaching standpoint is evident.

Also, you run the risk of increased harassment. The harassment is more then just male athlete to female athlete, or vice versa. I am talking about male supervision in a locker room that has girls changing in it. I don't know a male teacher or coach that feels comfortable even commenting on a female student's clothing when it borders on breaking the dress code. I am not comfortable with this and usually seek a female teacher to address the problem. The fear of being accused of 'checking a student out' far outweighs the breaking of a school dress code policy. If these young ladies were changing in the locker room they would be fully exposed. This is an uncomfortable situation for me and I would assume it is an uncomfortable situation for them. I would not want my daughters to be naked in front of a male coach, male teacher, or another male athlete within the school building.

In today's society we are trying to help adolescence with their emotional and psychological development. Adolescents deal with inadequacies all the time whether it is academic, social, or physical. Part of being an educator is to help student-athletes overcome these feelings. However, this does not mean that they should be comfortable enough to take their clothes off and undress in front of random males that they have as classmates. We have a responsibility to protect their rights and privacy. Having girls undress in a male locker room is much like institutionalizing strip clubs within the confines of an educational facility. Morals and ethics will be called into question. Placing males and females in the same locker room setting increases the problem exponentially. Questions regarding locker room supervision, which includes supervision in the shower, need to be addressed. Ask any father or mother if they want their daughters undressing in a locker room filled with male classmates and teachers and they would agree that this is unacceptable. Our bodies are sacred and being forces to share them with everyone is a violation of one's privacy and devalues ones self. Are we going to provide a special place for athletes to change that don't want to be exposed to members of the opposite sex? Or are we going to compromise their rights to privacy and strip them of their dignity?

I want to make clear that the crippling effects of transgendered locker rooms will not be reserved to females only. The damage to the male adolescents psyche will be equally devastating. This is because it is more likely to go unnoticed and not brought to anyone's attention. It is much like the belief that males should not show emotion and shouldn't cry. They need to be tough and able to deal with any situation that arises. Males that have been raised with this mentality suffer a great deal of emotional and mental turmoil. Males would suffer long lasting effects from having females in the locker room. It would extend beyond ribbing from a teammate and be more of an issue of harassment. The idea of having males and females together in a setting where either parties or one of the parties is exposed is perverse. It goes above and beyond the confused nature of one individual and affects the entire school community.

I have concerns when it comes to use of unisex bathroom facilities. My daughter has Crone's Disease and the thought of her entering a bathroom facility that contains male students during an episode of stomach distress is mortifying for me as well as for her. Another instance that I find distressing is a female student utilizing the facility during her menstruation cycle. It is a natural occurrence but it does not have to be forcibly shared with a member of the opposite sex who may not be mature enough to respect the young lady.

I believe in fighting for equal rights for all members of society but transgendered facilities would increase the complexity of learning institutions. Supervising such facilities in an adequate way would be close to impossible. There would be an increase in harassment and sexual misconduct. I know that we have an obligation to those individuals that believe they are transgendered but we are doing a disservice to the others that are affected negatively. My opposition to the legislation that would allow for, and mandate, unisex locker rooms stems from my position as being a teacher, coach, and father. All facets of my life would be affected negatively by this legislation. I encourage you to do what is right for the good of the majority of people involved. The ripple effect from casting a small stone into the calm water would be widespread and damaging to the youths that are trying to learn in a safe environment free of the added pressure and increase awareness of perversion. I know that individuality and diversity has led the charge for causes and effects of civilization to progress so that we may all benefit from living in such an accepting society where everyone has the right to express their uniqueness, however, this does not mean we should or can cater to the differences of a small group of individuals. In doing so, we cripple the moral and ethical well being of the masses. I strongly urge you to do what is best for the educational systems nation-wide, do not allow for the construction of unisex locker rooms in educational facilities.

Sincerely,

Mr. Jeffrey Wall
North Reading High School

Testimony of Clifford W. Bowers, 22 Pomeroy Road, North Reading relating to the so-called "Transgender Bill".

I am a husband, the father of three, the grandfather of three and a member of the North Reading School Committee. This testimony is based on my personal wisdom as gained from observations while raising my children, watching my grandchildren and traveling extensively worldwide as a consulting engineer.

Recently I read that the University of Chicago planned to begin the use of co-ed dormitories – not co-ed by floor or door but by bed. My reaction was instant and conclusive – ridiculous – a monumental impediment to the mission of higher education. Now I find that the Massachusetts legislature is considering a bill that is equally as absurd and potentially detrimental to education.

Historically bathrooms, showers and locker rooms have been designated as male or female based on anatomy. There is a reason for this. It is to help provide for the security, safety and privacy of the users while they are most vulnerable. Mixing anatomy in public restrooms is a prescription for trouble, maleness or femaleness notwithstanding.

Never mind that the bill would enable pedophiles, degenerates and rapists in stalking their quarry in public bathrooms across the state, the chaos it would create in the public schools would be catastrophic. Children, and teens in particular, face a wide range of development issues as they progress into puberty and adolescence. This stage of their lives is already unsettled and confusing. They need privacy. Many will advance ahead of their peers. The physical development and mental development of adolescents are not synchronized. The opportunity for mischief will not be inhibited or deterred.

By allowing random entrance of either a male or female into the domain of the other sex creates a threatening environment as well as an opportunity for claims of sexual harassment. The laws regarding sexual harassment are onerous and the burden of proof is low. Litigation resulting from passage will most likely be extensive. The implications in a school setting are numerous but the time spent by staff and administration will surely result in educational loss.

Consider a female just entering puberty or that happens to have a medical problem like Inflammatory Bowel Disease (Ulcerated Colitis, Crones, etc.) that requires urgent trips to the bathroom accompanied by cramps and exacerbated by stress, needing privacy and finding a male peer being female that day in that bathroom. Who is being protected? Who is the more vulnerable?

Consider a High School female locker room shower with a male wandering in because he feels that being a female today would be a hoot. Who supervises this activity, a teacher or coach? What happens to their career if something goes wrong or if they are accused of misdeeds? What is the benefit gained by allowing the intrusion? Keep in mind that there is no anatomical change possible at this age.

Consider the mischief an adolescent could create with a cell phone camera in an opposite sex locker room and email, Myspace or Facebook. Surely there are laws prohibiting this type of activity but the burden of actions to enforce those laws will seriously degrade the ability to educate.

It is every bit as important for laws to protect the majority as to protect the minority. Laws like elections have consequences. Making a law that distorts anatomical differences is folly and the electorate will see to it that the reversal in policy will occur in one election cycle.

30 Woodland Street
Southbridge, MA 01550
June 6, 2011

Senator Cynthia S. Creem
Representative Eugene L. O'Flaherty
Joint Committee on the Judiciary
State House
Boston, MA 02133

Dear Senator Creem and Representative O'Flaherty,

I and countless multitudes of other concerned Massachusetts citizens are praying for and watching closely the leadership and actions of the Joint Committee on the Judiciary in the matter of HB 502.

In the culture war that seeks to destroy the traditional family and moral values of Western civilization, it is unimaginable to me that any intelligent person would be in favor of such an outrageous and dishonorable bill that would legally mandate the use of public bathrooms by whatever gender wants to use them. The use of bathrooms by both sexes is an affront to common sense and will increase the crimes of sexual assaults in our state.

I think of vast number of people who have suffered assault, child abuse and rape in public facilities. Our highest priority must be the mental, emotional and physical well-being of our children. As a Father of twin girls, I plead with you, there is absolutely no justification for the passing of HB 502!

Children have ready access to explicit sexual material that cannot even be found in so-called adult bookstores. This is just another spiral downward in the destruction of our children and the Republic's moral values.

To allow BH 502 become law would be an unprecedented accomplishment for those who already seek to exploit our children. This is not a case of "civil liberties" it is absolute nonsense, and ridicules any ethics of decency.

Like millions of Americans, I stand behind the foundational belief of our Judeo-Christian heritage that has been our nation's motto, "In God We Trust" not in the destruction of decency, self-respect and traditional moral values.

Sincerely,

Rev. Esteban Carrasco Jr.

June 7, 2011

Massachusetts Judiciary Committee

Dear Sirs/Madams:

I am writing to oppose the Bathroom Bill (HB 502) (SB 764). It is a shame that with all the sensible issues that need to be addressed in our state during these times, we are spending energy and resources on such a piece of legislation. Have we completely lost our common sense?

I am not a psychologist, but believe God created each one us with our own obvious gender. Those that do not want to accept it need counseling and true love. That doesn't mean agreeing with them. There probably are deep-rooted difficulties in their past that are unresolved.

We expect our legislators to have some wisdom and understanding, and know the proper time and way to 'just say no'. The common good must be served. All bills labeled as progressive does not necessarily mean progress.

I urge you to defeat HB 502/SB 764.

Thank you.

Sincerely,

William J. Grant

492-494 East Broadway

Unit 1

South Boston, MA 02127-4417

June 7, 2011

To: Mass. Judiciary Committee members
Re: HB502 & SB764

Dear Sirs/Madames;

I am opposed to gender neutral public bathrooms and locker rooms. Currently we have family rooms, and gender indicated rooms. For the gender confused, if you are interested in establishing more family rooms, which can be privately used, fine. Otherwise, we go one more step in eroding modesty. I am founder of Veil Of Innocence, and I see the harm which immodesty does to our youth.

Sincerely,
Alice Grayson
17 Frazar Rd.
West Falmouth, MA 02574

To Whom It May Concern:

I am submitting this testimony as a concerned parent. There are four main reasons why I adamantly oppose this bill. First and foremost is concerning the safety of women and girls in what should be the most private of rooms – the bathroom. There is no protection against men and boys that simply want to enter women's bathrooms, whether they have this gender identity disorder or not. Since you cannot 'test' for proof of them having this disorder, you would be opening up women's bathrooms for any man or boy or molester who wanted to go in. This puts all women and girls in a very dangerous position, and certainly does not allow women to feel safe when needing to use public or private facilities.

Secondly, there was a lot of testimony given last year by parents of children who were bullied in school as a result of their gender identity confusion. I have six children, ranging in age from 29 down to 6 years old, and my oldest was also bullied in high school; not because of gender confusion, but because another boy took a disliking to him. After speaking to a policeman, we found that we had eleven different counts that we could have the boy charged with. We confronted the bully, and told him if he got within 50 feet of our son, we would have him arrested and charged with assault and battery. We had no further problems, but still removed our son from that school at the end of that semester. We did not ask for any special laws to be passed. Children are bullied for all kinds of reasons. Every type of assault, no matter the reason, is covered under current law, and kids who physically hurt other kids can be arrested under the current laws. There is no need for additional legislation for extra protection for one type of bullying.

Thirdly, the American Psychiatric Association classifies gender identity confusion as a psychiatric disorder. While some with this disorder are attempting to address it by making physical changes, such as surgeries, or dressing as the opposite gender, it still remains a mental issue, and no matter what physical changes are made, it does not change the fact that they are a male or female with a mental disorder. They should be encouraged to get professional help, but we should not consider legislation to accommodate a mental disorder. We would consider it ridiculous to pass a law requiring all public buildings with green tiles to tear out those tiles and replace them with another color simply because a small minority of the population had a mental disorder or phobia about green tile. This bill does the same thing, a small minority of the population has gender identity disorder, and those few want to put the majority of women and children at risk because of a mental health issue.

Fourthly, this bill will result in many fathers and mothers, with no previous encounters with the law, to be arrested and charged with crimes that will have mandatory punishments. The very natural instinct to protect your children will not disappear with the passage of this bill. When parents send their daughters into a women's bathroom, and they are followed in by a man or a boy, there is going to be trouble! Parents will not stand by and allow this dangerous scenario to take place without taking action. If you force this bill on the people of Massachusetts, you are going to have parents taking matters into their own hands, as we will not be able to trust the laws of our state to keep us safe. This bill would be a travesty to honest, hard working people trying to keep their daughters and wives safe.

I urge you to defeat this bill, and keep our daughters and women safe.

Respectfully,

Karen Hackett.
31 Hilltop Drive
Douglas, MA 01516

90 Ridgewood Lane #24
Gardner, MA 01440
June 6, 2011

Representative Eugene L. O'Flaherty
Joint Committee on the Judiciary
State House Room 136
Boston, MA 02133

Dear Representative O'Flaherty,

I and countless multitudes of other concerned Massachusetts citizens are praying for and watching closely the leadership and actions of the Joint Committee on the Judiciary in the matter of HB 502.

In the culture war that seeks to destroy the traditional family and moral values of Western civilization, it is unimaginable to me that any intelligent person would be in favor of such an outrageous and notorious bill that would legally mandate the use of public facilities by whatever gender wants to use them. The use of bathrooms by both sexes is an affront to common sense. From a mental health and psychological point of view, it is also a boundary issue.

The explosion of cyber porn on the internet and on-line services is a disgrace. Children have ready access to explicit sexual material that cannot even be found in so-called adult bookstores. This is just another spiral downward in the destruction of our children and the Republic's moral values.

I think of vast number of people who have suffered assault, child abuse and rape in public facilities. Our highest priority must be the mental, emotional and physical well-being of our children. There is absolutely no justification for the passing of HB 502!

To allow BH 502 become law would be an unprecedented coup for those who already seek to exploit our children. This is not a case of "civil liberties" it is absolute nonsense, and ridicules any ethics of decency.

Like millions of Americans, I stand behind the foundational belief of our Judeo-Christian heritage that has been our nation's motto, "In God We Trust" not in the destruction of decency, self-respect and traditional moral values.

Sincerely,

R. Gary Heikkila, Ph.D.
Board Certified Psychotherapist and Counselor
American Psychotherapy Association
American Board for Certification in Homeland Security
International Board of Christian Counselors
Certified Master Chaplain, CMC

June 8th, 2011

Respected Representatives of the Commonwealth;

Upon full review of the information available to me with respect to the "Bathroom Bill", I must implore you to reconsider any favor for the passing of this legislation. My opposition is not against the persons of whom this bill was intended to support. It is in opposition of the reality that this kind of law would provide sexual predators with, in essence, a full license to prey on victims in their most vulnerable state, half undressed in the bathroom.

As a widowed mother of a 4 year old little girl, my heart races when I think of having to bring her into the bathroom to find a man in the room with us who may or may not be there for a valid purpose. In the event that he isn't, the realization would be too late.

I am aware that there promises to be prosecution against said individuals who would use this law for grievous purposes, however there has to be a victim to prosecute! How can I stand by and not voice my concern that this bill would suppose that I trade a person who chooses to express their sexual identity, in what ever way they do, with the five minutes of comfort they would have in using a bathroom that they would feel more comfortable in for a lifetime of post sexual trauma for myself or my preschooler?

The very idea that the Commonwealth would consider putting the public at risk simply for the comfort of a population of less than 1% is ludicrous. My concern is also for the person who, while anatomically female, chooses to use the men's room and opens herself up to physical assault or sexual assault. I consider the consequences that such a person could face for choosing to use a bathroom intended to be used by anatomically male patrons. The safety of the persons of whom this bill is intended to serve needs to be weighed as well.

It is my heart that you will give full ear to the mothers, sisters, grandmothers, children, nieces, aunts and friends you all know and love and vote "NO" on putting them in harms way for sexual predators.

My Best Regards,

Ms. Brittany Elizabeth Hudson
172 Haverhill Street
North Reading, MA. 01864

TESTIMONY IN OPPOSITION TO HB 502 (Bathroom Bill)

My name is Linda Stanley; I reside in Peabody, Massachusetts. I am STRONGLY in opposition to the bathroom bill HB502 for various reasons. What about my rights to privacy in a public bathroom when I'm adjusting/fixing my underclothing, which many women do outside of a bathroom stall? What about the hundreds or thousands of stall doors which do NOT lock or STAY shut in public bathrooms—I don't want a MAN looking at me, my two daughters, my mother, or my 17 nieces with our pants down sitting on a toilet as he TRIES to come into our stalls. You are ASKING for women to get raped or molested while they are in vulnerable positions with their pants down or skirts lifted up sitting on a toilet where a door may be easily opened. LIVES are ruined after someone is raped or molested. Just KNOWING a man could walk into a pubic bathroom is reason enough to not feel safe. Parents would NOT be able to "just send their daughters into a public bathroom alone" EVER again and feel safe about it if this legislation passes. If this bill passes, pedophiles can say "I feel like a woman today" and go into a public women's bathroom and find children to molest who are in compromised positions sitting on toilets. I would NOT go to a restaurant that allowed men into a women's bathroom. This politically correct stuff must stop. God made men and God made women. If someone is not happy with their sex, they should see a psychiatrist and not get a bathroom of the opposite sex. No matter WHAT someone thinks in his head, IF HE HAS A PENIS OR HAD A PENIS, HE IS A MAN AND BELONGS IN THE MEN'S BATHROOM---END OF STORY.

WHERE ARE OUR RIGHTS AS WOMEN TO NOT HAVE A MAN IN A PUBLIC BATHROOM WITH US?

Respectfully submitted

Linda Stanley
17 Cleveland Rd.
Peabody, MA 01960

P.O. Box 87
Assonet, MA. 02702
June, 2011

Attn: Judiciary Committee

My name is Jane Wilcox and I am a wife, mother, grandmother and retired elementary school teacher.

I have to object, strenuously, to HB 502, otherwise known as "The Bathroom Bill". This bill, if passed, will cause tremendous emotional strain on people as grandparents see their grandchildren going to the ladies room and seeing a man dressed up like a woman be allowed to enter also. The fear of molestation is great and a man who may "feel" like a woman may also feel like hurting a child or a woman. It is well known in medical circles that transsexual behavior is an illness. I can't understand why anyone would want to enable these people to believe that they can change their sex. I am a white woman and will die a white woman no matter what I may like to think I can be. If I blacken my face I can not claim that I am an African American no matter how much I may "feel" like it. You are who you are, period. I have to wonder about people who try to enable paranoid behavior. If they go out of their way to help someone live a lie what does that make them? Even my young granddaughter knows, instinctly, the difference between male and female and can tell just by looking. One day she asked me why "that man has ladies clothes on"? To teach children that this life style is normal is abhorrent. Let's stick to medical facts and teach children the truth.

I ask those of you on the Judiciary Committee to stop bill HB 502. All of you know the difference and the truth. Now, act upon your common sense and let's get assistance for those who suffer from this illness.

Sincerely,

Jane Wilcox

Mrs. Jane Wilcox

Good afternoon. Thank you so much for the opportunity to speak with you today about an issue that is most important, the Bathroom Bill. Before I begin let me introduce myself. I am a mother, grandmother, retired special education teacher and elected school committee member. My primary concern in all these roles has been the safety of children first.

I believe the safety of children will be in jeopardy should this bill pass, primarily because predators routinely stalk children in restrooms. This bill would make it easier for predators gain access to children and difficult for parents, teachers, and schools to insure child safety.

The sanctuary and privacy of the bathroom is under assault. The common good of the people and the people's children impaired.

The bathroom is a vulnerable place. Defenseless children and those with disabilities could find themselves in situations, without the protection. The isolation and privacy afforded in a bathroom only increases the opportunity for predators to take advantage of the defenseless.

Both innocent men and women could be placed in situations where false accusations could be made with no witnesses to refute changes.

For the sake of the common good and common sense I strongly that this bill be tabled and

Andrea St. Germain

June 8, 2011

My name is Deborah Furtado and I am a retired elementary school teacher of thirty-six years from the city of New Bedford.

Let's talk about the Transgender Bill HB 502.
First it is common knowledge that this bill has failed to pass for six years because legislators are acutely aware that citizens across the state have serious concerns about their safety, privacy, level of personal comfort, and modesty if men are allowed into women's bathrooms and locker rooms.

It is my opinion that it is the responsibility of legislators to promote the common good. This bill would detrimentally change the standards of bathroom usage for 99.95% of the general population. Four decades of research by the Amsterdam Gender Dysphoria Clinic maintains that five/one hundredth of 1% of the general population is afflicted with gender identity mental disorder.

It saddens me to the depths of my soul and conscience about the detrimental and far reaching consequences of HB 502 on our very young elementary and pre school students. Studying this bill, talking with other educators, conversing with friends, speaking to various legislators, and applying common sense logic to what is suggested through HB 502 (The Bathroom Bill) convinces me without a doubt that the individual rights to complete privacy of our young children in school bathrooms would be trampled should this bill be passed. This bill presents a moral outrage and injustice to our children instead of insuring that their basic rights to complete comfort and privacy are upheld while at school.

I maintain that young children (both boys and girls) have the right to use bathroom facilities, and locker rooms in complete comfort and privacy in our public schools. It is understandable that many would not feel relaxed, happy and comfortable sharing bathrooms with transgender individuals and I personally believe they shouldn't be required to do so in our public schools.

Furthermore, studying the ramifications of this bill, offering basic commonsense ideals, complete understanding, and personal human empathy to all our students, and I reiterate ALL our students, I am extremely concerned about the negative and dangerous impact of this bill

on young children. Please let me tell you why I feel this way. It would be extremely unsettling, and confusing for small children to see individuals of the opposite sex using the restrooms while they are in the restroom.

I know from teaching young children for so many years that they are so innocent. Seeing an adult or older child dressed very differently, especially in and around the school, would be extremely frightening to many young children, not to mention the comfort level of other adults using public restrooms.

My thoughtful question is how would classroom teachers be expected to respond to or comfort children returning to class who are upset, nervous, curious, agitated, confused or unsettled about what he/ she has seen there? What does the classroom teacher need to do to protect the emotional well being of all the students in the public school setting? You must keep in mind that our teachers are entrusted with the safety and well being of all the students under their care. It is evident that HB 502 does not take into account practicalities that face educators in Massachusetts.

Adequate safeguards for our students are not provided in this bill. Are we going to require school administrators to be on "potty patrol" so students can use the facilities in comfort and privacy while they are in the care of our cities and towns? Who will be liable when something goes terribly wrong?

Next, the passing of this bill would open our school boards up to a tremendous amount of litigation such as one in Orono, Maine in which a fifth grade boy had been using the girl's bathroom due to gender issues. School officials in an attempt to accommodate ALL students and protect the boy from harassment, created a completely separate bathroom for the boy. The boy's parents petitioned Maine's Human Rights Commission to demand access for him to the girls' room. The school lost the battle. It is common sense that this precedent in Maine would certainly impact litigation in Massachusetts about HB 502. Furthermore, I maintain that the civil rights of All our citizens must be maintained at all times.

Quite simply put, this bill is a recipe for disaster and student abuse, not to mention laying additional financial and human burdens on school staff. But most importantly, it will put the emotional and physical health of our youngest children at risk. Having spent most of my adult life as a teacher of children, I maintain that this bill is an outrage and an injustice to children.

In summation, the premise of creating a perfectly equal society is an excellent goal, but HB 502 would not provide the appropriate outcome. It's a disaster in the making for all ages of our population from young children to the elderly. Legislators are aware of this and must continue to vote it down. I propose that they do it again.

Deborah Furtado
28 Huntington Avenue
New Bedford, Ma. 02740

June 5, 2011

Testimony before the Honorable Judiciary Committee

My name is Joseph Martins. I am a former Massachusetts high school principal, vocational school district superintendent and currently serve as a School Committee member of Fall River Public Schools. I oppose House Bill-502, An Act Relative to Transgender Equal Rights, on the grounds of its applicability to public and private schools of any form.

I agree there is no room for discrimination against anyone and I agree the rights of everyone should be protected; that includes the rights of the majority of students to certain privacies.

It is difficult enough to control student behavior, prevent discrimination for all students, ensure the safety of all students without having to distinguish between truth an a lie of some student claiming rights under Section 24 of House Bill - 502, having a gender-related identity, appearance, expression, or behavior, simply to gain access to the opposite at birth sex locker rooms showers, or lavatory facilities. This all encompassing definition is frequently repeated throughout the Bill.

If single or several girls occupy a girls' shower room and an offending male student simply walks in, saying nothing, just to get an eye full, the school administration will be powerless to take disciplinary action against the boy because at the moment he entered the girls shower room he, to himself, expressed the desire to be a female. House Bill – 502 will legally allow just such a scenario to occur and nothing in the Bill protects the reasonable rights to privacy of the female students occupying the girl's shower room. This Bill will promote the dropping of soap just to get a close-up better view and the so-called unintentional body touching.

I do not think parents of the subjected girls would accept the principal or superintendent's response of, "The law allows the opposite sex student to use the same facility, at the same time, if at that point in time the offending student claims rights under Section 24 of having a gender-related identity, appearance, expression, or behavior", and he accidentally dropped the soap so the touch was unintentional thus not an assault.

If House Bill – 502 ultimately becomes law, lawsuit liability will surely be incurred by school districts caught between the rights of privacy and the rights of those whose body is not what their mind wants it to be.

The Fall River School Department is currently facing a multimillion dollar reduction in its FY-12 Budget. Changing all shower and lavatory facilities to lockable single stall toilet and shower combination with an attached changing room requires building modifications and is cost prohibitive --- unless of course the Legislators in their collective wisdom appropriates the funds for such a massive statewide schools project.

I urge the Honorable Judiciary Committee to permanently reject House Bill – 502, An Act Relative to Transgender Equal Rights

Get the Facts

- Terminology
- Quick Facts
- Sexual Orientation
- Gender Identity Disorder (GID)
- Homosexuality
- Change Therapy
- Health Risks

Get More Info

- References
- Resources
- To Print: FACTS
- To Print: CDC Statistics
- To Print: School Letter

Letter to School Officials

March 31, 2010

Dear School Superintendent,

The American College of Pediatricians shares with you, your staff, parents, and other professional organizations the common goal of providing a healthful environment for your students. We are increasingly concerned, however, that in many cases efforts to help students who exhibit same-sex attractions and/or gender confusion are based on incomplete or inaccurate information. To correct this and assist you in establishing the optimal school environment, a Web resource, **www.FactsAboutYouth.com** (Facts), has been created to provide important factual information about healthful approaches to students experiencing sexual orientation and gender identity confusion.

Among the important questions addressed on the Facts site are:

- What are the science-based facts about the development of non-heterosexual attractions and gender confusion in youth?
- What is a school's proper role in dealing with students who are experiencing sexual orientation and gender confusion issues?
- How can schools better assist a student and his or her family in dealing with these issues?

Adolescence is a time of upheaval and impermanence. Adolescents experience confusion about many things, including sexual orientation and gender identity, and they are particularly vulnerable to environmental influences.

Rigorous studies demonstrate that most adolescents who initially experience same-sex attraction, or are sexually confused, no longer experience such attractions by age 25. In one study, as many as 26% of 12-year-olds reported being uncertain of their sexual orientation[1], yet only 2-3% of adults actually identify themselves as homosexual.[2,3] Therefore, the majority of sexually-questioning youth ultimately adopt a heterosexual identity.

Even children with Gender Identity Disorder (when a child desires to be the opposite sex) will typically lose this desire by puberty, if the behavior is not reinforced.[4] Researchers, Zucker and Bradley, also maintain that when parents or others allow or encourage a child to behave and be treated as the opposite sex, the confusion is reinforced and the child is conditioned for a life of unnecessary pain and suffering. Even when motivated by noble intentions, schools can ironically play a detrimental role if they reinforce this disorder.

In dealing with adolescents experiencing same-sex attraction, it is essential to understand there is no scientific evidence that an individual is born "gay" or "transgender." Instead, the best available research points to multiple factors – primarily social and familial – that predispose children and adolescents to homosexual attraction and/or gender confusion. It is also critical to understand that these conditions can respond well to therapy.[5] Dr. Francis Collins, former Director of the Genome Project, has stated that while

School Updates

- Attention: School Superintendents
- Letter to School Officials
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homosexuality may be genetically influenced, it is "... not hardwired by DNA, and that whatever genes are involved represent predispositions, not predeterminations." He also states [that] "...the prominent role[s] of individual free will choices [has] a profound effect on us." [6]

The National Association for Research and Therapy of Homosexuality (NARTH) recently released a landmark survey and analysis of 125 years of scientific studies and clinical experience dealing with homosexuality. This report, *What Research Shows*, draws three major conclusions: (1) individuals with unwanted same sex attraction often can be successfully treated; (2) there is no undue risk to patients from embarking on such therapy and (3), as a group, homosexuals experience significantly higher levels of mental and physical health problems compared to heterosexuals.

Among adolescents who claim a "gay" identity, the health risks include higher rates of sexually transmitted infections, alcoholism, substance abuse, anxiety, depression and suicide. Encouragingly, the longer students delay self-labeling as "gay," the less likely they are to experience these health risks. In fact, for each year an adolescent delays, the risk of suicide alone decreases by 20%.[7]

In light of these facts, it is clear that when well-intentioned but misinformed school personnel encourage students to "come out as gay" and be "affirmed," [8] there is a serious risk of erroneously labeling students (who may merely be experiencing transient sexual confusion and/or engaging in sexual experimentation). Premature labeling may then lead some adolescents into harmful homosexual behaviors that they otherwise would not pursue.

Optimal health and respect for all students will only be achieved by first respecting the rights of students and parents to accurate information and to self-determination. It is the school's legitimate role to provide a safe environment for respectful self-expression for all students. It is not the school's role to diagnose and attempt to treat any student's medical condition, and certainly not a school's role to "affirm" a student's perceived personal sexual orientation.

It is critical to the health of your students that you and your staff rely on accurate information regarding sexual orientation and gender confusion issues. We urge you to review the enclosed information card, ***What You Should Know***, and distribute it and this letter to your staff and to all interested parents and students. For more information, please visit www.FactsAboutYouth.com or we invite you to inquire by email at info@FactsAboutYouth.com.

Sincerely,

Tom Benton, MD, FCP

President

American College of Pediatricians

What You Should Know fact card

CDC Statistics

For further information, please refer to a statement by the American College of Pediatricians **"On the Promotion of Homosexuality in the Schools."**

References for letter

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[4]Zucker K, Bradley S.*Gender Identity Disorder and Psychosexual Problems in Children and Adolescents,* The Guilford Press, New York, NY 10012, 1995 (p. 283).

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[8]Just the Facts Coalition.*Just the Facts about Sexual Orientation and Youth.* American Psychological Association. 2008. Retrieved from http://apa.org/pi/lgbt/resources/just-the-facts.aspx (accessed 3/3/10).

Pediatricians Warn Educators: 'Pro-Gay' Attitude toward Gender Confusion Damages Children

By Kathleen Gilbert

GAINESVILLE, Florida, April 7, 2010 (LifeSiteNews.com) - The American College of Pediatricians has cautioned educators about the management of students experiencing same-sex attraction or exhibiting symptoms of gender confusion, saying that a pro-homosexuality attitude could disrupt a natural uncertainty in youth for the worse.

"As pediatricians, our primary interest is in the health and well-being of children and youth," Dr. Den Trumbull, Vice President of the College explains. "We are increasingly concerned that in too many instances, misinformation or incorrect assumptions are guiding well-intentioned educators to adopt policies that are actually harmful to those youth dealing with sexual confusion."

These concerns are outlined in a letter and fact sheet sent by College president Thomas Benton, MD, to all 14,800 school district superintendents in the U.S.

Dr. Benton also alerts them to a new web resource, FactsAboutYouth.com, which was created by a coalition of health professionals to provide factual information to educators, parents, and students about sexual development.

The College reminded school superintendents that it is not uncommon for adolescents to experience transient confusion about their sexual orientation, and that most students will ultimately adopt a heterosexual orientation if not otherwise encouraged. For this reason, the doctors warned that schools should not seek to develop policy which "affirms" or encourages these non-heterosexual attractions among students who may merely be experimenting or experiencing temporary sexual confusion.

Such premature labeling, they said, can lead some adolescents to engage in homosexual behaviors that carry serious physical and mental health risks.

Because there is no scientific evidence that anyone is born gay or transgendered, the College noted, schools should not teach or imply to students that homosexual attraction is innate, always life-long and unchangeable. Research has shown that therapy to restore heterosexual attraction can be effective for many people.

Family Watch International, a pro-family advocacy group, backed the pediatricians' letter and urged parents to spread the crucial information.

"While the ACP can lay out the facts to educators, it is up to parents and other concerned individuals to now follow up with them," wrote FWI president Sharon Slater in an email to constituents. "We must make sure schools do not simply ignore the facts for such reasons of personal bias or political correctness."

Arthur Goldberg, a board certified counselor and expert on assisting individuals with unwanted same-sex attraction, told LifeSiteNews.com (LSN) that, "Unfortunately prior to the American College of Pediatricians' (ACOP) effort to develop the new web site http://www.factsaboutyouth.com/ and the factual material they sent to school district superintendents, hundreds of false and misleading books, pamphlets, films, and other materials were absorbed - with our taxpayer dollars - into America's public school systems."

Goldberg cited as one example a pamphlet distributed in 2008 by the National Education Association and the American Psychological Association entitled "Just the Facts," which he says was "issued for the distinct purpose of radically impacting how schools dealt with the sexual consciousness and behavior of school age children." The booklet discourages discussion of therapy to change same-sex attraction, and upholds homosexuality as a "normal expression of human sexuality."

Contrary to the booklet's claims that homosexuality is unchangeable, said Goldberg, "there is clear and convincing evidence that many factors can lead an adolescent into homosexual behavior - including curiosity, a feeling of not fitting in, the experience of earlier molestation, and a desire for attention or a sense of belonging. Teen years often serve as a transitional phase when affectional, emotional and identification needs can be too easily sexualized."

"Because the premature gay self-labeling that is encouraged by 'Just the Facts' and other such material presents major public health risks, ACOP, as a medical organization dedicating to best practices in child-rearing, has performed a major public service by making their material available to school administrators, students and their parents," he said.

For more information, including printable factsheets on the dangers of encouraging homosexuality in children, visit FactsAboutYouth.com.

What You Should Know About
Sexual Orientation of Youth

- Homosexuality is not a genetically-determined, unchangeable trait.

- Homosexual attraction is determined by a combination of familial, environmental, social and biological influences. Inheritance of predisposing personality traits may play a role for some. Consequently, homosexual attraction is changeable.

- Most students (over 85%) with same-sex attractions will ultimately adopt a heterosexual orientation if not otherwise encouraged. Most questioning students are experiencing temporary sexual confusion or are involved in experimentation.

- The homosexual lifestyle, especially for males, carries grave health risks.

- Declaring and validating a student's same-sex attraction during the adolescent years is premature and may be personally harmful.

- Sexual reorientation therapy has proven effective for those with unwanted homosexual attractions.

- For many youth, homosexual attraction develops due to negative or traumatic experiences, such as sexual abuse. These students need therapy for the trauma, not affirmation of a "gay identity."

- There is no evidence that pro-homosexual programs, such as on-campus student clubs, ease the health risks or emotional disorders suffered by homosexuals.

- Regardless of an individual's sexual *orientation*, sexual *activity* is a conscious choice.

- It is in the best interest of all students to refrain from any sexual activity until adulthood; most optimally until they enter a life-long faithful marriage.

- The school's responsibility is to provide a safe environment for respectful self-expression for all students. It is <u>not</u> the school's role to diagnose and attempt to treat any student's medical condition, and certainly not the school's role to "affirm" a student's perceived personal sexual orientation.

FACTS About Youth

For further explanation of these important points and for the supporting references visit **www.FactsAboutYouth.com**, a Web resource created by the American College of Pediatricians® in coalition with other organizations who share a concern for the well-being of all youth.