SciMedCentral

JSM Sexual Medicine

Mini Review

The Crisis of Dichotomous Model - Variants of Gender Identity

María Fernández Rodríguez[1,2]* and Marta Menéndez Granda[3]

[1]*Mental Health Center I "La Magdalena" University Hospital San Agustín de Avilés. Health Area III Asturias, Spain*

[2]*Gender Identity Treatment Unit of Principality of Asturias (UTIGPA), Spain*

[3]*Master of General Health Psychology, University of Oviedo, Spian*

***Corresponding author**

María Fernández Rodríguez, Centro de Salud Mental I "La Magdalena", Valdés Salas, 4, 33400 Avilés, Asturias, Spain, Email: maria.fernandezr@sespa.es

Submitted: 29 July 2020

Accepted: 30 July 2020

Published: 31 July 2020

ISSN: 2578-3718

The World Health Organization (WHO) notes that gender refers to *"the socially constructed characteristics of women and men, such as norms, roles and relationships of and between groups of women and men. What is expected from one gender to another varies from one culture to another and can be changed"* [1].

Each society or culture assigns to people, from the birth and according to their biological sex, gender stereotypes that perpetuate sexual and gender dimorphism in time. In this way, a binary society is formed (male and female), where the masculine counter the feminine and vice versa, excluding the visibility of the gender variants located between the two opposite poles.

There is a certain degree of consensus among professionals to use the term trans women to refer or self-refer when their biological sex is male and gender identity is femenine, and trans men when biological sex is female and gender identity is masculine. In a broader sense, trans people would be those individuals who don't feel identified within the masculine-feminine binary category [2]. On the other hand, *gender variability* is understood as that expression of the gender that differs from the social rules and expectations traditionally associated with it, from their sex assigned at birth or from their gender identity [3].

The term transgender refers to "*self-identification as man, woman, both or none, which does not correspond to the gender assigned to oneself*" [4]. It includes a wide range of gender identities of which transsexual people may be included. Just as being born male or female of the human race does not necessarily imply feeling male or female, neither should we assume that a person who doesn't identify with the gender of birth the only alternative option would be to feel of the opposite gender. Gender is not a binary construct [5].

Transgenderism (trans people) includes different variants of gender identity. The common denominator of these variants of gender identity, expressions or roles is the nonconformity between the gender assigned at birth and the identity and/or expression of gender that they feel as their own.

A person's gender identity is not something that remains static throughout his life nor is it limited exclusively to the masculine or feminine identity. It's so simplistic and reductionist to think that there are only two genders and that we can only be totally masculine or feminine like dividing people into transsexuals or cisgenders. The reality is very different. There is a broad range of possibilities, where the different gender variants that overcome the leading dichotomies in society, have a place and are manifested [6].

We are in a new era of recognition of identities that don't fit into the binary categories. Female women or male men and female transsexuals or male transsexuals don't exhaust all possibilities. Not identifying as a man or woman doesn't necessarily imply the feeling of the opposite gender. Gender variants break with pre-established dichotomies. The DSM-5 considers this possibility describing Gender Dysphoria, in the diagnostic criteria, as the incongruence between the gender assigned at birth and the one experienced, indicating that this latter one may be the opposite gender or some other alternative to its assigned gender [7].

The strongest manifestation of this crisis of the traditional dichotomous model has already been demonstrated in the seventh version of the Standards of Care (SOC), the last version of the World Association of Professionals for Transgender Health (WPATH) [8]. These SOC promote and develop standards of care based on overcoming the traditional dichotomous model where there aren't only two opposite genders [9].

The fifth and sixth versions of SOC [10,11] didn´t allow too much freedom to do the diagnosis of transsexualism and consequently difficulted the initiation of hormonal treatment and/or carry out the appropiate surgeries. These SOC, supported by the current International Diagnostic Classifications [12,13] established with "clairvoyance" the diagnostic criteria of transsexualism [13] or gender identity disorder [12] that together with elegibility and disposition criteria guided the professional with "certainty". The clinicial not only determined who the true transexual was but also who was suitable to receive medical treatments.

The seventh version of SOC takes into account a social reality,

which is becoming a greater presence in our society where not only transsexual people but also transgender and nonconforming with the gender, manifest the diversity of their identities, expressions and gender roles. While some people may be defined as cross-gender, others claim that their gender identity is unique and they don't consider themselves as masculine or feminine [14-17], defining themselves as transgender, bigender or intergender and confirming that their experience transcends a binary understanding of gender [18-20].

The greater public visibility and the increase in demands for care of these people with gender diversity, establish the need for a deep reflection and a new approach by the gender identity attention units. Since 2011, the SOC has expanded the treatment options for people with gender dysphoria and also establish that not only transsexualism people are recipients of treatment, but also those who transcend the cultural definitions of gender (transgender) and who present gender nonconformity provided that they present gender dysphoria. Transsexual, transgender and gender nonconformity may experience with gender dysphoria at some point in their lives and consequently become recipients of medical treatments.

Professionals should not guide towards a dichotomous vision of society, but should help people with gender dysphoria to explore the different treatment options that allow them to afirm and express their gender identity with satisfaction. The treatment must be individualized, not all people need the same treatment to relieve their gender dysphoria nor do all the people manifest their desire to make a gender confirmation through medical treatments (harmonization and surgeries). While some people only want to live in the gender role they feel, others consider hormonal and/or surgery treatments, the only option to achieve well-being with their gender identity.

Although some trans people can assume their gender identity independently of medical treatments, updating their identity or finding a role/gender expression that is satisfactory, most of them demand medical treatments (hormones and/or surgeries). A research carried out in Asturias showed that the 75% of minors directly demanded masculinizing or feminizing medical treatments [21].

More to this point, some may question the convenience or not of applying medical treatments to people who don't feel identified with the gender assigned at birth or with the opposite gender (but with another alternative gender), and demand medical treatments that by definition infer corporal characteristics of the opposite gender to the assigned. The simple fact of making this statement show us how trapped we are the professionals in the traditional dichotomous model from which the definition of transsexualism comes and that determines our clinical practice. The incongruence, which historically has been assigned to trans people, is not between the felt and assigned identity, but it is in a society that denies human diversity.

If in our society there wasn't a sexual and gender normative system so rigid and binary that allowed each person to live their identity freely and independently of the assigned gender, this discordance wouldn't exist and therefore, there would be no trans people. From this perspective, the gender dysphoria is produced by intolerance and social discrimination that exert great pressure on individuals to perpetuate gender and sexual dimorphism [22] and consequently, demand medical treatment as a priority. A research carried out in the UTIGPA in 2017 concluded that people with hormonal treatment and psychological support, scored higher in life satisfaction than people who only received psychological support [23]. Moreover, the term "comfort" should be highlighted because it is very common in the speeches of trans people and is a true reflection of how they feel before and after medical treatments.

In any case, it is important to recognize and accept that the final decisions about treatments are the responsibility of the users and in the case of the minors, also of their families or guardians [8]. The responsibility of the mental health professional is to advise, support and accompany the users during the process to favor the making of informed decisions, and the principle of self-determination of the people must prevail at all times, respecting the right to the free development of the personality and gender identity freely manifested [24]. All sensations and all desires have the right to exist with no other limits than respect for the rights of other people [25].

REFERENCES

1. World Health Organization. 2015.
2. Human rights, Sexual orientation and Gender Identity, AG/RES. 2653. Inter-American Commission on Human Rights: IACHR. 2011.
3. WPATH Board of Directors. De-psychopathologisation statement. 2010.
4. International Observatory of Human Rights. 2017.
5. American Psychological Association- APA. Guidelines for Psychological Practice with transgender and gender nonconforming people. 2015.
6. FAQ on Health and Sexual Diversity: An Introduction to Key Concepts. Geneva: World Health Organization. 2016.
7. American Psychiatric Association-AP. Diagnostic and statistical manual of mental disorders, 5ª ed- DSM-5. Arlington: American Psychiatric Publishing. 2013.
8. The World Professional Association for Transgender Health-WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7ª version. 2011.
9. Fernández Rodríguez M, Guerra Mora P y GarcíaVega E. The 7th version of Care Standars of WPATH. A different approach that goes beyond sexual dimorphism and gender. Rev Asoc Esp Neurop. 2014; 234: 317-335.
10. The World Professional Association for Transgender Health-WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 5ª version. 1998.
11. The World Professional Association for Transgender Health-WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 6ª version. 2001.
12. American Psychiatric Association-APA. Diagnostic and Statistical Manual of Mental Disorders. 4ª ed. rev. DSM-IV-TR. Washington, DC: APA. Barcelona: Masson. 2002.
13. World Health Association-WHO. International Classification of Diseases 10ª ed. ICD-10. Ginebra: WHO. 1992.
14. Bornstein K. Gender outlaw: On men, women, and the rest of us New York, NY: Routledge. 1994.

15. Kimberly S. I am transsexual - hear me roar. Minnesota Law & Politics. 1997; 21-49.

16. Stone S. The empire strikes back: A posttransexual manifesto. In J Epstein, K Straub (Edn), Body guards: The cultural politics of gender ambiguity. London: Routledge. 280-304; 1991.

17. Warren BE. Transsexuality, identity and empowerment. A view from the frontlines. SIECUS Report, February/March. 1993; 14-16.

18. Bockting WO. Psychotherapy and the real-life experience: From gender dichotomy to gender diversity. Sexologies. 2008; 17: 211-224.

19. Ekins R, King D. The transgender Phenomenon. Thousand Oaks, CA: Sage. 2006.

20. Nestle J, Wilchins RA, Howell C. Genderqueer: Voices from beyond the sexual binary. Los Angeles, CA: Alyson Publications. 2002.

21. Fernández M, Guerra P, Martín-Sánchez E, Grupo Gidseen. Characteristics of Adolescents with Gender Dysphoria Referred to the Gender Identity Treatment Unit. Rev esp Salud Pública. 2001; 91: 1-9.

22. Juan Gavilán Macías. Sociocultural Intervention model in childhood transexualism. 2017.

23. Marta Cadenas. Satisfaction with life and gender disphoria [master's thesis]. University of Oviedo. 2018.

24. Free Personality Development. The Plenum of the Supreme Court (scjn). Thesis LXVI/2009. Application of Yogyakarta principles and international human rights law related to sexual orientation and gender identity. 2007.

25. Guide for public action against homophobia. Mexico, Conapred. 2012.

Cite this article

Rodríguez MF, Granda MM (2020) The Crisis of Dichotomous Model - Variants of Gender Identity. JSM Sexual Med 4(5): 1047.