

# INCOMPLETE SEX-REASSIGNMENT SURGERY AND PSYCHOSOCIAL FUNCTIONING: A PRELIMINARY STUDY

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## ABSTRACT

Sex reassignment surgery is a process which includes a decision to change one's biological sex through the use of medical intervention. Trans-sexualism is a condition in which a person experiences a discontinuity between their assigned sex and what they feel their core gender is. For example, a person who was identified as "female" at birth, raised as a girl, and has lived being perceived by others as a "woman", may feel that their core sense of who they are is a closer fit with "male". If this sense is strong and persistent, this person may decide to take steps to ensure that others perceive them as a man. The impact of gender affirming surgery on interpersonal relationships was studied and presented. The research question was: How does an individual with incomplete sex change surgery experience him/herself in relationships with males and females? The predominant finding was one of a mixed clinical picture wherein although the sex change does bring satisfaction in one area of their lives, it also raises dissatisfaction when it comes to other aspects of their lives. Psychotherapy and surgical intervention are to be considered jointly in order to aid effective integration for individuals considering such an option.

**Keywords:** psychological; psycho-social; relationship; sex-reassignment; surgical intervention; trans-sexual



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Trans-sexualism is a condition in which a person experiences a discontinuity between their assigned sex and what they feel their core gender is. For example, a person who was identified as “female” at birth, raised as a girl, and has lived being perceived by others as a “woman”, may feel that their core sense of who they are is a closer fit with “male”. If this sense is strong and persistent, this person may decide to take steps to ensure that others perceive them as a man.

Gender can be seen as a system of social differentiation and social placement (Ekins & King, 2006). Societies have an understanding about what constitutes gender, how many gender categories there are, what characterises members of each category and so on. Any particular society will express its understanding of gender in complex and largely unwritten set of rules that tell us what to expect of other people’s behaviour in both predictive and in a normative sense. Gender is also, of course, an important part of individual identity (Ekins & King, 2006).

Sexual identity, also termed gender identity, is a fundamental identity feature. It may be considered as encompassing three components, an individual’s basic conviction of being male or female; an individual’s behavior, which is culturally associated with males or females (masculinity and femininity); and an individual’s preference for male or female sexual partners, (Green, 1974).

We find it useful to think of gender not as something which people have, but to see the production of a gendered social identity as an on-going accomplishment, something which is constantly being done (Ekins & King, 2006). In societies which recognise only two genders, the basic rule of gender identity is that only biological males are expected to be male and only biological females are expected to be female (Brickell, 2006; Kessler, 1978). Trans-sexualism poses a perplexing challenge to psychosocial theories of human development, to social organisation and to medical theories of the sources of maleness and femaleness (Feinbloom, 1976). Trans-sexualism represents a disruption of ‘everyday reality’ and significantly jars basic beliefs.

The term trans-sexual may therefore be used for persons of either sex who display the following characteristics:

1. A sense of belonging to the opposite sex and of having been born into the wrong sex,
2. A sense of estrangement from one’s own body, so that any evidence of one’s own biological sex is regarded as repugnant,
3. A strong desire to resemble physically the opposite sex and to seek treatment, including surgery, towards this,
4. A wish to be accepted in the community as belonging to the opposite sex,
5. Persistence of these feelings and convictions, often since childhood, and
6. No evidence of biological or associated psychiatric illness, such as schizophrenia (Olsson & Moller, 2006).

The trans-sexual individual often feels that he or she is trapped in the wrong body. Male trans-sexuals feel feminine from childhood and often believe they were “girls”. This belief is typical of these individuals, and it is consistent with their distaste of their own genitals, which are described as “not mine”, “not wanted” and “useless”. Yousafzai & Bhutto state that a lack of interest for the penis as an insignia of maleness and a source of erotic pleasure is accompanied by the wish to be rid of it and to be given a woman’s body (2007).

The same applies to the female trans-sexual who demands removal of the breasts and of the womb, (Feinbloom, 1976). These individuals often remember puberty as a painful confusing period, during which erections and emissions for the male, and breast development and menstruation for the female, shattered the illusion that they were to grow up in the preferred body (Kessler, 1990).

He or she, often from the earliest memories feels that the biological sex assigned at birth is incongruent with subjective feelings of maleness or femaleness (Ekins, 1997). Cross-dressing often begins in early life, usually on the individual’s own initiative and without associated sexual gratification. Cross-dressing often produces a sense of wellbeing which cannot be obtained by any other means.

Passing is a controversial topic in the transgender community. Passing implies that transgender people are trying to trick the public into believing they are a gender that they actually are not. Original definitions of passing follow a performative-centric model that suggests that everyone is always performing the culturally acceptable behaviour prescribed for men and women. The real life test is when a person lives as the other sex in all social, public spheres, such as work or in the train station. This proves to others that the person has made a complete transformation and is ready for permanent surgery (Bischoff, 2012). Such requirements only continue the process of normalization and emphasize the need pass. Passing successfully in the opposite gender role reinforces the belief of being trapped in the wrong body and makes imperative the request for hormonal and surgical treatment (Meyerowitz, 2002).

Some trans-sexual individuals have a limited or absent sexual life. The male trans-sexual prefers masculine “straight” men intimately. These sexual relationships are explained as “heterosexual”. This is mainly because the patient believes that he is female and therefore naturally attracted to men. Heterosexual activity is accompanied by the fantasy of being a woman made love to by a man. This fantasy is necessary in order to achieve arousal and orgasm (Risman, Lorber & Sherwood, 2012).

The concept of body image has particular relevance to the phenomenon of trans-sexualism. Body image has come to mean not only the way one perceives his or her own body, but also the way he or she feels about these perceptions. As such, it is an important part of one’s overall self-concept, (Farber, 1985). The trans-sexual is unable to form a satisfactory body image because of the incongruence between anatomic sex and gender identity. Thus, the reality of the trans-sexual’s body does

not conform to the preferred or desired body image. The result is a disturbance in the formation of a complete and consistent self-concept, thus trans-sexualism, (Farber, 1985).

In order to bring the physical body in alignment with the psychological gender identity, some trans-sexual individuals opt for the process of sex re-assignment surgery. The process typically entails three elements of triadic therapy, which starts with hormone therapy → real-life experience → surgery, or sometimes: real-life experience (Bowman & Goldberg, 2006). The entire process is often referred to as ‘sexual transitioning’, as it truly does require a transition over time. Social reassignment, which is often recommended before the individual commits to sex reassignment surgery, entails living and working for perhaps two years as if the individual were already a member of the opposite sex (Barrett, 2007). Sex reassignment surgery is a process which includes a decision to change one’s biological sex through the use of medical intervention.

Ekins & King (2006) refer to this stage as ‘migrating’ insofar as the individual literally moves from one gender to another. Because of migration, that individual is ‘out of place’, translating into out of the birth sex and not yet into the preferred sex. The right to be both in the birth sex and in the preferred sex is in some way and by someone, questionable.

Given the severity of the conflict and ordeal suffered over an extended period of time, one would expect that once started, the process would be smooth sailing with individuals getting the anticipated relief. However, this is found not to be the case. A significant number of transitioning individuals do not see the surgical process through, and decide to leave the sex change process at the stage of hormone therapy (Kuipers, 2005).

## THEORETICAL ORIENTATION TO GENDER REASSIGNMENT

The focus of this study is thus the individual’s life experience after hormone therapy and not beyond the surgical process of altering the genitals, thus the psychosocial functioning of an individual after an incomplete sex re-assignment surgery. The medical perspective generally includes the assertion that normalcy is preferable to abnormalcy therefore; trans-sexualism is viewed as abnormalcy. Normalcy is a synonym for health and abnormalcy is a synonym for pathology, (Feinbloom, 1976).

Health and pathology are defined in terms of a scientific standard which claims objective truth based on experiments, laboratory research and proven hypothesis, (Bolin, 1988). Because it is better to be healthy than it is to be sick, the medical model has within it implicit support for interventions both requested and forced to provide health for the patient.

The patient is not regarded as responsible for his or her condition and since the condition is viewed as unwanted, he or she is assumed to want to get well. The patient is assumed to be unable to do this him or herself and therefore is dependent upon others for help. The benefits that may be enjoyed are a gain, but only permitted given the understanding that the patient sees him or herself as sick, actively participating in the curative process and expecting to resume ‘normal functioning’ as soon as possible (Tully, 1992).

Since the medical model conceptualizes social reality as thoroughly determined and since it regards social and human processes as static and natural entities, it cannot account for social factors. Its application to functional disturbance has thus been criticized as inappropriate and reductionist. In solving the medical problem, it creates interpersonal difficulties for which the individual is not thoroughly prepared. This becomes the downfall of the medical perspective, in that it focuses on the trans-sexual individual as though he does not have interpersonal relationships (Feinbloom, 1976).

This perspective is further accused of being based on unscientific ideas and causing more harm than good. Sex change surgery is viewed as mutilation of a physically healthy body in pursuit of fame for medical doctors than authentic treatment for the so called patients. Having laid the theoretical foundation, the focus now shifts to the sex re-assignment process (Evans, 2009).

Technically, you cannot truly change one’s sex. That is why the procedure is not really called “sex change surgery” but “sex re-assignment surgery”. The idea is to alter the physical appearance of a person’s anatomy to approximate as nearly as possible the anatomic arrangement of the other sex (Mocke, 2006).

Part of this procedure involves extended hormone therapy, which alters secondary sexual characteristics. In male to female trans-sexuals, it leads to the growth of breasts and the buildup of body fat in particular areas. In female to male trans-sexuals, it lowers the voice and causes body hair and beard to grow (Bowman & Goldberg, 2006).

Once a diagnosis of trans-sexualism has been made, recommendation for SRS should be based on strict criteria as laid down by The Harry Benjamin International Gender Dysphoria Association (1985) as follows:

1. The individual should show evidence of stable transsexual orientation.
2. The individual should show insight into his or her condition and should not suffer from any serious psychiatric disorder.
3. The individual should be able to pass successfully as a member of the opposite sex, and there should be clear evidence of cross-gender functioning.
4. Improvement in personal and social functioning should be predicted for the individual prior to and after surgery (Bowman & Goldberg, 2006).

Professional involvement with individuals with gender identity disorders involves any of the following; psychotherapy, real life experience, hormonal therapy, surgical therapy and once again real life experience (Bowman & Goldberg, 2006).

Furthermore, the individual seeking Sex Reassignment Surgery (SRS) must meet the following specifications:

1. Live for at least one year full-time in the new gender role (called Real Life Training or RLT).
2. Engage in hormone therapy for at least one year (which can be simultaneous with the real life experience).

The administration of hormones is not to be undertaken lightly because of their medical and social risks. Three criteria exist for hormone therapy:

- 2.1. Age 18 years;
- 2.2. Demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks;
- 2.3. Either:
  - a) A documented real-life experience of at least three months prior to the administration of hormones; or
  - b) A period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months).
3. Gain the recommendation of a psychologist or therapist after an appropriate series of sessions.
4. Gain a recommendation of a psychiatrist that surgery is not contrary to the mental health of the patient (European Parliament, 2010).

When all these criteria have been met, each surgeon also requires an HIV test to read negative (which they have performed at their facilities) and a personal interview so that they may verify the individual's mental and physical condition personally (Levine, Brown, Coleman, Cohen-Kettenis, Hage, Van Maasdam, Petersen, Pfafflin, Leah & Schaefer, 1998). As a joint venture, the professional has obligations to fulfill in the treatment of the trans-sexual individuals. Trans-gendering is accomplished by altering the signifiers in some way through a process consisting of various steps, the first of which is 'erasing', which entails the eliminating of aspects of maleness or femaleness, masculinity or femininity. A genetic male may undergo castration thereby replacing a penis with a vagina, or a genetic female may undergo a hysterectomy, referred to as Bottom Surgery (Cohen-Kettenis & Pfafflin, 2003). Both males and females may wear unisex clothes and adopt un-gendered mannerisms.

The second sub-process involves ‘substituting’, the person who is trans-gendering replaces the body parts, identity, dress, posture, gesture and speech style that are associated with one gender, with those associated with the other gender, (Ekins & King, 2006). In relation to the body, for example, a flat chest is replaced with breasts, referred to as Top Surgery (Cohen-Kettenis & Pfafflin, 2003), smooth skin replaces rough skin, no body hair replaces body hair, and a short hair style is often replaced with a longer hair style.

The degree of substitution will depend on a number of factors such as the particular personal project of the individual, the personal circumstances, the development of any technology and aids that may be used, and the financial resources to afford them (Ekins & King, 2006).

The third sub-process refers to the concealing or hiding of things that are seen to conflict with the intended gender display (Ekins & King, 2006). It may involve hiding body parts, wrapping a scarf around the Adam’s apple, tucking the penis or binding the breasts.

The fourth sub-process entails implying. Because the body is usually apprehended in social interaction in its clothed form, it is possible to imply the gendered form of the body beneath (Ekins & King, 2006). The fifth sub-process is ‘redefining’. Whereas the meanings of substitution, concealing and implying, are relatively easily grasped, particularly in relation to the acceptance of the binary divide, redefining is more subtle and multilayered (Ekins & King, 2006). At one level, the nature of the body, body parts and gendered accompaniments may be re-defined.

However, for some individuals the sex re-assignment surgery process is not completed for a variety of reasons. These reasons could be financial, in that the individual is not able to pay for the required surgical procedure to complete the process. Other reasons could be that an individual achieves a sense of congruence on the basis of just the hormone therapy.

Yet for others it could be the apprehension with which they view the surgical process and lack of guarantee that the desired genitals will function to their satisfaction or the satisfaction of their future partners. For the female-to-male trans-sexual, phalloplasty (construction of a penis) is a complex multi-stage operative procedure with universally unsatisfactory results so far. Until surgical techniques improve, the female trans-sexual can be better served by peno-scrotal prostheses obtained from a manufacturer of plastic surgical appliances. In this way some relief of anxiety and embarrassment about physique and inability to function sexually as a male can be achieved (Walters & Ross, 1986).

For the male-to-female trans-sexual the end-product of the treatment process is by appearance a female, bearing female secondary sexual characteristics. Since surgery is directed at these superficial manifestations, these constructed ‘females’ retain their male chromosome pattern and internal male secondary sexual organs, they do not menstruate, have neither a uterus nor ovaries and thus are incapable of reproducing (Kuipers, 2005).

Having obtained the body of a female, the ultimate success of this transformation depends on the development of a 'feminine' demeanor and life style to reinforce and complement bodily appearance. For those who eventually decide that the physical surgical change is not possible because of financial reasons or fear of unintended consequences of surgery such as complications or the failure of the surgically constructed genitals to 'launch', this stage of incomplete sex change continues and varies in duration from anything between two years and a lifetime.

While acknowledging the role of the medical model as the point of departure in the diagnosis and treatment of trans-sexualism, it is important to recognize the multifaceted nature of human existence. Therefore, it becomes necessary to include the political and cultural processes of the individual, hence the need to discuss the political context of being trans-gender.

## METHOD

An exploratory methodology was used, as the researcher aimed to investigate relatively unknown area of research. The aim was to discover personal experiences of individuals who have had incomplete sex re-assignment surgery and the impact of such on their lives. Qualitative research is multi-method in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret phenomena in terms of meanings people bring to them (Henning, Gravett & Rensburg, 2005). Qualitative researchers seek to make sense of personal stories and the ways in which these individuals interact. Qualitative research allows for active involvement of participants and effective building of rapport thus improving credibility in the study.

Sampling is the process used to select cases for inclusion in a research study (Neuman, 1997). The study applied two sampling strategies in order to maximize the possibility of obtaining research samples and these were the purposive or judgemental as well as the snowball sampling techniques. Purposive or judgemental sampling best suits the current research because it is less strict and makes no claim for representativeness.

The research sample had to meet the following criteria: the individual must have undergone either Hormone Therapy or Top Surgery or Bottom Surgery. Furthermore, at least one of these treatments must have been undertaken at the time of the interview. These are individuals who have started with hormone treatment but have not, as yet completed surgery to change their biological sex. The individual must be 18 years and older. They must be able to communicate in English. They should be willing to participate in the study and share their experiences. This requirement will add significant bias which will have to be kept in mind when interpreting the results.

Permission was requested from three organizations that deal with trans-gender communities for research participants; these are Gender DynamiX, GALA and



Out. Thereafter the researcher arranged interviews with the participants. The final sample comprised of five (05) participants. Structured interviews were conducted at a mutually convenient venue. A consent form was completed by the participants.

One on one interviews were conducted with each participants, this was done so as to ensure confidentiality and privacy. In this study unstructured interviews were used to gather information whereby the researcher orally asked questions for individuals to answer orally thus allowing the interviewees to speak for themselves, telling their own stories. The reason for using interviews as a method of data collection is because this method is deemed the most suitable to gather the required personal and subjective experiences. Interviews have the advantage that the interviewers can establish rapport with the persons being interviewed. Interviewers may be able to notice when respondents seem to misunderstand a question and explain its meaning.

The interviews were audio taped and data transcribed verbatim by the researcher. Thereafter, the researcher gave the transcript to three independent clinicians with the request to analyze the data to ensure trustworthiness of the study.

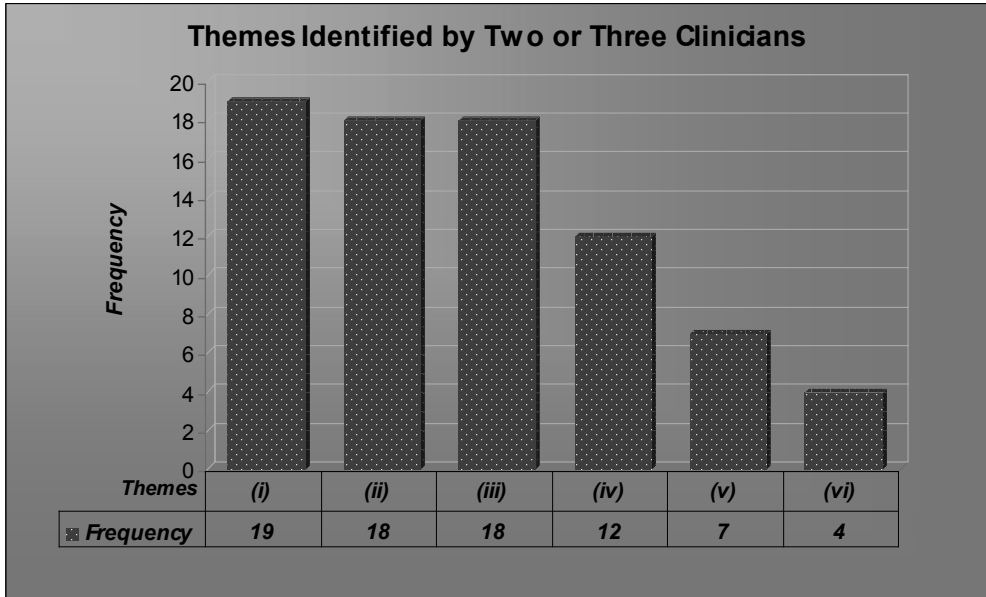
## DISCUSSION AND CONCLUSION

The purpose of this study was to determine the individual's experience of him/herself in intimate relationships after the transitioning process. It aimed at describing the experience of the gender transitioning process and its impact on interpersonal relationships. The general finding of the research is that sex re-assignment surgery is a complex phenomenon that requires a multi-disciplinary approach if it is to yield a psychologically stable outcome.

The findings present a mixed clinical picture wherein although there is some level of satisfaction and contentment with the transitioning process, there are some new difficulties experienced. The experience of unconditional acceptance and empathy is shadowed by personal experiences of not being able to effectively integrate in intimate relationships leading to uncertainty, isolation and withdrawal from such relationships.

Of significance is that although the participants experience personal satisfaction with the surgical changes undertaken, these experiences are shadowed by feelings of rejection on an interpersonal relationship level and this is experienced as dissatisfaction on an emotional level. Furthermore, the participants identified subjective experience of incongruence and uncertainty with regard to new gender roles and this presents difficulty in integrating in social contexts.

The solution seems to have become a new problem insofar as it presents the participants with similar practical difficulties. After the transition the participants find themselves having to explain their gender to authorities, new friends, potential lovers and colleagues. The gender-transitioning, seems to have solved the gender identity dilemma yet replaced it with a set of complex pragmatic difficulties.



**Figure 1:** Histogram of themes identified by two or three clinicians in all five cases  
 Theme (i) was identified 19 times followed by themes (ii) and (iii) which were identified 18 times. Thereafter theme (iv) was identified 12 times. Theme (v) was identified 7 times. Theme (vi) is the least identified appearing 4 times.

**Table 1:** Themes and frequencies

Themes identified	Frequency
i. Feeling judged and rejected after sex reassignment surgery	19
ii. Feeling content with the surgery undertaken in that the physical appearance now represents for the participant his/her psychological gender	18
iii. Experiencing unconditional acceptance and empathy	18
iv. Ineffective integration in intimate relationships leading to feelings of uncertainty and withdrawal	12
v. Subjective experience of incongruence and uncertainty with regard to new gender roles	7
vi. Pragmatic and administrative difficulty when it comes to identifying oneself to authority and service providers	4

Mixed results were predominant with all five respondents. In as much as sex change resolves the gender identity, it brings to the fore a myriad of complex interpersonal difficulties which indicate that there is no simple yes answer to sex change. Sex change does have a huge impact on the work context, to the degree that it complicates work relationships and creates new challenges. On a romantic level, some respondents experience acceptance, though it is not without major adjustment difficulties and the risk of losing existing relationships and apprehension in initiating new relationships.

Sex re-assignment surgery needs in-depth psychological counselling before and after the surgery to assist the subject to achieve a higher likelihood of adjustment in interpersonal relationships afterwards. It appears that psychotherapy would be required after the sex change so as to better equip the participants in the final adjustment to their new gender realities.

## LIMITATIONS

The current sample is relatively small thus implying that the data is unrepresentative of the actual population. This study was conducted in an exploratory manner which allowed for in depth exploration of unique individual experiences. Therefore, for this reason, all conclusions should be tentative before the study can be replicated with a greater sample.

The participants in this research were willing and eager to share their experiences. This may have biased the findings. However, their bias was safeguarded by the use of independent clinicians in analyzing the interviews thematically.

## BIOGRAPHICAL NOTES



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