Clerk's stamp:

COURT FILE NUMBER	1808-00144
COURT	COURT OF QUEEN'S BENCH OF ALBERTA
JUDICIAL CENTRE	MEDICINE HAT
APPLICANTS	P.T., and others; see attached Schedule "A"
RESPONDENT	HER MAJESTY THE QUEEN IN RIGHT OF ALBERTA
INTERVENORS:	CALGARY SEXUAL HEALTH CENTRE and ASSOCIATION FOR REFORMED POLITICAL ACTION
DOCUMENT	**AFFIDAVIT OF JAMIE SHUPE**

ADDRESS FOR SERVICE AND CONTACT INFORMATION OF PARTY FILING THIS DOCUMENT

Justice Centre for Constitutional Freedoms
Jay Cameron and Marty Moore
#253, 7620 Elbow Drive SW
Calgary, Alberta T2V 1K2
Phone: (403) 909-3404
Fax: (587) 747 5310
Email: jcameron@jccf.ca

Schedule "A" : Full Style of Cause

APPLICANTS	P.T., D.T., F.R., K.R., P.H., M.T., J.V., A.S., R.M., UNIVERSAL EDUCATION INSTITUTE OF CANADA, HEADWAY SCHOOL SOCIETY OF ALBERTA, THE CANADIAN REFORMED SCHOOL SOCIETY OF CALGARY, GOBIND MARG CHARITABLE TRUST FOUNDATION, CONGREGATION HOUSE OF JACOB MIKVEH ISRAEL, KHALSA SCHOOL CALGARY EDUCATION FOUNDATION, CENTRAL ALBERTA CHRISTIAN HIGH SCHOOL SOCIETY, SADDLELAKE INDIAN FULL GOSPEL MISSION, ST. MATTHEW EVANGELICAL LUTHERAN CHURCH OF STONY PLAIN, ALBERTA, CALVIN CHRISTIAN SCHOOL SOCIETY, CANADIAN REFORMED SCHOOL SOCIETY OF EDMONTON, COALDALE CANADIAN REFORMED SCHOOL SOCIETY, AIRDRIE KOINONIA CHRISTIAN SCHOOL SOCIETY, DESTINY CHRISTIAN SCHOOL SOCIETY, KOINONIA CHRISTIAN SCHOOL-RED DEER SOCIETY, COVENANT CANADIAN REFORMED SCHOOL SOCIETY, LACOMBE CHRISTIAN SCHOOL SOCIETY, PROVIDENCE CHRISTIAN SCHOOL SOCIETY, PONOKA CHRISTIAN SCHOOL SOCIETY, LIVING WATERS CHRISTIAN ACADEMY, NEWELL CHRISTIAN SCHOOL SOCIETY, SLAVE LAKE KOINONIA CHRISTIAN SCHOOL, YELLOWHEAD KOINONIA CHRISTIAN SCHOOL SOCIETY, THE RIMBEY CHRISTIAN SCHOOL SOCIETY, LIVING TRUTH CHRISTIAN SCHOOL SOCIETY, LIGHTHOUSE CHRISTIAN SCHOOL SOCIETY, PARENTS FOR CHOICE IN EDUCATION, and ASSOCIATION OF CHRISTIAN SCHOOLS INTERNATIONAL- WESTERN CANADA
RESPONDENT	HER MAJESTY THE QUEEN IN RIGHT OF ALBERTA
INTERVENORS:	CALGARY SEXUAL HEALTH CENTRE and ASSOCIATION FOR REFORMED POLITICAL ACTION

AFFIDAVIT OF JAMIE SHUPE

Sworn on June 25 ,2019

I, JAMIE SHUPE of Ocala, Florida, SWEAR AND SAY THAT:

1. I have personal knowledge of the matters and facts hereinafter deposed to by me, except where same are stated to be based upon information and belief, in which case I believe them to be true.

Young Adulthood – Gender Non-Conformity

2. Growing up as one of eight children, I developed the perception that I was less masculine than my male peers and siblings. I believed that I had soft and feminine characteristics, especially with how I expressed myself emotionally. I tended to prefer the company of females over males, and while the other boys wanted to play sports, I preferred to refrain from such activities. Despite this, throughout my adolescent years, I never believed that I was a female or identified as one – I knew that I was innately male.

3. During my pre-teen years, I was sexually abused by the uncle who I shared my name with. I was frequently punished by my mother who called me a "sissy" while I was being physically abused. My early years were filled with violence and confusion.

4. I served in the U.S. Army from 1982 to 2000. See attached Certificate of Release or Discharge from Active Duty attached as **Exhibit "A"** to this Affidavit.

5. In my mid 20's and 30's, while serving in the military, I started viewing a lot of pornography. After doing so, I started to cross-dress and began to think about having sex with other men. I fantasized playing the female role during sexual encounters. The effective erotic stimulus I experienced when I eventually engaged in these types of sexual liaisons was not the other man's physique, but rather it was the thought of being a woman

while being penetrated by a man that excited me. In order to make my fantasies of being the female more realistic, I purchased a set of fake breasts to wear during my sexual encounters. After the episodes of cross-dressing and sexual encounters, I was content to return to my life as a male and my role as a father and husband.

Transitioning

6. In 2013, at the age of 49, I first encountered the term "gender identity." After consuming readily available online literature about gender dysphoria, I convinced myself that I was a woman trapped in a man's body despite not feeling that way. I rapidly became obsessed with the idea that I must be transgender because of my exposure to the online literature. I remembered not fitting in with the other boys and preferring female company. I remembered how two neighborhood girls put a dress and wig on me for a Halloween party and pretended that I was a girl.

7. Shortly after this self-diagnosis, I was so distressed with my masculine physical appearance that I spent four days in the bathroom removing all of my facial hair with a pair of tweezers. Prior to being exposed to the concept of gender identity and the online materials about transgenderism, I had never behaved like that or felt psychological distress about my body.

8. According to what I learned from social media and websites, all I needed to do to become a female was take cross-sex hormones and then undergo sex-reassignment surgery to invert my penis into a vagina. Once I did this, I would be the same as any other woman.

9. Convinced that a gender transition to female would cure my many mental health issues, in January 2013, I made an appointment with Jean Ruiz, a licensed nurse practitioner ("LNP") in Cumberland, Maryland. Although she had never met me previously and

despite having no previous experience treating transgender patients, Ms. Ruiz prescribed me cross-sex hormones, antiandrogen drugs and mental health medications at my first appointment with her on or about February 2013, specifically daily doses of Spironolactone 200 mg, Oral Estradiol 2 mg, Adderall 20 mg, and Escitalopram 10 mg. I had informed Ms. Ruiz that I was a permanently disabled veteran who had been diagnosed with chronic PTSD, anxiety, depression, panic attacks and bipolar disorder. See attached VA Problem Listing attached as **Exhibit "B"** to this Affidavit.

10. During an appointment a few months later, despite previously prescribing the medications, the LPN informed me that she lacked the required skills to treat me, was uncomfortable about doing so, and refused to see me any further as a patient.

11. I subsequently sought treatment from Dr. Allison Aiken at Metro Family Practice in Pittsburgh, Pennsylvania. Without engaging in her own independent diagnosis, Dr. Aiken immediately resumed my prescriptions to continue the hormone therapy. On or about May 2013, Metro Family Practice prescribed me daily doses of Oral Estradiol 6 mg, Prometrium Progesterone 200 mg, Finasteride 5 mg, Spironolactone 100 mg, and Alprazolam 0.5 mg.

12. In April 2014 the Department of Veterans Affairs took over providing my transgender health care. The informed consent document I signed stated that taking cross-sex hormones "can greatly improve mental health and quality of life" (attached to this affidavit as **Exhibit "C"**).

13. In March 2014, with the help of the Transgender Legal Defense and Education Fund, I changed my name to Jamie. I then used a letter provided by Dr. Aiken at Metro Family Practice (attached to this affidavit as **Exhibit "D"**) to change my sex from male to female

on my Pennsylvania identification card and Washington, D.C. birth certificate.

Identifying as non-binary

14. Despite undergoing extensive hormone therapy, I felt like I looked nothing like a female. I began to realize that I would never truly be a woman. In March 2016, I started using "they" and "their" pronouns rather than gender-specific pronouns. I also started identifying as non-binary, a catch-all category for gender identities that are not exclusively male or female. Further, in May, 2016, two medical doctors who had previously treated me with hormone replacement therapy and validated my identity as a female signed letters attesting that I was, in fact, neither male nor female (see letters from Dr. Rebecca Cantone and Dr. Leslie Strickland, dated May 2016, attached to this affidavit as **Exhibit "E"**).

15. On April 27, 2016, my attorney filed a petition in Oregon to change my sex to a third option. Within minutes at the court hearing on June 10, 2016, the judge had signed the court order (attached to this affidavit as **Exhibit "F"**), and I became the first legally recognized non-binary person in the United States of America.

16. Within five months, Whitman Walker Health, a Washington D.C.-based legal aid organization, had convinced the Department of Vital Records to issue me a birth certificate that designated my sex as "unknown." This was the first time in Washington D.C. history that a birth certificate had been issued with a sex marker other than male or female.

Personal consequences experienced as a result of transitioning

17. The hormonal, physical and legal transition that I underwent did not have the positive effects that the online resources and my medical doctors assured me they would have.

Rather than experiencing resolution of my mental suffering and distress, after undergoing these treatments and gender transition, my mental suffering, anxiety, depression, suicidal ideation and general sense of well-being was worse than it had been before.

18. Under the influence of the hormones, with my testosterone at times suppressed and at other times completely shut off, I became severely emotionally destabilized. I alternated between states of having no control over my emotions with episodes of uncontrollable crying that lasted up to hours at a time to periods of deep despair, where I lacked the energy to do anything and frequently thought of killing myself because I felt so helpless and depressed.

19. The treatment I underwent for transitioning resulted in irreversible medical consequences. As a result of hormone therapy, I suffer from irreversible breast growth, bone density problems, and kidney complications. See e.g. VA Radiology bone density report attached as **Exhibit "G"** to this affidavit.

20. Distressed by my sexual behaviors in 2018 after my second of three psychiatric hospitalizations, I began studying the effects of childhood sexual abuse on males, including for example, David Lisak, *The Psychological Impact of Sexual Abuse: Content Analysis of Interviews with Male Survivors*, Journal of Traumatic Stress, Vol. 7, No. 4 1994, attached as **Exhibit "H"** to this affidavit. I also began to examine Dr. Ray Blanchard's work on autogynephilia (see e.g. Ray Blanchard, *Clinical Observations and Systematic Studies of Autogynephilia*, Journal of Sex & Marital Therapy, Vol. 17, No. 4, Winter 1991 235, attached as **Exhibit "I"** to this affidavit), something I long suspected I suffered from but had previously avoided reading because of the associated stigma. At the time, my sexual behaviors were out of control. I was forcing my wife to engage in

BDSM sessions and having her lock my genitals in a chastity device. I was also performing sex acts for men online via a webcam while cross-dressed and seeking out males for sexual activities in public. The reading led me to understand that my mental health problems and extreme sexual behaviors were rooted in trauma related to my PTSD. I began to understand that I was engaging in compulsive sexual behavior (CSB) (see e.g. article, *Study yields insight on sexual disorder and its effects on Vets*, VA Research Currents, June 7, 2017, attached as **Exhibit "J"** to this affidavit and suffering from a transvestic disorder with autogynephilia rather than gender dysphoria. This information made me realize that my gender transitions had been a mistake. I credit the work of Dr. Ray Blanchard and David Lisak with helping me to understand my illnesses and behaviors. That knowledge and realization resolved the need to identify as transgender or non-binary any further and helped me to accept my male birth sex.

21. I have reclaimed my innate male identity, and have taken steps to correct my legal identity documents to reflect my male sex. See letter of Dr. Ashok Srihari, dated February 8, 2019, attached as **Exhibit "K"** to this affidavit.

22. To cope and get help for my underlying mental health and sex addiction issues, I have begun attending weekly therapy sessions with a therapist that specializes in treating trauma. In order to control my sexual compulsive behavior, urges to crossdress for sexual pleasure and to stop having risky sex with men, I am now attending a weekly sex addiction group. The meeting is modeled on the 12-step program. Both are helpful and the VA has since given me a new diagnosis of Paraphilia Disorder (SCT 50299009).

23. I have had much difficulty finding civilian mental health providers willing to treat me since detransitioning, because of their ties to affirming treatment models.

24. Returning to my birth sex has been beneficial both mentally, physically and spiritually, and I am no longer fighting against my male biology. I am also much healthier and more grounded to reality by accepting the knowledge that I am male because I have male chromosomes and a male reproductive system, something based in science rather than sex stereotypes. I now reassure myself that it's okay for me to be a feminine male, rather than being distressed by this trait.

25. While I have suffered irreparable physical and persistent psychological harm as a result of testing the theories that I have a gender identity rather than a biological sex, and that gender transitions and hormone treatments would resolve my mental health issues, my wife of over 30 years and my daughter have suffered greatly because of me becoming temporarily detached from my birth sex due to gender ideology.

26. I swear this Affidavit bona fide and for no improper purpose.

SWORN BEFORE ME at Ocala,)
in the State of Florida, this 25th day)
of June, 2019.)
)
)
)
)

Commissioner for Oaths

Jamie Shupe
JAMIE SHUPE

ESMIRNA L CARABALLO
Notary Public – State of Florida
Commission # GG 134903
My Comm. Expires Aug 15, 2021

CAUTION: NOT TO BE USED FOR IDENTIFICATION PURPOSES | THIS IS AN IMPORTANT RECORD. SAFEGUARD IT. | ANY ALTERATIONS IN SHADED AREAS RENDER FORM VOID

CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY

This Report Contains Information Subject to the Privacy Act of 1974, As Amended.

1. NAME (Last, First, Middle)	2. DEPARTMENT, COMPONENT AND BRANCH	3. SOCIAL SECURITY NUMBER
SHUPE, JAMIE	ARMY/RA	

4a. GRADE, RATE OR RANK	b. PAY GRADE	5. DATE OF BIRTH (YYYYMMDD)	6. RESERVE OBLIGATION TERMINATION DATE (YYYYMMDD)
SFC	E07	19630810	00000000

7a. PLACE OF ENTRY INTO ACTIVE DUTY	b. HOME OF RECORD AT TIME OF ENTRY (City and state, or complete address if known)
LOUISVILLE, KY	FORT RITCHIE, FL 33568

8a. LAST DUTY ASSIGNMENT AND MAJOR COMMAND	b. STATION WHERE SEPARATED
B CO 710TH MSB FC	FORT DRUM, NY 13602-5000

9. COMMAND TO WHICH TRANSFERRED	10. SGLI COVERAGE
USAR CON GP (RET) AR-PERSCOM, 9700 PAGE BLVD, ST LOUIS, MO 63132	NONE AMOUNT: $ 200,000.00

11. PRIMARY SPECIALTY (List number, title and years and months in specialty. List additional specialty numbers and titles involving periods of one or more years.)

63H40 P5 TRACK VEH REPAIRER- - 17 YRS-2 MOS//NOTHING FOLLOWS

12. RECORD OF SERVICE	YEAR(S)	MONTH(S)	DAY(S)
a. DATE ENTERED AD THIS PERIOD	1987	05	20
b. SEPARATION DATE THIS PERIOD	2000	07	31
c. NET ACTIVE SERVICE THIS PERIOD	0013	02	11
d. TOTAL PRIOR ACTIVE SERVICE	0004	00	00
e. TOTAL PRIOR INACTIVE SERVICE	0000	10	18
f. FOREIGN SERVICE	0000	00	00
g. SEA SERVICE	0000	00	00
h. INITIAL ENTRY TRAINING	0000	00	00
i. EFFECTIVE DATE OF PAY GRADE	1996	03	01

13. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED (All periods of service)

MERITORIOUS SERVICE MEDAL (2ND AWARD)// ARMY COMMENDATION MEDAL (4TH AWARD)//ARMY ACHIEVEMENT MEDAL (8TH AWARD)//ARMY GOOD CONDUCT MEDAL (5TH AWARD)//NATIONAL DEFENSE SERVICE MEDAL//SOUTHWEST ASIA SERVICE MEDAL//SHARPSHOOTER MARKSMANSHIP QUALIFICATION BADGE WITH//CONT IN BLOCK 18

14. MILITARY EDUCATION (Course title, number of weeks, and month and year completed)

NCO EDUCATION ADVANCED, 13 WEEKS, 1996// NCO EDUCATION BASIC, 20 WEEKS, 1991//NCO EDUCATION PRIMARY, 4 WEEKS, 1988//SUPPORT OPER LOGISTICAL CRS, 2 WEEKS, 1999//MASTER FITNESS CRS, 4 WEEKS, 1991//EEO REP CRS, 2 WEEKS, 1989//INFORMATION SYSTEMS (ISSO) OFFICER, 2 WEEKS, 1996//NOTHING FOLLOWS

15a. COMMISSIONED THROUGH SERVICE ACADEMY		YES	X NO
b. COMMISSIONED THROUGH ROTC SCHOLARSHIP (10 USC Sec. 2107b)		YES	X NO
c. ENLISTED UNDER LOAN REPAYMENT PROGRAM (10 USC Chap. 109) (If Yes, years of commitment: NA)		YES	X NO

16. DAYS ACCRUED LEAVE PAID	17. MEMBER WAS PROVIDED COMPLETE DENTAL EXAMINATION AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION	YES	NO
9			X

18. REMARKS

SUBJECT TO ACTIVE DUTY RECALL BY THE SECRETARY OF THE ARMY//SERVICE IN SOUTHWEST ASIA 19941030-19941205//SERVICE IN BOSNIA 19960601-19960806//MEMBER HAS COMPLETED FIRST FULL TERM OF SERVICE//CONT FROM BLOCK 13: GRENADE BAR//DRIVER MECHANIC BADGE//DRIVERS AND MECHANIC BADGE WITH DRIVER "W" BAR//NOTHING FOLLOWS

The information contained herein is subject to computer matching within the Department of Defense or with any other affected Federal or non-Federal agency for verification purposes and to determine eligibility for, and/or continued compliance with, the requirements of a Federal benefit program.

19a. MAILING ADDRESS AFTER SEPARATION (Include ZIP Code)	b. NEAREST RELATIVE (Name and address - include ZIP Code)
PO BOX 366 MECHANICSVILLE, MD 20659	SANDRA E. SHUPE PO BOX 366 MECHANICSVILLE, MD 20659

20. MEMBER REQUESTS COPY 6 BE SENT TO (Specify state/locality) MD	OFFICE OF VETERANS AFFAIRS	X	YES		NO
a. MEMBER REQUESTS COPY 3 BE SENT TO THE CENTRAL OFFICE OF THE DEPARTMENT OF VETERANS AFFAIRS (WASHINGTON, DC)			YES	X	NO

21.a. MEMBER SIGNATURE	b. DATE (YYYYMMDD)	22.a. OFFICIAL AUTHORIZED TO SIGN (Typed name, grade, title, signature)	b. DATE (YYYYMMDD)
NOT AVAILABLE TO SIGN		ESIGNED BY: AVERY.WALTER.JR.1037036745 WALTER AVERY, GS13, CHIEF, PROMULGATION TM A	20151117

SPECIAL ADDITIONAL INFORMATION (For use by authorized agencies only)

23. TYPE OF SEPARATION	24. CHARACTER OF SERVICE (Include upgrades)	
DISCHARGE	HONORABLE	
25. SEPARATION AUTHORITY	**26. SEPARATION CODE**	**27. REENTRY CODE**
AR 635-200 CHA 12	RBD	4R
28. NARRATIVE REASON FOR SEPARATION		
SUFFICIENT SERVICE FOR RETIREMENT		
29. DATES OF TIME LOST DURING THIS PERIOD (YYYYMMDD)		**30. MEMBER REQUESTS COPY 4 (Initials)**
NONE		

DD FORM 214, AUG 2009 | PREVIOUS EDITION IS OBSOLETE. GENERATED BY ARBA | MEMBER - 4

ESMIRNA L CARABALLO
Notary Public – State of Florida
Commission # GG 134903
My Comm. Expires Aug 15, 2021

This is Exibit "A" referred to in the Affidavit of Jamie Shupe sworne before me this 25th day of June 2019.

VA Problem List

Source:	VA
Last Updated:	21 Jun 2019 @ 0828
Sorted By:	Date/Time Entered (Descending) then alphabetically by Problem

Your VA Problem List contains active health problems your VA providers are helping you to manage. This information is available 3 calendar days after it has been entered. It may not contain active problems managed by non-VA health care providers. If you have any questions about your information, visit the FAQs or contact your VA health care team.

Problem:	Paraphilia (SCT 50299009)	**Date/Time Entered: 29 Apr 2019 @ 1200**
Provider:	SRIHARI,ASHOK K	
Location:	N. FLORIDA/S. GEORGIA VHS	
Status:	ACTIVE	
Comments:	--	

Problem:	Gender dysphoria (SCT 93461009)	**Date/Time Entered: 31 Aug 2018 @ 1200**
Provider:	SRIHARI,ASHOK K	
Location:	N. FLORIDA/S. GEORGIA VHS	
Status:	ACTIVE	
Comments:	--	

Problem:	Gender identity disorder (SCT 87991007)	**Date/Time Entered: 03 Aug 2018 @ 1200**
Provider:	LEVIS-DUSSEAU,SILVINA	
Location:	Miami FL VAMC	
Status:	ACTIVE	
Comments:	--	

Problem:	Anxiety (SCT 48694002)	**Date/Time Entered: 01 Aug 2018 @ 1200**
Provider:	GARCIA,TERESA	
Location:	N. FLORIDA/S. GEORGIA VHS	
Status:	ACTIVE	
Comments:	--	

Problem:	Asthma (SCT 195967001)	**Date/Time Entered: 01 Aug 2018 @ 1200**
Provider:	GARCIA,TERESA	
Location:	N. FLORIDA/S. GEORGIA VHS	
Status:	ACTIVE	

ESMIRNA L CARABALLO
Notary Public – State of Florida
Commission # GG 134903
My Comm. Expires Aug 15, 2021

This is exibit "B" referred to in the Affidavit of Jamie Shupe sworne before me this 25th day of June 2019.

Comments:	--

Problem:	Bipolar disorder (SCT 13746004)	**Date/Time Entered: 01 Aug 2018 @ 1200**
Provider:	GARCIA,TERESA	
Location:	N. FLORIDA/S. GEORGIA VHS	
Status:	ACTIVE	
Comments:	--	

Problem:	Cervical lymphadenopathy (SCT 127086001)	**Date/Time Entered: 01 Aug 2018 @ 1200**
Provider:	GARCIA,TERESA	
Location:	N. FLORIDA/S. GEORGIA VHS	
Status:	ACTIVE	
Comments:	left anterior report negative biopsy, no change in size or quality	

Problem:	Chronic Sinusitis (SCT 40055000)	**Date/Time Entered: 01 Aug 2018 @ 1200**
Provider:	GARCIA,TERESA	
Location:	N. FLORIDA/S. GEORGIA VHS	
Status:	ACTIVE	
Comments:	--	

Problem:	Depression (SCT 35489007)	**Date/Time Entered: 01 Aug 2018 @ 1200**
Provider:	GARCIA,TERESA	
Location:	N. FLORIDA/S. GEORGIA VHS	
Status:	ACTIVE	
Comments:	--	

Problem:	Folliculitis (SCT 13600006)	**Date/Time Entered: 01 Aug 2018 @ 1200**
Provider:	GARCIA,TERESA	
Location:	N. FLORIDA/S. GEORGIA VHS	
Status:	ACTIVE	
Comments:	--	

Problem:	History of tobacco use (SCT 1221000119103)	**Date/Time Entered: 01 Aug 2018 @ 1200**
Provider:	GARCIA,TERESA	
Location:	N. FLORIDA/S. GEORGIA VHS	
Status:	ACTIVE	
Comments:	--	

Problem:	Male-to-female transsexual (SCT 407376001)	**Date/Time Entered: 01 Aug 2018 @ 1200**
Provider:	GARCIA,TERESA	
Location:	N. FLORIDA/S. GEORGIA VHS	
Status:	ACTIVE	
Comments:	--	

Problem:	Nasal polyp (SCT 52756005)	**Date/Time Entered: 01 Aug 2018 @ 1200**
Provider:	GARCIA,TERESA	
Location:	N. FLORIDA/S. GEORGIA VHS	
Status:	ACTIVE	
Comments:	--	

Problem:	PTSD - Post-Traumatic Stress Disorder (SCT 47505003)	**Date/Time Entered: 01 Aug 2018 @ 1200**
Provider:	GARCIA,TERESA	
Location:	N. FLORIDA/S. GEORGIA VHS	
Status:	ACTIVE	
Comments:	--	

Problem:	Seborrheic dermatitis of scalp (SCT 156329007)	**Date/Time Entered: 01 Aug 2018 @ 1200**
Provider:	GARCIA,TERESA	
Location:	N. FLORIDA/S. GEORGIA VHS	
Status:	ACTIVE	
Comments:	--	

Problem:	Solar lentigo (SCT 72100002)	**Date/Time Entered: 01 Aug 2018 @ 1200**
Provider:	GARCIA,TERESA	
Location:	N. FLORIDA/S. GEORGIA VHS	
Status:	ACTIVE	
Comments:	left forearm and frontal scalp evaluated with dermatology in April 9, 2018	

Problem:	Solitary nodule of lung (SCT 427359005)	**Date/Time Entered: 01 Aug 2018 @ 1200**
Provider:	GARCIA,TERESA	
Location:	N. FLORIDA/S. GEORGIA VHS	
Status:	ACTIVE	
Comments:	--	

Problem:	Chronic post-traumatic stress disorder (SCT 313182004)	**Date/Time Entered: 22 Jan 2018 @ 1200**
Provider:	THODE,KIRSTIN I	

Location:	Washington DC VAMC
Status:	ACTIVE
Comments:	--

Problem:	Gender dysphoria (SCT 93461009)	**Date/Time Entered: 27 Dec 2017 @ 1200**
Provider:	GANDHI,SHRUTI MAHENDRA	
Location:	Washington DC VAMC	
Status:	ACTIVE	
Comments:	--	

Problem:	Bipolar affective disorder, current episode depression (SCT 191627008)	**Date/Time Entered: 21 Nov 2017 @ 1200**
Provider:	WARRAICH,SAIMA	
Location:	Washington DC VAMC	
Status:	ACTIVE	
Comments:	--	

Problem:	Asthma - currently active (SCT 312453004)	**Date/Time Entered: 11 Jun 2017 @ 1200**
Provider:	MILLS,TRUDY L	
Location:	VA Roseburg Health Care System	
Status:	ACTIVE	
Comments:	--	

Problem:	Hormone replacement therapy requested (SCT 394888000)	**Date/Time Entered: 11 Jun 2017 @ 1200**
Provider:	MILLS,TRUDY L	
Location:	VA Roseburg Health Care System	
Status:	ACTIVE	
Comments:	androgens are not supressed enough	

Problem:	Male-to-female transsexual (SCT 407376001)	**Date/Time Entered: 11 Jun 2017 @ 1200**
Provider:	MILLS,TRUDY L	
Location:	VA Roseburg Health Care System	
Status:	ACTIVE	
Comments:	--	

Problem:	Mood disorder due to a general medical condition (SCT 37739004)	**Date/Time Entered: 11 Jun 2017 @ 1200**
Provider:	MILLS,TRUDY L	
Location:	VA Roseburg Health Care System	
Status:	ACTIVE	
Comments:	--	

Problem:	Onychomycosis of toenails (SCT 403059006)	**Date/Time Entered: 11 Jun 2017 @ 1200**
Provider:	MILLS,TRUDY L	
Location:	VA Roseburg Health Care System	
Status:	ACTIVE	
Comments:	--	

Problem:	Posttraumatic stress disorder (SCT 47505003)	**Date/Time Entered: 11 Jun 2017 @ 1200**
Provider:	MILLS,TRUDY L	
Location:	VA Roseburg Health Care System	
Status:	ACTIVE	
Comments:	--	

Problem:	Gender dysphoria (SCT 93461009)	**Date/Time Entered: 30 Aug 2016 @ 1200**
Provider:	RAMACHANDRAN,MEERA	
Location:	Portland OR VAMC	
Status:	ACTIVE	
Comments:	not tolerant of spiro or finasteride identifies as non-binary, identifies as lesbian lidocaine and tramadol for pain with electrolysis progesterone added 10/2015 estrogen started 2/2013	

Problem:	Allergic rhinitis (SCT 61582004)	**Date/Time Entered: 07 Oct 2015 @ 1200**
Provider:	LLOYD,CLEE E	
Location:	Portland OR VAMC	
Status:	ACTIVE	
Comments:	--	

Problem:	Chronic sinusitis (SCT 40055000)	**Date/Time Entered: 07 Jun 2015 @ 1200**
Provider:	STRICKLAND,LESLIE E	
Location:	Portland OR VAMC	
Status:	ACTIVE	
Comments:	ENT consult May 2015	

Problem:	Posttraumatic stress disorder (SCT	**Date/Time Entered: 03 Feb**

	47505003)	2015 @ 1200
Provider:	STRICKLAND,LESLIE E	
Location:	Portland OR VAMC	
Status:	ACTIVE	
Comments:	--	

Problem:	Anxiety (SCT 48694002)	Date/Time Entered: 01 Feb 2015 @ 1200
Provider:	STRICKLAND,LESLIE E	
Location:	Portland OR VAMC	
Status:	ACTIVE	
Comments:	--	

Problem:	Asthma (SCT 195967001)	Date/Time Entered: 01 Feb 2015 @ 1200
Provider:	STRICKLAND,LESLIE E	
Location:	Portland OR VAMC	
Status:	ACTIVE	
Comments:	--	

Problem:	Chronic sinusitis (SCT 40055000)	Date/Time Entered: 20 Aug 2014 @ 1200
Provider:	FUCHS,CHRISTIAN J	
Location:	Pittsburgh Health Care System	
Status:	ACTIVE	
Comments:	--	

Problem:	Panic disorder with agoraphobia (SCT 35607004)	Date/Time Entered: 05 Jul 2014 @ 1200
Provider:	HORVITZLENNON,MARCELA V	
Location:	Pittsburgh Health Care System	
Status:	ACTIVE	
Comments:	--	

Problem:	Acute asthma (SCT 304527002)	Date/Time Entered: 31 Jan 2014 @ 1200
Provider:	WALLISCH,JOAN M	
Location:	Pittsburgh Health Care System	
Status:	ACTIVE	
Comments:	patient report, ends up in ER if doesnt take Advair	

Problem:	Anxiety (SCT 48694002)	Date/Time Entered: 31 Jan 2014 @ 1200
Provider:	WALLISCH,JOAN M	
Location:	Pittsburgh Health Care System	

Status:	ACTIVE
Comments:	patient report

Problem:	Atonic seizure (SCT 42365007)	**Date/Time Entered: 31 Jan 2014 @ 1200**
Provider:	WALLISCH,JOAN M	
Location:	Pittsburgh Health Care System	
Status:	ACTIVE	
Comments:	patient report	

Problem:	Bipolar disorder (SCT 13746004)	**Date/Time Entered: 31 Jan 2014 @ 1200**
Provider:	WALLISCH,JOAN M	
Location:	Pittsburgh Health Care System	
Status:	ACTIVE	
Comments:	patient report	

Problem:	Gender identity disorder (SCT 87991007)	**Date/Time Entered: 31 Jan 2014 @ 1200**
Provider:	WALLISCH,JOAN M	
Location:	Pittsburgh Health Care System	
Status:	ACTIVE	
Comments:	patient report	

Problem:	Panic attack (SCT 225624000)	**Date/Time Entered: 31 Jan 2014 @ 1200**
Provider:	WALLISCH,JOAN M	
Location:	Pittsburgh Health Care System	
Status:	ACTIVE	
Comments:	patient report	

Problem:	Posttraumatic stress disorder (SCT 47505003)	**Date/Time Entered: 31 Jan 2014 @ 1200**
Provider:	WALLISCH,JOAN M	
Location:	Pittsburgh Health Care System	
Status:	ACTIVE	
Comments:	PATIENT REPORT	

Problem:	Severe depression (SCT 310497006)	**Date/Time Entered: 31 Jan 2014 @ 1200**
Provider:	WALLISCH,JOAN M	

Location:	Pittsburgh Health Care System
Status:	ACTIVE
Comments:	patient report

Problem:	chronic sinus disease (ICD-9-CM 799.9)	**Date/Time Entered: 31 Jan 2014 @ 1200**
Provider:	WALLISCH,JOAN M	
Location:	Pittsburgh Health Care System	
Status:	ACTIVE	
Comments:	patient report	

DATE OF NOTE: JAN 26, 2015@11:08 ENTRY DATE: JAN 26, 2015@11:08:56
AUTHOR: STRICKLAND,LESLIE E EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Informed Consent for Feminizing Hormone Therapy

Start date *****

This form refers to the use of estrogen, progesterone, and/or androgen antagonists (sometimes called "anti-androgens" or "androgen blockers") by persons born as genetic males who wish to become feminized to reduce gender dysphoria and facilitate a more feminine gender presentation. While there are risks associated with taking feminizing medications, when appropriately prescribed they can greatly improve mental health and quality of life. You are asked to initial the statements on this form to show that you understand the benefits, risks and changes that may occur from taking feminizing medication. If you have any questions or concerns about the information below, please talk with the people involved in your care so you can make fully informed decisions about your treatment. It is your right to seek another opinion if you want additional perspective on any aspect of your care.
Please initial and date each statement.

A. General Standards of Care
1. This clinic ascribes to the Standards of Care (SOC) promulgated by the World Professional Association for Transgender Health (WPATH, formerly known as the Harry Benjamin International Gender Dysphoria Association (HBIGDA)). The Standards of Care are an evolving set of guidelines representing an international consensus on best practices relating to eligibility, readiness, and appropriateness of hormones and surgery for people seeking gender transition.
Appropriateness is the determination that hormones and/or surgery are an appropriate treatment for a patient with gender concerns.
Eligibility refers to the minimum criteria that anyone seeking to transition must meet.
Readiness relates to a person being mentally ready for a particular type of treatment. [Note: the HBIGDA standards explicitly state that mental illness does not necessarily mean a patient is not ready for hormones or surgery. Readiness does not mean an absence of any mental health concerns, but rather a confidence that there is sufficient stability to both make an informed decision and also withstand the stresses of hormones/surgery.]

2. I understand that I must seek a referral to this clinic from a mental health care provider knowledgeable in gender dysphoria (unless this has already been done or continuing treatment that has already been initiated), certifying that I have been evaluated for other mental conditions that may

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Notary Public – State of Florida
Commission # GG 134903
My Comm. Expires Aug 15, 2021

This is Exhibit "C" referred to in the Affidavit of Jamie Shupe Sworne before me this 25th day of June 209.

affect my hormonal treatments.

3. I understand that I may desire to take hormones or seek various surgical procedures (e.g. castration) as part of my process of feminization and that these decisions may affect the type and dosage of other medications for other medical or mental conditions (such as high blood pressure or depression). I will inform my health care provider of any such surgeries.

4.I understand that it is strongly recommended that I participate in social or therapeutic groups of other people in various stages of gender transition for support. There are many such groups in Portland and can be found

at http://www.resourcespdx.org/non-medical/support-groups/

B.Feminizing Effects
1. I understand that estrogen, progesterone, androgen antagonists, or a combination of these may be prescribed to reduce male physical features and

feminize my body.

2. I understand that the feminizing effects of estrogen, progesterone, and androgen antagonists can take several months or longer to become noticeable, and that the rate and degree of change can't be predicted.

3. I understand that if I am taking estrogen I will probably develop enlarged breasts, and:
Breasts may take several years to develop to their full size.
Even if estrogen is stopped, the breast tissue that has developed will remain.As soon as breasts start growing, it is recommended to start doing monthly self-exams and to have an annual breast exam by a knowledgeable health care provider.There may be milk nipple discharge (galactorrhea). This can be caused
by taking estrogen or by an underlying medical condition. It is advised to check with a health care provider to determine the cause.
Estrogen may increase the risk of breast cancer in certain people, and may have an effect on the development of prostate or testicular cancers. I must

conduct regular Breast Self Examinations (BSE) as a screening for breast cancer,

and have regular prostate exams if indicated.

4.I understand that the following changes are generally not permanent (that is, they will likely reverse if I stop taking femininizing medications):
Skin may become softer.
Muscle mass decreases and there may be a decrease in upper body strength.
Body hair growth may become less noticeable and grow more slowly, but it will likely not stop completely even after years on medication.
Male pattern baldness may slow down, but will probably not stop completely, and hair that has already been lost will likely not grow back.

Fat may redistribute to a more feminine pattern (decreased in abdomen, increased on buttocks/hips/thighs - changing from "apple shape" to "pear shape").

5. I understand that taking feminizing medications will make my testicles produce less testosterone, which can affect my overall sexual function:
Sperm may not mature, leading to reduced fertility. The ability to make sperm normally may or may not come back even after stopping taking feminizing medication. The options for sperm banking (http://www.ubcivf.com) have been explained to me. I understand that I may still be able to make someone pregnant and am aware of birth control options (if applicable).
Testicles may shrink by 25-50%. Regular Testicular Self Examinations (TSE) are still recommended as a screening for testicular cancer.
The amount of fluid ejaculated may be reduced.
There is typically decrease in morning and spontaneous erections.
Erections may not be firm enough for penetrative sex.
Libido (sex drive) may decrease.

6. I understand that there are some aspects of my body that are not significantly changed by feminizing medications:
Beard/mustache hair may grow more slowly and be less noticeable, but will not go away. I may need to consider electrolysis or similar therapy to reduce unwanted hair.Voice pitch will not rise and speech patterns will not become more feminine. I may need to pursue speech/voice therapy to sound more feminine.
The laryngeal prominence ("Adam's apple") will not shrink.
Although feminizing medication does not change these features, there are other treatments that may be helpful. If there are any concerns about these issues, referrals can be provided to help explore treatment options.

C. Risks of Feminizing Medications
1. I understand that the medical effects and safety of feminizing medications are not fully understood, and that there may be long-term risks that are not yet known.

2. I understand that I am strongly advised not to take more medication than I am prescribed, as this increases health risks. I have been informed that taking more than I am prescribed will not make feminization happen more quickly or increase the degree of change: extra estrogen can be converted to testosterone, which may slow or stop feminization; other complications or side effects may develop.

3. I understand that feminizing medications can damage the liver, possibly leading to liver disease. I have bee
n advised that I should be

monitored for possible liver damage as long as I am taking feminizing medications.

4. I understand that feminizing medications will result in changes that will be noticeable by other people, and that some transgender people in similar circumstances have experienced harassment, discrimination and violence, while others have lost support of loved ones. I have been advised that referrals can be made for support/counseling if I feel this would be helpful.

D. Medical Risks Associated with Estrogen
1. I understand that taking estrogen increases the risk of blood clots, which can result in:
Pulmonary embolism (blood clot to the lungs), which may cause permanent lung damage or death.
Stroke, which may cause paralysis, permanent brain damage or death
Heart attack
Chronic leg vein problems

2.I understand that the risk of blood clots is much worse if I smoke cigarettes, especially if I am over 40. I understand that the danger is so high that I have been advised that I should stop smoking completely if I start taking estrogen. I am aware that I can ask my health care provider for advice about options to stop smoking.

3. I understand that taking estrogen can increase deposits of fat around my internal organs, which is associated with increased risk diabetes and heart disease.

4.I understand that taking estrogen can cause increased blood pressure. I have been advised that if I develop high blood pressure, my health care provider will work with me to try to control it by diet, lifestyle changes,

and/or medication.

5. I have been informed that taking estrogen increases the risk of gallstones. I understand that if I have abdominal pain that is severe or prolonged, it is recommended that I discuss this with my health care provider.

6. I have been informed that estrogen can cause nausea and vomiting, similar to morning sickness in pregnant women. I understand if nausea/vomiting are severe or prolonged, it is recommended that I discuss this with my health care provider.

7.I have been informed that estrogen can cause headaches or migraines. I understand that if I am frequently having headaches or migraines, or the pain is unusually severe, it is recommended that I talk with my health care provider.

8.I understand that it is not known if taking estrogen increases the risk of non-cancerous tumors of the pituitary gland (prolactinoma). I have been informed that although prolactinoma is typically not life-threatening, it can damage vision and cause headaches. I understand that this will be monitored

for at least three years when I start taking estrogen.

9. I have been informed that I am more likely to have dangerous side effects from estrogen if I smoke, am overweight, am over 40 years old, or have a history of blood clots, high blood pressure, or a family history of breast cancer.

10. I have been informed that if I take too much estrogen, my body may convert it to testosterone, which may slow or stop feminization.

E.Risks Associated with Androgen Antagonists
1. I have been informed that spironolactone affects the balance of water and salts in the kidneys, and that this may:
Increase the amount of urine produced, making it necessary to urinate more frequently
Reduce blood pressure, Increase thirst
Rarely, cause high levels of potassium in the blood, which can cause changes to heart rhythm that may be life-threatening

2.I understand that some androgen antagonists make it more difficult to evaluate the results of PSA (prostate-specific antigen) test, which can make it more difficult to monitor prostate problems. I have been informed that if I am over 50, I should have my prostate evaluated every year.

F. Prevention of Medical Complications
1. I agree to take feminizing medications as prescribed and to tell my health care provider if I am not happy with the treatment or am experiencing any problems.

2. I understand the right dose or type of medication prescribed for me may not be the same as for someone else.

3. I understand that physical examinations and blood tests are needed on a regular basis every 6-12 months to check for negative side effects of feminizing medications.

4. I understand that feminization medications can interact with other medications (including other sources of hormones), dietary supplements, herbs, alcohol, and street drugs. I understand that being honest with my health

care provider about what else I am taking will help prevent medical complications that could be life-threatening. I have been informed that I will continue to get medical care no matter what information I share.

5. I understand that some medical conditions make it dangerous to take estrogen, progesterone, or androgen antagonists. I agree that if my health

care provider suspects I may have one of these conditions, I will be checked for

it before the decision to start or continue feminizing medication is made.

6. I understand that any surgery I undertake (such as castration) will affect the medications that I am taking.

7. I understand that I can choose to stop taking feminizing medication at any time, and that it is advised that I do this with the help of my health care provider to make sure there are no negative reactions to stopping. I understand that my health care provider may suggest I reduce or stop taking feminizing medication, or switch to another type of feminizing medication, if there are severe side effects or health risks that can't be controlled.

My signature below confirms that:
My health care provider has talked with me about the benefits and risks of feminizing medication, the possible or likely consequences of hormone therapy, and potential alternative treatment options.
I understand the risks that may be involved.
I understand that this form covers known effects and risks and that there may be long-term effects or risks that are not yet known.
I have had sufficient opportunity to discuss treatment options with my health care provider. All of my questions have been answered to my satisfaction.
I believe I have adequate knowledge on which to base informed consent to the provision of feminizing medication.

Based on this:
___I wish to begin taking estrogen and/or progesterone.
___I whish to being taking antiandrogen medication (spironolactone)
___I do not wish to begin estrogen therapy at this time.
___I do not wish to begin anti estrogen therapy at this time.

Whatever your current decision is, please talk with your health care provider any time you have questions, concerns, or want to re-evaluate your options.

Patient Signature
Date

Prescribing Clinician Signature
Date
Leslie Strickland MD

Informed consent signed and dated by Veteran, copy will be sent to Veteran and copy scanned into record.

/es/ Leslie E. STRICKLAND

Signed: 01/26/2015 11:11

Metro Family Practice, Inc.

901-B West Street, Pittsburgh, PA 15221 • 412-247-2310 • FAX: 412-247-2373

March 19, 2014

Re: Jamie Shupe
3314 Riverfront Dr
Pittsburgh, PA 15238
SSN: [redacted]

To Whom it May Concern:

I,Allison Aiken MD (MD#432892) licensed in the State of Pennsylvania (DEA # FA0607448), am the attending physician of Jamie Shupe , with whom I have a doctor/patient relationship. I am a board certified Family Physician. Jamie has had appropriate clinical treatment for gender transition to female.

I declare under penalty of perjury under the laws of the United States that the forgoing is true and correct.

Sincerely,

Allison Aiken MD

ESMIRNA L CARABALLO
Notary Public – State of Florida
Commission # GG 134903
My Comm. Expires Aug 15, 2021

This is Exibit "D" referred to in the Affidavit of Jamie Shupe sworne before me this 25th day of June 2019.

OHSU
Oregon Health & Science University

Family Medicine at Scappoose
Mail code SCP • 51377 Old Portland Rd • Scappoose, Oregon 97056
TEL: 503 418-4222 • FAX: 503 418-4223

5/2/2016

Re: Jamie Shupe
DOB: 8/10/1963

To Whom It May Concern,

This letter is in support of Jamie Shupe. As Jamie's primary care physician, Jamie's gender should be declared as "non-binary," reflecting the association with both genders and not as female or male. This stems from sex assigned at birth and self-gender identity, which should not be forced into the binary system when not appropriate. I have known Jamie for 1.5 years and believe this is an accurate and medically appropriate assessment and designation. I am very familiar with many people who identify as non-binary and this should be reflected in Jamie's legal documents

Please feel free to contact me with any further questions,

Rebecca Cantone, MD
OR License MD166938
OHSU SCAPPOOSE
Family Medicine
51377 Old Portland Road
Scappoose OR 97056-4023
(p) 503-418-4222
(f) 503-418-4223

This is Exibit "E" referred to in the Affidavit of Jamie Shupe Sworne before me the 25th day of June 2019.

DEPARTMENT OF VETERANS AFFAIRS
Medical Center
3710 Southwest US Veterans Hospital Road
Portland OR 97239-2964

Re: Jamie Shupe
DOB: 8/10/1963

To Whom It May Concern,
I have been providing care to my patient named above since January 2015. Jamie's gender identity and expression does not fit the current simplistic binary model of male or female. Therefore, I support Jamie in deciding for themselves what gender identity most closely reflects their reality, in Jamie's case "non binary" is suitable as Jamie neither identifies as completely male or completely female. To force Jaime into identifying as male or female soley is not only limiting and inaccurate but is also detrimental to Jamie's self expression and pursuit of happiness which is a basic human and constitutional right.

Thank you for your consideration.

Sincerely,
Leslie Strickland MD
Portland VA Medical Center

MD 29322

Patient Requesting

Md's Signature.

License #

FORM 4

FILED

16 JUN 10 AM 11:18

4TH JUDICIAL DISTRICT

IN THE CIRCUIT COURT OF THE STATE OF OREGON

FOR THE COUNTY OF MULTNOMAH

Probate Department

IN THE MATTER OF THE SEX CHANGE of JAMIE SHUPE, Petitioner	Case No.: 16CV13991 **GENERAL JUDGMENT OF SEX CHANGE**

Based on the Petition, and the court finding that proper notice to interested parties has been given; that the above-named person has undergone surgical, hormonal, or other treatment appropriate for this person for the purpose of gender transition; that sexual reassignment has been completed; and that no person has shown cause why the requested General Judgment should not be granted,

IT IS HEREBY ORDERED AND ADJUDGED:

The sex of Jamie Shupe is hereby changed from female to non-binary. Notice of this legal change shall be posted in a public place in Multnomah County as required by law.

6/10/16

Amy Holmes Hehn

AMY HOLMES HEHN
CIRCUIT COURT JUDGE

CIRCUIT COURT STATE OF OREGON MULTNOMAH COUNTY

CERTIFIED TO BE A TRUE COPY OF THE ORIGINAL.

DATED JUN 10 2016

Karen Hall
Clerk of the Court

ESMIRNA L CARABALLO
Notary Public – State of Florida
Commission # GG 134903
My Comm. Expires Aug 15, 2021

LAW WORKS LLC
1906 SW Madison Street, Suite 201
Portland, OR 97205
T(503) 227.1928 . F (503) 334.2340

This is Exibit "F" referred to in the Affidavit of Jamie Shupe sworn before me this 25th day of June 209

VA Radiology Reports

Source:	VA
Last Updated:	18 Oct 2018 @ 1025
Sorted By:	Date/Time Exam Performed (Descending)

VA Radiology Reports are available 3 calendar days after they have been completed. Some studies done at a non-VA facility may not be available or they may not necessarily include an interpretation. If you have any questions about your information please visit the FAQs or contact the provider who ordered the study or your primary care provider.

Procedure/Test Name:	GNV-DXA SCAN (HIP/SPINE) INCLUDES VERT FX ASSESSMENT
Date/Time Exam Performed:	27 Sep 2018 @ 1027
Ordering Location:	N. FLORIDA/S. GEORGIA VHS
Requesting Provider:	GARCIA,TERESA
Reason for Study:	transgender , on hormones
Performing Location:	N. FLORIDA/S. GEORGIA VHS 1601 S.W. ARCHER ROAD, GAINESVILLE 32608-1197
Clinical History:	
Radiologist:	DURST,GREGORY ROBERT

Report

Report:
Exam: DEXA with lateral thoracolumbar scan for vertebral fracture

History: Reason for Study: transgender , on hormones

Comparison: None

Bone densitometry: Dual energy x-ray absorptiometry of the spine and left hip were obtained. The L1-L4 region has a value of 0.966 grams per square centimeter which correlates to a T score of 0.7 standard deviations below the mean and Z score of 0.3 standard deviations above the mean.

The femoral neck has a value of 0.714 grams per square centimeter which is a T score of 1.2 standard deviations below the mean and a Z score of 0.2 standard deviations below the mean. This is abnormally low and is indicative of osteopenia.

The total hip has a value of 0.960 grams per square centimeter which is a T score of 0.1 standard deviations above the mean and a Z score of 1 8 standard deviations above the mean.

The lateral view of the thoracolumbar spine demonstrates no significant vertebral fractures.

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Notary Public – State of Florida
Commission # GG 134903
My Comm. Expires Aug 15, 2021

This is exibit "G" referred to in the Affidavit of Jamie Shupe sworne before me this 25th day of June 2019.

Impression:
Abnormal bone mineral density. Findings indicative of osteopenia.
No vertebral fractures.

According to the WHO absolute fracture risk model criteria:

FRAX Major fracture risk for this patient within the next 10 years is 9.8%. FRAX risk for hip fracture is 0.7%.

Primary Diagnostic Code: NO ALERT REQUIRED

Procedure/Test Name:	MAMMOGRAPHY, DIGITAL SCREENING
Date/Time Exam Performed:	27 Aug 2018 @ 1044
Ordering Location:	N. FLORIDA/S. GEORGIA VHS
Requesting Provider:	GARCIA,TERESA
Reason for Study:	Screening Mammogram
Performing Location:	N. FLORIDA/S. GEORGIA VHS 1601 S.W. ARCHER ROAD, GAINESVILLE 32608-1197
Clinical History:	
Radiologist:	RAMIREZ,HECTOR JR

Report

Report:
EXAM: MAMMOGRAPHY, DIGITAL SCREENING, TOMOSYNTHESIS DIGITAL SCREENING, BILATERAL

ACCESSION: 573-082718-1989, 573-082718-1991

EXAM DATE AND TIME: 8/27/2018 10:44 EDT

COMPARISON: Outside mammogram from 10/19/2017

HISTORY: 55 year old transgender, male to female. The patient has been on estrogen therapy for the past 4 years. Screening.

TISSUE DENSITY: There are scattered fibroglandular densities.

FINDINGS: Technique: Full field digital mammography with tomosynthesis and synthetic 2D was done on a Hologic Selenia Dimensions mammography system. The exam was interpreted with the

Journal of Traumatic Stress, Vol. 7, No. 4, 1994

The Psychological Impact of Sexual Abuse: Content Analysis of Interviews with Male Survivors

David Lisak[1]

Autobiographical interviews with 26 adult male survivors of childhood sexual abuse were audiotaped, transcribed verbatim and content analyzed to identify common psychological themes. Approximately equal numbers of men were abused by male and female perpetrators, almost half came from disrupted or violent homes and a majority had a history of substance abuse. Fifteen psychological themes were identified: Anger, Betrayal, Fear, Homosexuality Issues, Helplessness, Isolation and Alienation, Legitimacy, Loss, Masculinity Issues, Negative Childhood Peer Relations, Negative Schemas about People, Negative Schemas about the Self, Problems with Sexuality, Self Blame/Guilt and Shame/Humiliation. The themes are discussed and illustrated with examples drawn from the transcripts.

KEY WORDS: sexual abuse; male survivors; post-traumatic stress disorder.

INTRODUCTION

The increased awareness among mental health professionals of the sexual abuse of males has produced an emergent data base on both the prevalence and the long-term effects of this abuse. Prevalence estimates vary remarkably depending on the nature of the sample, the method of assessment, the types of questions used and the definition of abuse adopted by the investigator. Low-range estimates include: 3.0% (Kercher and McShane, 1984), 3.8% (Siegel *et al.*, 1987), 4.8% (Fritz *et al.*, 1981),

[1]Department of Psychology, University of Massachusetts at Boston, 100 Morrissey Boulevard, Boston, Massachusetts 02125-3393.

0894-9867/94/1000-0525$07.00/0

This is Exibit "H" referred to in the Affidavit of Jamie Shupe sworne before me this 25th day of June 2019.

6.0% (Finkelhor, 1984), 7.3% (Risin and Koss, 1987), 8.0% (Baker and Duncan, 1985) and 8.7% (Finkelhor, 1979). Higher-range estimates include: 11.0% (Murphy, 1987, cited in Urquiza and Keating, 1990), 16% (Finkelhor *et al.*, 1990), 17.3% (Urquiza, 1988, cited in Urquiza and Keating, 1990), 24% (Fromuth and Burkhart, 1987), and 34% (Lisak and Luster, 1994).

Reports on the long-term consequences of this abuse have come from two, somewhat distinct sources; either systematic investigations of symptom severity using standardized measures, or qualitative studies of more complex, psychological themes, usually based on individual or cumulative case studies. From the former group, it has been demonstrated that abused men tend to score significantly higher on measures of depression, anxiety, obsessive-compulsiveness, dissociation, hostility, low self-esteem, sleep disturbance, sexual dysfunction, impaired relationships and suicide attempts (Briere *et al.*, 1988; Fromuth and Burkhart, 1989; Hunter, 1991).

Qualitative investigations have identified a number of psychological themes which characterize the long term adaptation of men who were sexually abused as children. These include: *sexual problems, dysfunctions or compulsions* (Johnson and Shrier, 1987; Dimock, 1988; Lew, 1988; Myers, 1989; Hunter, 1990); *confusion and struggles over gender and sexual identity* (Nasjleti, 1980; Johnson and Shrier, 1987; Dimock, 1988; Lew, 1988; Myers, 1989; Gilgun and Reiser, 1990); *homophobia and confusion about sexual orientation* (Nasjleti, 1980; Lew, 1988; Myers, 1989; Gilgun and Reiser, 1990); *problems with intimacy* (Dimock, 1988; Lew, 1988; Krug, 1989; Hunter, 1990); *shame* (Nasjleti, 1980; Lew, 1988; Myers, 1989; Gilgun and Reiser, 1990; Hunter, 1990); *guilt and self-blame* (Lew, 1988; Myers, 1989; Hunter, 1990); *low self-esteem and negative self images* (Lew, 1988; Myers, 1989); and *anger* (Lew, 1988; Hunter, 1990). Other findings include: *substance abuse* (Krug, 1989); *a tendency to deny and de-legitimize the traumatic experience* (Nasjleti, 1980; Myers, 1989); *symptoms of Post Traumatic Stress Disorder* (Myers, 1989); *fear* (Lew, 1988; Hunter, 1990); and *depression* (Krug, 1989).

While these qualitative descriptions of the aftermath of abuse in men provide invaluable information, using single clinician's observations renders them open to the usual biases of such research. This study was intended to contribute to a cross-validation of previous qualitative findings. To this end, interviews with adult male survivors of childhood sexual abuse were content analyzed and coded by independent raters to derive a reliable set of psychological themes which together describe some of the legacy of abuse in men.

METHOD

Subjects

Subjects were 26 men, 23 students and three employees, at an urban, commuter university in New England. With a mean age of 33.7 years, and a range from 21 to 53, the sample was somewhat older than the campus mean of 27. The ethnic composition of the sample was less diverse than that of the university: One subject was African American, two were Native American, and the remaining 23 were European American. Seven of the subjects' mothers (26.9%) had less than a high school education, eight (30.8%) had completed high school, and 11 (42.3%) had college degrees. Among the fathers, 5 (19.2%) had less than a high school education, 9 (34.6%) had completed high school, and 12 (46.2%) had college degrees. Five of the men were raised at least partially by step-parents (three step-mothers and two step-fathers).

Procedures

Subjects were recruited via posters placed around the university which asked for volunteers to participate in an interview study concerning male sexual abuse. Examples of sexual abuse were described to help potential subjects identify themselves. Responses to the posters came from 29 men, 3 of whom decided not to participate after the initial informational phone conversation.

Each subject was given a written consent form to read before beginning the interview, and the consent issues were then explained by the interviewer. In addition to the usual issues of the subject's right to withdraw, etc., each subject was told what the limits of confidentiality were, i.e., under what circumstances the interviewer would be forced to break confidentiality either to inform appropriate social services or to warn an identified, intended victim. The interviews were described to subjects as "autobiographical," and began with the simple instruction that their entire life story was of interest and that they could begin at any point in their lives and proceed in any order or manner that felt comfortable. The interviews were audiotaped. Questions were asked only to clarify information or to inquire about prominent topics which had been left out of the subject's narrative. Following the interview, subjects completed questionnaires consisting of demographic information and the Symptom Check List (SCL-90R) (Derogatis, 1977).

Table I. Percentage Agreement Between Raters and Percentage of Subjects in Which the 15 Themes Appeared

Theme	% Agree Rater #1	% Agree Rater #2	No. and Percentage Appearing in Transcripts: Men Abused by Men $n = 9$	Men Abused by Women $n = 9$	Total $n = 20$[a]	Chi Squ[b]
Anger[a]	97.1	94.3	9 (100.0)	7 (77.8)	18 (90.0)	ns
Betrayal	78.1	75.8	4 (44.4)	4 (44.4)	10 (50.0)	ns
Fear[a]	97.1	98.2	9 (100.0)	9 (100.0)	20 (100.0)	ns
Homosexuality issues	96.8	96.8	7 (77.8)	1 (11.1)	10 (50.0)	$p < .01$
Helplessness[c]	80.5	82.9	7 (77.8)	5 (55.6)	14 (70.0)	ns
Isolation and Alienation[c]	91.5	84.7	8 (88.9)	7 (77.8)	17 (85.0)	ns
Legitimacy[c]	91.7	100.0	3 (33.3)	2 (22.2)	6 (30.0)	ns
Loss[c]	100.0	100.0	4 (44.4)	3 (33.3)	9 (45.0)	ns
Masculinity issues	83.9	93.8	8 (88.9)	6 (66.7)	15 (75.0)	ns
Negative childhood peer relations	92.6	95.7	2 (22.2)	5 (55.6)	9 (45.0)	ns
Negative schemas about people	88.2	89.8	7 (77.8)	5 (55.6)	14 (70.0)	ns
Negative schemas about the self	88.4	89.7	6 (66.7)	7 (77.8)	14 (70.0)	ns
Problems with sexuality	96.9	93.8	3 (33.3)	4 (44.4)	8 (40.0)	ns
Self-blame/guilt[c]	90.8	87.5	7 (77.8)	7 (77.8)	16 (80.0)	ns
Shame/humiliation[c]	93.7	90.5	3 (33.3)	8 (88.9)	13 (65.0)	$p < .05$

[a]Of the 20 men whose transcripts were content analyzed, two were abused by both a man and a woman.
[b]Fisher's Exact Test.
[c]Theme identical to one appearing in Lebowitz (1990).

Audiotapes of the interviews were transcribed verbatim. Six of the transcripts were selected at random to be used by a five-member team whose task was to identify the common, salient themes which appeared consistently. These themes were then compared to themes derived by Lebowitz (1990) in a content analysis of interviews with women survivors of rape. The two sets of themes were reconciled by adopting from Lebowitz the themes which were identical to those identified by this team and adding new themes, unique to men, derived from the six sample transcripts (see Table I for a list of the themes).

A coding manual was created consisting of detailed descriptions and examples of the 15 themes. The manual was used to train two coders who were naive to the study. These coders, working independently, read through the remaining 20 transcripts. There were 1004 codable passages which had been marked, and each coder identified the theme which they judged best described the marked passage. Reliability of the coding system was assessed by measuring the agreement between the ratings of the author and each independent coder. Cohen's Kappa, a measure of percent agreement which removes the effect of chance agreement, was .89 between the author and rater No. 1 and .91 between the author and rater No. 2. Table I presents the percent agreements between each coder and the author for each of the 15 themes, as well as the percentage of subjects in which each theme appeared.

RESULTS

Descriptive Information

All 26 subjects experienced contact sexual abuse. The mean reported age at the onset of the abuse was 7.6 years, with a range of four to 16. In 24 cases (92.3%) the abuse involved multiple incidents. The perpetrators of the abuse included seven mothers, one father, five siblings, three aunts, two uncles, one priest, one scout master, three neighbors and six strangers (the total exceeds 26 because several men were abused by more than one perpetrator). Fourteen men (53.8%) were abused by intrafamilial perpetrators and 12 (46.2%) by extrafamilial perpetrators. In 12 (46.2%) cases the perpetrator was a male, in 11 (42.3%) cases it was a female, and in three (11.5%) cases there were both male and female perpetrators.

The family environments in which the men were raised were often characterized by disruption and/or violence. Eleven (42.3%) of the 26 men came from families of divorce, separation or parental death. Twelve (46.2%) of the men were physically abused, and nine (34.6%) witnessed violence

between their parents. Half of the men had at least one alcoholic or drug abusing parent. Twenty-one of the 26 men (80.8%) had a history of substance abuse, 13 (50%) had actively thought about suicide, six (23%) had attempted suicide, and 18 (69.2%) had received psychological treatment.

Almost a third of the men (31%) had victimized others at some point in their lives. The types of victimization included sexual abuse of children; rape of adult women; battery of female intimate partners; and sadistic, physical assaults on adult men.

Quantitative Measure of Symptoms

Completed SCL-90R forms were available from 22 of the 26 men. The mean Global Severity Index (GSI) score for the abused men was 1.43 (standard deviation of 0.75) compared to a mean GSI score for non-patients in the SCL-90R normative sample (Derogatis, 1977) of 0.31 (standard deviation of 0.68). The mean score on the SCL-90R PTSD subscale (Saunders *et al.*, 1990) was 1.48 (standard deviation of 0.85) compared to a mean of 0.39 (standard deviation of 0.41) for the non-PTSD sample reported in Saunders *et al.*, (1990).

Chi square analyses were performed on the frequency with which each of the 15 themes appeared in the transcripts of female-abused vs. male-abused subjects (see Table I). There were only two significant differences: Homosexuality Issues appeared more frequently in the transcripts of male-abused subjects, and Shame/Humiliation appeared more frequently in the transcripts of female-abused subjects.

Thematic Analysis of the Interviews

What follows are descriptions of the 15 coded themes, with verbatim examples extracted from the transcripts.

Anger

Anger emerged in the men's autobiographies in many different forms. They talked about the experience of feeling overwhelmed with rage, of being afraid of their anger, of suppressing it, and of discovering its existence. In the following example a subject describes the anger he uncovered when, years after being abused, he wrote a letter to his abuser:

> *S*: It was the first time in my life that I felt anger. Like I could take the friggin' wall apart, a brick at a time. I could pick up the world and throw it. I used to tell

people I feel like, like my anger is like a raging fire, it's like molten, burning just like it won't go out.

Many of the men, having discovered the well of anger within them, described the discovery as unsettling. For some it seemed to conflict with their view of themselves, to make them see themselves in a less favorable light. Others expressed their fear of their violent fantasies or of losing control of their anger:

S: If they knew what I thought, they wouldn't let me in society. No way. There's an incredible amount of violence and stuff that runs through my mind. And I'm real scared of it.

The fear of this anger, or confusion about how and when to express it appropriately, caused some men to actively suppress it. However, control and suspression of anger does not always work, and some of the men described what several of them termed "snapping." One subject described a confrontation with an abusive father:

S: And I looked at him and I was enraged. He didn't even say that much. But I just looked at him and I said shut the fuck up. I can't see the sides. My peripheral vision is gone when I get into a rage. And I'm like I've got to be careful here. Because I thought I was going to take him and kill him.

For some of the men, the "snapping" resulted in the perpetration of considerable violence, as described in the following quotations:

S: One evening I strangled her, I was choking her. I never really felt that anger before. And it was not just television sitcom choking. I was feeling for her larynx with my thumbs. I had tunnel vision. It was frightening.
S: And I started beating him up. And I clearly won. What I did was I took his face and shoved it into the bicycle spokes, and then I stamped my foot into the back of his head in there. And it cut his face.

Finally, some men expressed anger at a world which they perceived to have turned its back on them as male victims:

S: For women, you just call your local 800 rape line and you've got everything from a place to stay, food, money. They take care of your bills and your kids and everything else. I can call up and plead all I want, I can't get a cup of coffee. And that is like one of the biggest, most frustrating things in the world for me.

Betrayal

The essence of this theme is a subject's sense of having had their trust or faith in someone violated by that person, either directly or by the person's perceived actions or thoughts or feelings. Subjects rarely used the word "betrayed." Rather they expressed, often subtly, a hurt feeling resulting from their disappointment in another's behavior, or a violation of their expectations, or frequently, a feeling of having been abandoned by the

other person. Most frequently, men expressed these feelings toward a parent, and most often because the parent failed to protect them from the abuse. One man described one of several attempts to signal his father that he was being abused by a neighbor:

> *S*: And I remember going to my dad and telling him...It was my way of telling him, just like, "I can't go over to the D's anymore." I didn't directly say this is what he's doing because I didn't know what he was doing. But I remember nothing happened. And I was raped about an hour later. And that's when I just knew nothing was safe.

A similar recollection was described by another man:

> *S*: And I'd go to my mother, even when she wasn't drunk, to plead for some protection. And never got it. She didn't see it. She just ignored it.

Some men explicitly told a parent what was happening to them and were still rebuffed and offered no protection:

> *S*: And her response to me when I told her that he used to make me suck his cock was "how dare you make up something so horrible about another human being, how dare you!"

Fear

Fear was the most frequently coded theme, with fully one sixth of the 1004 codable passages falling into this category. Men described fear pervading their lives, during the abuse, in the childhood aftermath of the abuse, and throughout the rest of their lives into adulthood. They described fear which could be a dull, ever present reality, or a dizzying experience of abject terror. And they described the effects of the fear, alienating them, confining them, and undermining their self confidence. Some descriptions of fear experienced during the actual abuse included:

> *S*: My hands were sweating, my knees were shaking. I mean I'm shaking now just remembering how scared I was that night.
> *S*: I can remember waking up one night with him, having me in a bear hug, and being scared shitless.

Perhaps the most common experience of fear described by the men was of fear associated with intrusions. The intrusions might be images of events which then evoked fear reactions, or they might be purely affective intrusions — unbidden and sudden experiences of raw fear or panic:

> *S*: I remember the first night I spent in there I screamed just to get out of there. Because that's where I had been molested. Though I didn't know that's why I was screaming. I was just terrified of that room.

For some, the fear became so pervasive that they were paralyzed and terrorized by their fear of the fear, and by the disorientation caused by the fear:

S: I started having panic attacks and I was afraid to have anybody in the house and I was afraid to go out and socialize with peope.
S: And I was afraid I was going insane.
S: I would visualize Jesus, because I was so fucking scared, I mean I was just constantly scared. To even sit down and be alone in my room and have my body be floating around me, imagining that, it was terrifying. It was the most terrifying experience that ever happened.

Some men recalled a specific fear which gripped them in the aftermath of the abuse, the fear that they would be "discovered," that the secret they harbored would be revealed:

S: And I would be petrified, utterly petrified that somebody might find out about me.

Helplessness

One of the most crucial aspects of the experience of abuse is a fundamental loss of control: over one's physical being, one's sense of self, one's sense of agency and self-efficacy, and one's fate. The profound helplessness inherent in this loss of control was one of the most deeply felt, yet also difficult to articulate aspects of the abuse experience for these men. This difficulty in expressing helplessness may have stemmed, in part, from the conflict between helplessness and a person's basic sense of self. Men talked directly about feeling helpless, or gave detailed descriptions of incidents in which they were helpless, or related dreams which expressed helplessness:

S: It's like my reoccurring dreams, like I can't run. I always have dreams of the same thing. If I'm running, I can't move my legs and my arms. And somebody is coming down on top of me, and I can't get up. And I'll wake up and I'll jump out of my bed.
S: The world was evil, it's coming to get you, and you could do almost nothing to defend from it.
S: I didn't realize how much of a little boy I was compared to this size. He was a grown man. It was just that kind of feeling that I had living there of like helplessness.
S: I just had to put up with it. That's the way she was. They were her rules. If she said I have to kiss her, I have to kiss her. If she says I have to hug her, I have to hug her. It was like I kept trying to fill her cup and it just kept running out. And she's standing there screaming "fill it, fill it, fill it!"

For many men, the helplessness they experienced during the abuse seemed to generalize to other domains of their lives. Most commonly, particularly for men who were abused by adult women, the helplessness characterized their sexual encounters with women:

S: The defeat that I felt with my mother comes back often. I find it in my sexual relationships. A lot of times I'll allow people to be invasive because I'm used to it. And I've had a hard time setting up boundaries. I've had a hard time believing that my boundaries were worthwhile, that they were worth keeping. I guess I often felt like I was the property of somebody else. And that anybody could just do whatever they wanted. And that I didn't have a right to have feelings about it.
S: All the scenes in college where the girls would seduce me, and I'd just kind of let them do whatever they want to do. Or I would do for them whatever they wanted me to do. And then just get out.

Another common expression of helplessness emerged in men's need for control, in their descriptions of the emotional consequences of feeling out of control, in the ways they compensated for the underlying feeling of helplessness:

S: I'm not going to be that vulnerable. And I know that's all part of the control thing I have.

S: And sometimes if I lose the slightest control, I think I'm going to die inside, I really do. I feel like I'm going to lose it, I'm going to die.

For a minority of the men, the need to feel in control drove them to victimize other people:

S: The joy of seeing other people hurt, maybe not hurt... I guess it's hard to describe. Feeling that I was in control of dominating somebody. I had control over them, and they were below me.
S: So I always felt somewhat powerless in sex for awhile, except with the younger kids, where I felt in control.

Homosexuality Issues

Many investigators have noted the pervasive concerns among sexually abused men about their sexual orientation (e.g., Myers, 1989; Nasjleti, 1980). These concerns were evident in this sample, but they were primarily voiced by men who were abused by men (see Table I). Most often the men expressed confusion over their sexuality and sexual orientation:

S: And a lot of it for me was being okay with my own sexuality—was it a gay thing or wasn't it.
S: Sometimes I wonder because of it, until I really got into therapy and things, if, you know, if it was me. Maybe I was bisexual or things like that.

Many of the men expressed a fear of homosexuals and homosexuality, a fear that was traceable to their fear that they themselves were, or had the potential to be, homosexual:

S: And it's like am I gay? And then the homophobia comes in, being afraid of gay people. And I'm like paranoid to death because maybe inside I am.
S: I have a lot of like internalized homophobia. And I don't know what my sexuality is. Like I don't know if I'm bi, or if I'm gay.

For other men, the conflict over sexual orientation was expressed overtly in hostility toward homosexuals. For several men, the hostility was obsessive, suggesting its roots in a powerful, unconscious conflict:

S: If I get in a crowd, and I think a person is of questionable character towards the offensive-gay type, ah, that I will defend myself and ah, I would not think twice of doing violence to that person or anyone else associated with him that tried to do the same thing to me again.
S: And everybody that I do meet, I look at, you know, are you straight, are you gay, or what? That's about the first thing I want to know.

Isolation and Alienation

One of the most destructive legacies of childhood abuse is the stigma which attaches itself to the child, separating him from his peers, robbing him of his sense of belongingness, and seeding the potential for a lifelong struggle with alienation from other people. This sense of differentness, almost always linked to a deeply ingrained feeling of inferiority, interferes with the survivor's ability to seek and accept intimacy with others, sometimes resulting in a history of problematic relationships and chronic isolation (e.g., Lew, 1988; Lisak and Luster, 1994; Urquiza and Capra, 1990):

S: But we had talked about intimacy and pain. And how I equate intimacy with pain. The people that I was intimate with from childhood, I went through incredibly painful experiences. Who would want to get intimate with someone... Basically if you get that intimate someone could kill you, if you make one false move.
S: Nobody cares, nobody loves me. And no matter how much people tried to care and love me, I always said nobody did, because I couldn't feel it.

For many of the men, the stigma of abuse was then exacerbated by the alienation which stemmed from having to keep the abuse a secret. The secret wedged between them and any form of support or validation, breeding more and more isolation:

S: I didn't have anybody to talk to. There was nobody I could confide in. Or nobody I thought I could confide in. Nobody I thought would be able to understand or do any good. And I thought just to reveal this secret to anybody would just kill me.
S: During that period of time I think I was out of contact with my friends. And I felt like I couldn't talk to them because I felt like everybody knew what was going on. And I don't think any of them knew where I was living. I kept that a secret. Imagine that, some of your best friends didn't know where you are living.

The men described a sequence, from the abuse to the internalization of the stigma, to the alienation from their peers, that became unbridgeable:

S: I didn't feel like everyone else. I felt different. I was different. I was different because I had done this weird thing with this man, and I don't know what that's about but I did it. And definitely no ordinary person would do that.
S: I remember clearly being on the playground and just not fitting in. I've heard a lot of people talk about being on the outside looking in. That was me.

For some of the men, that profound sense of alienation endured, leading to lives spent with few friends and few meaningful relationships:

> *S*: I was alone. I was drifting. I would go from one social group to another, and just never stay anywhere enough time to develop any kind of deep relationship with any one. I felt very isolated and alone.

Legitimacy

Like many survivors of childhood abuse, many of the men struggled to acknowledge to themselves that they were in fact abused, and that the abuse had greatly affected them. And like many other survivors, the struggle centered on a crucial point: Either they were abused and the abuse is responsible for the distress they had been experiencing, or, they are fabricating or exaggerating the abuse to mask inherent deficiencies in themselves which are responsible for their difficulties:

> *S*: I feel like I'm just defective and a depressed person and that's why I feel this way.
> *S*: This is the voice that goes on in my head. It makes me think I made it up. And it's subtle, because I know that I didn't make up the abuse. I think I'm making up the memory. I know that happened, but I think I'm making a mountain out of a mole hill, is what I tell myself.

But there was a second obstacle to legitimizing their experience which many of the men voiced: Nobody, including they themselves, sees men as victims, so how could they take seriously what had happened to them?

> *S*: It's like, men aren't abused? You know, who ever heard of that? Who talks about that? If men aren't abused how could I have been abused?
> *S*: But as a man, in that same respect I feel like this is typical of my life, there are all these women's organizations that are starting, they're becoming very conscious of not treating women as victims, not having violence towards women. But women have been victims and now they're reasserting themselves and women are physically different from guys. So they can see themselves as victims. Maybe they can see themselves that victims are okay, they're good somehow, they martyred themselves. Some way if you can have a black and white, good or evil, women were good and men were bad, well, I'm the victim and I'm a guy, but guys are bad. So I can't even be a victim, right?

Loss

The experience of childhood abuse often became associated with loss, although fewer than half of the men were able or willing to articulate the connection. Those who did mourned the loss of their childhoods and the loss of their innocence. Some regretted the loss of whole chapters of their lives, buried with still-repressed memories of parts of their abuse:

S: It's like where is my childhood? It feels like somebody put it in a box somewhere and I'm not allowed to look at it. Like it's locked up. And going through recovery is like trying to get somebody to open that key for me. It's like I want my box, I know I got one. And who took it and who had the right to steal it from me?
S: Because I have a lot of lost history. And that lost history, I may never get back.

Masculinity Issues

Numerous clinicians and researchers have argued that to be victimized, to be the helpless object of another person's sexual gratification, is an experience that violates male gender norms (e.g., Dimock, 1988; Lew, 1988; Nasjleti, 1980). Men who have been victimized must struggle to reconcile this conflict, and it is a struggle which often endures lifelong, and which shapes much of their post abuse adaptation. Their descriptions of this struggle suggest that male gender norms inhibit the internal psychological processes necessary for healing from abuse. The norms dictate that "appropriately masculine" men do not acknowledge and certainly do not express their own pain, vulnerability or feelings of helplessness. Of the many affective sequelae of abuse, only anger fits well within the norms.

Thus, among the men interviewed for this study, there were two, divergent, clearly defined paths taken in the aftermath of their sexual victimization. One group of men could not or would not deny the victimization. They struggled with the "unmasculine" feelings which overwhelmed them, and the struggle left most of them convinced that they were inadequate men because real men would not have those feelings. The second group of men, a small minority in this sample, largely succeeded in denying the feelings associated with their victimization. To reinforce this denial, they took on hypermasculine attributes and dispositions and were much more expressive of their rage. Most of the men oscillated between the two paths. They were continually buffeted by deeply ingrained feelings of masculine inadequacy which they often countered with gestures toward hypermasculinity: masculine styles of dress, masculine hobbies, etc.

The feelings of masculine inadequacy described by the men emerged long before puberty. Many men described a profound sense of inferiority, of being alienated from their male peers, already well established during their early years in school:

S: And I remember watching the boys play basketball and I wanted to do that, but I wouldn't dare ask them or mess with them.
S: Like I was not well versed in all the cool sayings. I still don't know exactly what the guys say and all.
S: I always felt I was faking it...compared to the boys who...grew up with a real life and real family and that kind of thing, and had lots of support in their lives.

These feelings of inadequacy persisted into adulthood, undermining their self esteem and self worth:

> *S*: Feeling like a man, an adult, that passage of adulthood and feeling significant and important, it was just not attainable for me.
> *S*: I never hung out with the guys. I didn't have a girlfriend that often. I didn't get to do things a lot of the other guys did...When you're the brunt of people's jokes, people make fun of you, you're not as tough as the other guys are...I always backed down.
> *S*: I worried a lot about the size of my manhood or whatever, the size of my penis. I did. I was always comparing. I'd ask my girlfriends. And then I felt like I was going to die when they told me no, you're not the biggest man I've been with. You felt like a piece of dog shit.

A few men were able to articulate some of the ways in which their need to be masculine, to be tough, conflicted with their experience of themselves, and their perception of the legacy of the abuse they carried within them.

> *S*: I think what was harmful about the abuse was a number of things. One was that first of all I was like a tough from the projects. You got to be a man, you got to like football, and yet I had no control.
> *S*: It embarrasses me to see somebody sad. If I had to guess, it probably has to do with male programming. That you're not supposed to be sad and you're not supposed to cry.

One man described how the abuse made him fear violence, his use of the words "wimp" and "pussy" indicating what this fear of violence had done to his feelings about his own maleness:

> *S*: I hate violence. I was always the wimp or the pussy to back down in school. I always shied away from violence. I even get nervous if people are yelling. Like somebody being mad at me for whatever reason. It's all interrelated.

Some of the men who were abused by men contended with another complication in their feelings about being male: the contamination of their own sexuality by that of the abuser, the sense that male sexuality, their own now included, is dangerous and bad. This contamination is greatly exacerbated by what men perceive to be cultural messages about male sexuality. One man explained it this way:

> *S*: And I feel like yea, I really have a hard time sometimes seeing myself as a male. I'm scared of my sexuality for all the reasons I had mentioned before plus the fact of being perceived as the perpetrator. I mean just because I'm a guy and I want to express myself sexually doesn't mean that I'm trying to become a perpetrator but there's a message out there that yea, guys are violent, they express themselves through sex in a violent way. You're a perpetrator of sex and maleness and violence. It's like this congealed thing.

Finally, some of the men described ways in which they compensated for chronic feelings of masculine inadequacy. They sought assurances

through institutional identifications (exactly one half of the men in this sample had served in the armed forces), and some resorted to victimizing others:

S: Well, I decided to go in because the Marine Corps has a reputation as being the toughest. And, of course, I could never picture myself being in anything except the Marine corps.
S: She was definitely raped. She definitely did that much of the thing against her will with my will. I didn't think that much about it. I didn't think it was wrong at all. I didn't have any remorse over that. I thought finally, wow, it wasn't that great, but at least I got that. I 'm not a wimp. You can't tease me around like that. And I did what the man is supposed to do. And too bad she didn't love it. But she would next time if we had another time. And stuff like that.

(The rape described by this subject occurred 16 years prior to the interview, and, conscious of the stated limits to confidentiality, he did not name or otherwise identify the victim. At the conclusion of the interview, he expressed profound remorse, which led to a lengthy discussion of the links between his own abuse and his victimization of others.)

S: I want to assert myself as a man. I want to be recognized as a person, I want to achieve something as a human being, and I'm angry at women...

Negative Childhood Peer Relations

The chronic feelings of isolation and alienation described earlier, while being rooted in the experience of abuse and the stigma which then attaches itself, are consolidated by the abused boy's difficulties in interacting with peers. Many of the men recalled with considerable pain the profound insecurity they felt around other children:

S: I always had that insecure personality and sensitivity that I could never really make any real friends...I've never had any real best friends, like most of the other kids did.
S: I think the older kids more or less knew that I guess I was a sucker or a schmuck but I was just too little, I didn't know, and I think a part of it was always seeking for some kind of acceptance...I wanted to feel like I was a part or accepted somewhere...

Their insecurity and alienation often led to rejection, which seemed to deepen their feelings of insecurity:

S: When I had my first interaction with other people, children are very cruel. And I tried to hang around with the girls. And they didn't like guys because they were too young. And then the guys didn't like me because I tried to hang around with the girls.

For many of the men, alienation from their childhood peers both robbed them of the opportunity to develop desperately needed sources of validation and interpersonal skills, and also robbed them of a way out of an often miserable home life:

S: So now, when I look back at it, I felt like my only avenue to get out of that house was to make friends, make friends with people around me, and I felt like that avenue was cut off because I was a freak, I was a mutant.

Negative Schemas About People

One of the most pervasive and far-reaching consequences of childhood abuse is that it damages the victim's ability to trust, and therefore to connect to other people (e.g., Dimock, 1988; Lew, 1988; Myers, 1989). Having been abused as a child by someone typically older and more powerful, the victim finds himself unable to trust others. For many of the men, this evolved into a general philosophy of life, an expectation that people will hurt you if you give them the chance, and that you must only rely on yourself:

S: And a lot of it is lack of trust. It's like I know I'm on my own, and there's no way I can trust anybody.
S: So you have to do it for yourself. You cannot trust people.

Linked to this basic lack of trust was the expectation that people will not help you or care about you:

S: It's like walking into a hospital with a gunshot wound and people saying well, unless you have the money, you're just going to have to take your best shot at life with it. And that's the way I feel. It's like I feel I'm friggen' wounded. I'm dying. And everybody is saying well, sorry.
S: There's nobody else that's going to back you up. Even if there's 100 people watching, you get raped. Nobody is going to say or do a damn thing.

This expectation is so ingrained that when someone violates it by being caring or trustworthy, the outcome is often the same:

S: But every time somebody devotes themselves totally to me is the time when I say fuck this, I've got to get out of here. I think that relates back to what I'm here for. Because I really don't trust people at all. I really don't like people that much. I get scared.

The philosophy of life which grows out of these expectations is a bleak one, and one that is likely to be self-fulfilling. You can't trust people so you don't let them get close to you; nobody ever gets close to you so you never experience people as potentially caring or trustworthy:

S: To expose myself on a really intimate level, you get stomped is what I thought. If you give them something to hurt you with, they'll hurt you with it. That's basically it.
S: So it was a cycle where if you weren't a predator, you were the prey. So I was prey for no one.
S: It made me not trust people at all. Really not like people to a big extent. Because I feel like they'll abuse that trust. I just get the feeling that everybody wants something from me. There's always an ulterior motive to everyone.

Negative Schemas About the Self

Children who are abused often internalize the "badness" of the experience: Something bad is happening to them because *they* are bad (e.g., Briere, 1992). The men interviewed for this study expressed this basic sense of badness in myriad forms: As a feeling of inferiority, of insignificance, of being unacceptable and unlovable. Some men described this sense of badness in terms akin to "infection," as though the abuse was in them, an indelible and eternally bad part of themselves:

S: I'll look at it now and I know the extent that this abuse, that it's in every pulsing cell I have in my body.
S: My fucking mother wants to fuck me. I mean, and I'm too ugly to be with people and my mother wants to fuck me. This is who I am, this is what I'm coming from.

Other men located the source of their negative feelings about themselves in their need to somehow make sense of the abuse:

S: I had to make sense out of what was going on. And the sense I made out of this was that I'm not really a good person. There's something different about me and something wrong.

The "something wrong" took many forms. Many of the men expressed profound self-hatred and a profoundly negative view of themselves:

S: But I just feel like if people really knew what really goes on with me, they wouldn't let me live.
S: I feel totally unacceptable. There's nothing about me that anybody else could possible enjoy or accept.
S: I was like a beaten dog.
S: That's what I mean about feeling inferior. I always feel inferior to people just as a whole person.
S: That's at the core of all this, is that I feel inaequate and terribly less than, and I'm never going to be good enough.
S: I was the most disgusting kid I knew on the inside. If anybody knew what was on the inside I would have been horrified, because they would have known what a jerk I was.

A few men countered this profound feeling of badness and inferiority by claiming the one domain that the abuse seemed to offer them:

S: I basically thought that the only thing I was good at, the only thing I was good for was sex. I knew how to do sex. I learned how to do sex when I was five. I knew sex. I wanted to be a sex machine because that's all I was good for. I didn't think my insides were worth paying attention to. And so if a woman no longer wanted to have sex with me, that was so incredibly painful to me.

Their profound sense of inner badness was yet another force driving a wedge between these men and other people. Most men believed that nobody could ever care about them:

S: I could not see anybody loving me, I could not see anybody liking me or wanting to be with me, I could not see myself as significant to the point where I would actually be in a relationship with someone else.

Problems with Sexuality

Almost all of the men evinced a profound effect of the abuse on their sexuality. For some, their internalized badness focused on their sexuality, as though it was primarily responsible for their victimization. This focusing typically led to confusion about their sexuality, and often to outright rejection:

S: I figured I was too much of a mutant for anybody to love me and any type of sexual feelings would probably be really unappreciated by a woman so I'd hide them, I tried not to show them at all. I figured the best thing I could possibly do was maybe try to figure out a way if I could take a, I don't known some drug I'd heard, maybe it's eldelpamine, that sex offenders took to discourage any type of sexual wantingness.

S: I guess I would be thinking how I didn't want to be attracted to this person. Or I needed to not be attracted to this person... And so the mental state was always I'm not attracted to them, I'm not attracted to them. And that relates back to how I didn't want to be... I couldn't have sex with my mother, so I had to cut that off, cut that part of me off.

For some men, sexual intimacy was frightening because it re-evoked feelings related to the abuse:

S: I'm sexually attracted to her and she's sexually attracted to me. So we went back to her house. And we started fooling around. And somehow intercourse came up. And I said not tonight. I was scared. I was scared because she wasn't scared. That scared me.

Other men went in the opposite direction, involving themselves in repeated sexual interactions, unable to protect their sexual boundaries:

S: I've been to bed with a lot of people I didn't want to go to bed with because I didn't know how to say no, didn't know I had any rights in that direction.

For other men, compulsive sexuality was focused more on fantasy and masturbation:

S: And the more that I talk about abuse, or have feelings around that, the more I feel less control over acting out sexually. I think that there's this incredible need for control around that. I think that I was able to keep whatever feelings I had in check by masturbating and sort of fantasizing about past sexual experiences.

Self Blame/Guilt

Self blame was almost universal among these men. As one man articulated it:

S: If sexual abuse occurs, you really feel like you're so bad that it's supposed to happen. That it's a punishment. That you did something wrong and this is more shame and guilt sort of coming down on you. And when you're that young you don't know any differently.

The men blamed themselves for not preventing or not stopping their abuse, often irrationally attributing to their childhood selves capacities that no child could possibly have:

S: I used to blame myself for it. I always thought I was a real smart two year old. So why didn't I get out of it. I blame myself. I don't blame him. I could have got out of it; I was plenty smart enough.
S: I still blame myself for all that happened... I feel I was real intelligent at that age, and I should have been able to get out of it.

Other men focused not on what they should have done, but rather on their inherent guilt; that there was something about them that provoked the abuse:

S: But it's so much easier to just take the blame for it. That there's something wrong with me. There was something defective from the beginning.

Self-blame often fused with the survivors' rage to become a potent and dangerous self-destructive force. One man described a transformative experience he had while in a hypnogogic state:

S: And just as I get up to the little boy, he turns around and looks at me and it's me as a little child. And I was like I, I'm going to kill him. And that was the first time in my life, like through all my suicide I realize, it's not so much I want to kill myself, but I want to kill that little boy that caused all that pain. It wasn't me. It's like that little boy is just a different person than me. I'm just a shell, but that little boy is living it, is what it is. And I wanted to kill him immediately.

For many of the men self blame generalized into a global feeling of guilt and hyper-responsibility:

S: And when someone says that something's wrong, like it's pathetic, the first thing I think it's me, that I did something wrong.

Shame/Humiliation

Feelings of shame and humiliation are some of the most persistent legacies of sexual abuse, and are often linked to feelings of badness and worthlessness. Few men talked easily about their feelings of shame, although many spontaneously referred to them. The most common reference was to chronic shame which linked directly back to their abuse:

S: I felt ashamed, like I had done something really dirty, really bad.
S: And God, he treated me like a whore. It was horrible. He shamed me so horribly.

For some men, the shame became separated from the abuse itself and attached to their selfhood, contributing powerfully to their negative feelings about themselves:

> *S:* I feel ugly. There are physical imperfections that I have on my body that I focus on and I use that as a concrete tool to verify any type of psychological insecurities I have about this shame issue I have.

Finally, for some men the shame attached itself specifically to their sexuality:

> *S:* It's like when I have sex with a girl, as soon as I have an orgasm the guilt and shame is incredible. Then I feel like the minute I ejaculate then I feel I should be killed. I should be shot for what I just did. The shame that comes out is incredible.

DISCUSSION

An empirically based, thematic content analysis of autobiogaphical interviews with sexually abused men validated the clinically based observations of numerous clinicians who have worked with male survivors (e.g., Dimock, 1988; Hunter, 1990; Lew, 1988; Myers, 1989). The analysis identified prominent affects and affective states (anger, fear, helplessness, loss, guilt, and shame), salient cognitive sequelae (inability to legitimize their experience as abuse, negative schemas about the self and about people and self-blame), pervasive issues around gender and sexuality (homosexuality issues, masculinity issues and problems with sexuality), and interpersonal difficulties (betrayal, isolation and alienation, and negative childhood peer relations). Together, these psychological themes describe a legacy of childhood abuse that permeates all of the important domains of its victims' lives: Their beliefs and feelings about themselves and about other people, and their basic sense of connection to others. The effects of this on the lives of these men are expressed eloquently by the men themselves, and they are also manifested in the increasing evidence of lives damaged, derailed or simply made more difficult by childhood abuse (e.g., Browne and Finkelhor, 1986; Lisak and Luster, 1994).

While the themes identified in this analysis appeared in many different forms among the survivors, a pattern of interconnections was evident, often described explicitly by the men themselves. Sexual abuse has the power to fundamentally damage a victim's relationship both to themselves and to other people. The men in this study expressed profound feelings of worthlessness, badness, ugliness, emptiness, and inferiority. These feelings, although rooted in their experiences of abuse, typically endured and often worsened with time, becoming ingrained, deeply negative identities. The depth and breadth of this negative identity is understandable given the many

sources feeding into it. Feeling inadequate about their masculinity, unsure of their sexual orientation, deeply shamed, blaming themselves for their victimization and fraught with often inexplicable fears, the survivor's ability to sustain a positive sense of self is subject to constant challenge and buffeting.

Paralleling this damage to the survivor's self is an equally pervasive assault on his connection to others. Almost every man described this breech beginning in childhood, with feelings of inferiority and alienation separating him from his peers. The alienation in turn prevents the formation of positive interpersonal connections, connections needed to mitigate their basic mistrust of others, their expectation that others can and will do you harm, and that you cannot expect help from others. For some, this outlook coalesced into a philosophy best described as "dog eat dog," and a commitment to never again be the underdog.

Together, the survivor's damaged sense of self and sense of community with others produced a profound and often lifelong isolation and separation from others. Men described their loneliness and aloneness, their fear of intimacy and their unsatisfied needs for intimacy, their friendlessness, their sense of being different and stigmatized. This isolation and alienation in turn served to consolidate their negative self schemas. Having internalized the negative experience of the abuse as "I'm bad," the men were overprepared to interpret their isolation as further proof of their fundamental inferiority and worthlessness.

One of the most salient aspects of this analysis was the interaction of sexual abuse with its victims' perception of their own gender and sexual identities. These men described, often with remarkable eloquence, their struggle to reconcile the experience of sexual victimization with the demands which their culture places on them to be "masculine." Masculinity, as defined by cultural norms, rejects vulnerability, passivity and helplessness, psychological states which comprise the very core of the experience of sexual victimization. Thus, the male survivor, who has been given no choice but to experience these "nonmasculine" states intensively, feels himself to be at the core defectively masculine, inadequately masculine, a male who must struggle to hide and repress the inner stigmata of his "nonmasculinity." This profound sense of gender inadequacy feeds directly their more generalized sense of inferiority and negative self-image, and exacerbates their alienation and isolation from others. Some men actively fight the insecurity, compensating by adopting some or many of the emblems of hypermasculinity, from their dress, to their mannerisms, to styles of speech and, in some cases, to aggressive behavior.

For men who were abused by men, a second channel feeding into their feelings of insecurity was their confusion about their sexual orientation. Absorbing the culture's homophobia, as well as its confused fusion of sexual

orientation and gender identity, many men internalized their sexual victimization by another man as a sign of their own nonmasculinity, rendering them insecure about their adequacy as men and confused about their sexual orientation.

The culture's rigid gender norms harmed these men beyond creating feelings of insecurity and inadequacy. They also impeded the process of healing from sexual abuse by forcefully warning survivors away from the very capacities they needed to foster their own healing. Like all males, survivors hear from numerous sources one of the codes of masculinity: "Don't acknowledge your pain, don't express it, and don't talk about it with anyone else." Thus, they are compelled to reject their capacity to feel and empathize with their own pain, thereby dramatically reducing their ability to begin the process of healing the legacy of abuse.

Even men who actively struggled against this gender tide found little or no support for their efforts. Many men expressed how alone and ignored they felt as male survivors of sexual abuse, as though they belong to a nonexistent category in the culture's lexicon: "male victims." The same forces which drove them to reject the reality of their victimization also shaped the attitudes of the people they encountered in their struggle to recover from their abuse. Many men described numerous attempts at obtaining help, most thwarted by the disbelief of potential helpers.

What makes this feeling of rejection and nonexistence so poignant is that often the words and expressions used by these men to describe their feelings and experiences are identical to those used by women survivors. Most professionals who have worked with women survivors of sexual abuse would immediately recognize statements such as: "My only value is as a sexual object;" or, "I couldn't say no if they wanted sex," or "I'm always afraid," or "I feel like I belong to somebody else." Probably many professionals would be far less likely to recognize those same statements coming from male survivors. That they did come from male survivors underscores the common humanity which, despite the cultural overlay of gender norms, lies at the core of the response to childhood abuse.

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Clinical Observations and Systematic Studies of Autogynephilia

RAY BLANCHARD

The term autogynephilia *denotes a male's paraphilic tendency to be sexually aroused by the thought or image of himself as a woman. This term subsumes transvestism as well as erotic ideas or situations in which women's garments per se play a small role or none at all. This review article presents clinical examples of the lesser known types of autogynephilia (i.e., those in which the element of cross-dressing is secondary or entirely absent), sketches earlier attempts to label and conceptualize these phenomena, summarizes recent quantitative studies exploring the relationships between autogynephilia and other psychosexual variables (e.g., heterosexual attraction), and speculates on the etiology of autogynephilia and its relationship to transsexualism. It is concluded that the concept of autogynephilia is needed to fill a gap in our current battery of concepts and categories for thinking about gender identity disorders.*

All contemporary clinicians are familiar with the phenomenon known as *transvestism,* that is, recurrent cross-dressing in heterosexual males that, at least in puberty or adolescence, is associated with sexual arousal. Less well known, however, is the wide range of other cross-gender behaviors and fantasies that are sexually arousing to subgroups of men who cross-dress, engage in other symbolically feminine activities, or habitually imagine themselves as females.

In a previous article,[1] I coined the term *autogynephilia* to refer to the full gamut of erotically arousing cross-gender behaviors and fantasies. This term was intended to subsume transvestism as well as erotic ideas or situations in which women's garments per se play a small role or none at all. The word autogynephilia was constructed from Greek roots meaning "love of oneself as a woman" and was formally defined as a male's propensity to be sexually aroused by the thought or image of himself as a female.

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I wish to thank Dr. Friedemann Pfäfflin for researching the first appearance in print of the word *automonosexualism,* which I have in previous articles attributed to the wrong edition of Rohleder's work.

This is Exibit "I" referred to in the Affidavit of Jamie Shupe sworne before me this 25th day of June 2019.

In this article, I review most of the clinical and all of the research data currently available on this erotic phenomenon. In the first section, I present clinical examples of the lesser known types of autogynephilia, that is, those in which the element of cross-dressing is secondary or entirely absent. In the second, I summarize earlier attempts to label and conceptualize these phenomena. In the third, I review recent quantitative studies exploring the relationships between autogynephilia and other psychosexual variables, for example, heterosexual attraction. Finally, in the fourth section, I speculate on the etiology of autogynephilia and its relationships to *gender dysphoria* (discontent with one's biological sex, the desire to possess the body of the opposite sex, and the desire to be regarded by others as a member of the opposite sex) and *transsexualism* (the extreme form of gender dysphoria).

The purpose of this review is to highlight, for clinicians and researchers alike, a class of clinically significant cross-gender behaviors and fantasies that has largely been overshadowed by its most conspicuous exemplar, namely, transvestism. I hope to show, among other things, that the broader concept of autogynephilia explains the correlation of various, seemingly dissimilar sexual behaviors in cross-gendered male populations, and also that this concept is useful in understanding the development of transsexualism in nonhomosexual men.

DESCRIPTION OF THE PHENOMENA

Autogynephilic fantasies and behaviors may focus on the idea of exhibiting female physiologic functions, of engaging in stereotypically feminine behavior, of possessing female anatomic structures, or of dressing in women's apparel. The last-mentioned class of fantasies and behaviors represents the familiar form of autogynephilia, transvestism. All four types of autogynephilia tend to occur in combination with other types rather than alone.

The first of the above-listed types may be designated *physiologic autogynephilia.* Prime examples of this variety are those occasional males, called "pregnancy transvestites" by Hirschfeld,[2] who masturbate with the fantasy of being a pregnant woman or of giving birth. There are, in a similar vein, men whose favorite masturbation fantasy is that they are lactating or breast-feeding[3] and others whose favorite fantasy is that of menstruating. These physiologic functions may also be simulated during masturbation with the aid of appropriate props.

The second type, *behavioral autogynephilia,* involves the thought or performance of activities that symbolize femininity to the affected male. For example, one individual, whom I have described elsewhere,[4] reported that his early masturbation fantasies included the thought that he was helping the maid clean the house or that he was sitting in a girls' class at school. Another 33-year-old patient, whom I recently interviewed, reported that his current masturbation fantasies were knitting in the company of other women and being at the hairdresser's with other women.

The most common behavioral fantasies of adult autogynephilic men involve the thought of themselves, as women, engaging in sexual intercourse or other erotic activities. Male patients at the author's gender identity clinic, for example, commonly report inserting dildos or similar objects into their rectum while masturbating; this behavior is accompanied by the fantasy that their anus is a vagina. The same fantasy may be inferred in other male populations: Blanchard and Hucker[5] found a significant correlation, in 117 fatal cases of autoerotic asphyxia, between the presence of dildos at the death scene and feminine attire on the corpse, suggesting that anal self-stimulation had a symbolic cross-gender meaning within that group of men as well.

Some autogynephiles fuse the idea of being a woman with their sexual attractions toward real women in sexual fantasies in which they are lesbians engaging in lesbian interactions.[6–8] The occasional man will find a wife or girlfriend who is prepared to participate in this fantasy to some extent, stimulating his nipples during intercourse as if she were fondling another women's breasts, and so on.[9]

The erotic idea of interpersonal sexuality in the cross-gender role may also find expression in the fantasy of having intercourse, as a woman, with a man. The male partner represented in these fantasies is usually a vague, anonymous figure rather than a real person and probably has little excitatory function beyond that of completing the fantasy of vaginal intercourse in the female role. Fantasies of this class sometimes lead to actual sexual intercourse with men, particularly with the affected individual in cross-dress or otherwise performing in some role he conceives as feminine.[10–12] The effective erotic stimulus in such interactions, however, is not the male physique of the partner, as it is in true homosexual attraction, but rather the thought of being a woman, which is symbolized in the fantasy of being penetrated by a man.[13,14]

The fantasy of vaginal intercourse in the female role may be enacted with a female rather than a male partner, and even without the partner's knowledge. In many cases, the autogynephile prefers to have intercourse with his wife in the female superior position. He then fantasizes that his wife—imagined as a man—is penetrating him—a woman.[15–18] This may go on for years without the individual's wife ever realizing why her husband prefers that position for intercourse or how she is transformed in his imagination.

The third type might be described as *anatomic autogynephilia.* Anatomic autogynephilia, in its purest form, is represented by rather static fantasies—one might call them rather images or icons—consisting of little more than the idea of having a woman's body. These may focus on female anatomic structures such as the breasts or the vulva or on typical but acquired characteristics such as hairless legs. A patient seen by one of my colleagues, for example, was sexually aroused by shaving his legs and then contemplating the result.

The fourth major type of autogynephilia, as I have defined it, is *transvestic autogynephilia* (or simply, *transvestism*). The rationale for subsuming transvestism under the heading of autogynephilia is that the

transvestite's excitement results from making himself, in some sense, more like a woman, whatever his conscious thoughts during that act. In fact, most transvestites do fantasize themselves as females when they are cross-dressing and may also act this out in their behavior. Other individuals, who have no explicit thoughts of femininity, spend considerable amounts of time admiring their appearance in the mirror and are sexually aroused by the image of themselves as women.[8,19,20]

In all the above-mentioned types of autogynephilia, the relationship between the cross-gender stimulus and sexual excitement is probabilistic rather than inevitable. An autogynephile does not necessarily become sexually aroused every time he pictures himself as a female or engages in feminine behavior, any more than a heterosexual man automatically gets an erection whenever he sees an attractive woman. Thus, the concept of autogynephilia—like that of heterosexuality, homosexuality, or pedophilia—refers to a *potential* for sexual excitation.

The first three types of autogynephilia—physiologic, behavioral, and anatomic—are usually found in association with cross-dressing. This is probably one reason why clinicians and researchers have tended to regard these phenomena, when they have noted them at all, as outgrowths or extensions of transvestism. The questionability of this assumption is illustrated by the following clinical vignette of an adult male outpatient with a lifelong history of anatomic and behavioral autogynephilia together with a virtual absence of transvestism.

Vignette

Philip was a 38-year-old MBA referred to our gender identity clinic for assessment. His presenting complaint was chronic gender dysphoria, which had led, on occasion, to episodes of depression severe enough to disrupt his professional life. He presented as an intelligent and cooperative individual, unremarkably masculine in appearance and in manner. He had never been married and he had no children.

Philip was the third of four children in a happy and prosperous middle-class home. Most of his childhood friends were other boys, but he also got along well with girls. He did well in grammar and high school, obtaining good grades and excelling in sports. He was popular with his classmates and enjoyed harmonious relations with his family. This pattern of social competence continued into adult life, although, in later years, he exhibited a preference for friendship with women.

His first specific recollection of wanting to be a female dated back to age 6. Encountering a wishing well for the first time, he begged a penny from his father to throw in. His wish was that God would listen to his prayers and let him change into a girl. At about the same age, he cross-dressed for the first and only time in his life. This consisted of trying on a dress belonging to an older cousin. When questioned why he did not cross-dress at present—he lived alone and there was nothing to prevent him—he indicated that he simply did not feel strongly impelled to do so.

He began masturbating at puberty, which occurred at age 12 or 13. The earliest sexual fantasy he could recall was that of having a woman's body. When he masturbated, he would imagine that he was a nude woman lying alone in her bed. His mental imagery would focus on his breasts, his vagina, the softness of his skin, and so on—all the characteristic features of the female physique. This remained his favorite sexual fantasy throughout life. His other masturbatory fantasies were less frequent and much less powerful. One of these was the idea of dressing as a woman; another was the fantasy of himself, as a woman, being penetrated vaginally by a man. The latter thought began to occur to him in his thirties; by the time he presented to us, it was arising in one-third to one-half of masturbatory sessions. The imagined partner remained vague in outline, however: a nameless, faceless abstraction rather than a real acquaintance or remembered stranger.

Philip's first heterosexual intercourse was at age 18. This was a one-night stand with a woman he met at a party. He experienced no erectile difficulties. During the next two decades, he had intercourse with nine different women, of which six were one-night stands. In common with most heterosexual male gender dysphorics, he tended to employ cross-gender ideation as an aid during coitus. He preferred to have intercourse with the woman on top, and he would fantasize that he was the woman and his partner was the man. At the time he presented, he had not had intercourse for over a year. His last attempt had been unsuccessful because of erectile difficulties.

His only long-term heterosexual relationship was with a fellow student, Elisa, in graduate school. This was in his early twenties and lasted about two years. The couple had intercourse only during their first few months of living together. The frequency of coitus then tapered off to zero, although they continued sleeping in the same bed.

Philip never had a homosexual experience. This was from lack of interest rather than lack of opportunities. Elisa had been interested in the arts, and Philip had known a number of gay individuals through her.

This vignette illustrates that when a patient's primary sexual object is the thought of himself with a woman's body, there may be little overt paraphilic behavior. This does not, of course, mean that the deviant interest has no clinical significance. In the present case, for example, it was clearly related to the patient's gender dysphoria and to his inability to form long-term relationships with women.

PREVIOUS CLINICAL FORMULATIONS

Many clinical observers have noted behaviors similar to those described above. They have often, however, attributed them to motivations other than autogynephilia. The following quote from Karpman[21] provides a good example:

> If a married man insists in his relations with his wife in occupying the succubus position and at the same time demands of

> her that she massage his breasts, this can hardly be interpreted as anything else but an expression of unconscious or latent homosexuality. (p. 293)

It was self-evident to Karpman that such behavior betokened a sexual interest in men; he never even considered that the fundamental and irreducible sexual stimulus was the idea of being a woman. Other writers, however, both before and after Karpman, have perceived such behavior in terms resembling my own notion of autogynephilia.

Probably the first such writer was Hirschfeld.[2] He identified the erotic idea of being a woman in a group of cross-dressing males whom he described as *automonosexuals*:

> We are almost tempted to believe that we are here faced with a splitting of the personality in the sense that the masculine component in the psyche of these men is sexually stimulated by the feminine component and that they feel attracted not by the women outside them, but by the woman inside them.[22] (p. 167)

Hirschfeld borrowed the term "automonosexualism" from Rohleder.[23] Rohleder, however, had used the term to denote a kind of pathological narcissism in which the individual is excited by his own body in its real (i.e., male) form; whereas Hirschfeld's automonosexual cross-dresser is aroused by the fantasy that his body is that of a woman.

Havelock Ellis, a contemporary of Hirschfeld's, had similar perceptions, although he couched them in somewhat different language. Ellis used the term *Eonism*, usually in regard to nonhomosexual males, to designate overt cross-gender behavior as well as subjective feelings; he sometimes used an alternative term, *sexo-aesthetic inversion*, for the same thing. In his view:

> The Eonist is embodying, in an extreme degree, the aesthetic attribute of imitation of, and identification with, the admired object. It is normal for a man to identify himself with the woman he loves. The Eonist carries that identification too far.[24] (p. 244)

In other writings, Ellis reiterated his opinion that "Eonism" and normal heterosexual interest have some common point of origin: "Psychologically speaking, it seems to me that we must regard sexo-aesthetic inversion as really a modification of normal hetero-sexuality"[14] (p. 103). This point will be taken up again in the next section.

Fenichel,[25] writing on transvestism, also noted autogynephilic phenomena in terms not dissimilar from Hirschfeld and Ellis. He did not, however, dwell long at the descriptive level:

> Love for the subject's own self—phantasies that the masculine element in his nature can have intercourse with the feminine

> (i.e., with himself) are not uncommon. Love for the phallic mother is often transformed into love for the ego in which a change has been wrought by identification with her. This is a feature in the psychic picture which has struck even non-analytical writers, who have described a narcissistic type of transvestist. (p. 214)

Although Fenichel noted the same fantasies as Hirschfeld and Ellis, he also, in a sense, denied their importance. In Fenichel's view, the transvestite's driving fantasy was not the conscious thought of himself as a woman with a vulva but rather the unconscious thought of himself as a woman with a penis.

Buckner[26] advanced an elaborate theory of the developmental events leading to transvestism. In his theory, the future transvestite begins with fetishistic masturbation, but then

> begins to build in fantasy a more complete masturbation image. . . . Through a process of identification and fantastic socialization he takes the gratificatory object into himself. . . . [The next step] involves this elaboration of masturbation fantasies into the development of a feminine self (pp. 383–384) . . . [which is] gratifying in both sexual and social ways. When it becomes fixed in his identity, he begins to relate toward himself in some particulars as if he were his own wife. (p. 387)

Thus, Buckner also recognized the erotic idea of being a woman, although it is debatable whether he located it correctly in the developmental sequence.

The foregoing examples show that a variety of writers have specifically noted autogynephilic ideation, although their formulations of it have been differently colored by their theoretical views. One final comment on the phenomenology of autogynephilia is necessary. Some of the foregoing clinical quotes might give the impression that the autogynephile experiences his feminine persona as a sort of imaginary twin, somehow distinct or detached from himself. Although this might be true in some cases, it is my sense that, most often, the individual simply experiences himself, in his own body, as a woman.

FINDINGS OF QUANTITATIVE STUDIES

Although clinical observations of autogynephilia go back several decades, the only quantitative studies I know that bear directly on this topic are four recent investigations of my own. These studies suggest three main conclusions: 1) Autogynephilia is a misdirected type of heterosexual impulse, which arises in association with normal heterosexuality but also competes with it. 2) The majority of men who acknowledge anatomic autogynephilia also report some history of transvestism, and a substantial proportion also report some history of attraction to specific garments or

materials. 3) Anatomic autogynephilia is more closely associated with gender dysphoria than is transvestism. The research program generating these conclusions is described in the remainder of this section.

Autogynephilia and Heterosexuality

Hirschfeld's observation that autogynephilic men "feel attracted not by the women outside them, but by the woman inside them" actually contains two separate ideas. The first is that autogynephilia may be conceived as a kind of misdirected heterosexuality. The second is that autogynephilia competes with normal heterosexual attraction.

The first hypothesis suggested by Hirschfeld's observation—that autogynephilia is a misdirected type of heterosexual impulse—predicts that one should find higher levels of autogynephilia in heterosexual—or at least nonhomosexual—men than in comparable homosexual men. This prediction has been supported by the results of a study by Blanchard.[27] The subjects in this study were 212 adult male-to-female transsexuals. These were divided into four groups: one homosexual (attracted to other males) and three nonhomosexual (attracted to females, to both sexes, or to neither sex).

The measure of autogynephilia used in this study was called the Core Autogynephilia Scale,[27] or CAS for short. Most of the items in this multiple-choice questionnaire measure ask whether the respondent has ever become sexually aroused while picturing himself with various features of the female anatomy (e.g., breasts). Therefore the CAS is primarily a measure of anatomic autogynephilia.

The four transsexual groups were compared on the CAS (and on several other psychosexual variables that are not immediately relevant). As predicted, all three categories of nonhomosexual males were more likely to report sexual arousal in association with fantasies of womanhood than the homosexual males. This finding supports the view that autogynephilia is, as Ellis put it, "really a modification of normal hetero-sexuality."

A subsequent study[28] examined the second hypothesis suggested by Hirschfeld's observation, namely, that autogynephilia and normally directed heterosexual interest are competing drives (or behaviors, or orientations). The subjects were 427 adult male outpatients who reported histories of dressing in women's garments, of feeling like women, or both. These were selected without regard to sexual orientation, and the sample included men reporting all degrees of sexual attraction to adult women.

For a sample thus composed, Hirschfeld's first hypothesis predicts that men reporting little interest in (real) women will also report little autogynephilia; as one moves along the continuum from subjects with low levels of heterosexual attraction toward subjects with intermediate levels, the amount of observed autogynephilia should increase. The second hypothesis concerns the middle-to-high range of the heterosexual interest continuum. The notion of intrinsic competition implies that high degrees of interest in the one type of sexual object preclude high degrees of interest

in the other. Thus, as one moves further along the continuum from subjects with intermediate levels of heterosexual attraction to subjects with high levels, the amount of observed autogynephilia should reverse direction and begin to decrease again. In operational terms, the combined hypotheses imply that a plotted function relating measures of autogynephilia and heterosexual interest should take the form of an inverted U; this was the prediction tested in the study.

As in the previous study, autogynephilia was measured with the CAS. Heterosexual interest was measured with the Modified Gynephilia Scale,[13] or MGS, a measure of erotic attraction to physically mature women specifically developed for the assessment of adult male gender patients. A third variable of present relevance, transvestism, was measured with the Cross-Gender Fetishism Scale,[29,30] or CGFS for short. This is a measure (for males) of the erotic arousal value of putting on women's clothes, perfume, and make-up, and shaving the legs. The items in the CGFS focus on the act of cross-dressing rather than subjective feelings of femininity.

As predicted, the highest levels of autogynephilia were observed at intermediate rather than high levels of heterosexual interest; that is, the function relating the CAS and the MGS did take the form of an inverted U. A different result was obtained for transvestism; the CGFS curve appeared to level off rather than reverse direction at the highest degrees of heterosexual interest. The former finding supports the view that autogynephilia is a misdirected type of heterosexual impulse, which arises in association with normal heterosexuality but also competes with it. The latter further suggests that some types of autogynephilia (e.g., anatomic autogynephilia) may compete more strongly with normal heterosexual attraction than other types (e.g., transvestism).

These findings are reinforced by other kinds of evidence that also suggest autogynephilia and normal heterosexual attraction are competing phenomena. The foregoing study was entirely cross-sectional in nature, the autogynephilic and heterosexual tendencies of each subject having been measured concurrently and only once. Clinical experience, however, suggests that this competition may also be observed longitudinally. It is not rare for a heterosexual male cross-dresser or gender dysphoric to report that, when he first met a woman and fell in love, his desires to cross-dress or engage in other cross-gender behaviors diminished or disappeared, sometimes for longer than a year. When, however, the intensity of passionate love resolved into the mellower comforts of married life, his desires to dress or live as a female reasserted themselves.

The results of the above study bear upon, and perhaps illuminate, one further clinical observation. Person and Ovesey[12] (p. 307) remarked that "interpersonal sexuality is almost always attenuated" in transvestism, and other clinical authors have made similar statements. My findings suggest that it may not be transvestism per se that competes with normal heterosexual attraction so much as the anatomic autogynephilia that often accompanies transvestism.

The conclusion of this section requires one additional point. In some autogynephilic men, the loss of sexual attraction to women is offset by a

kind of secondary erotic interest in men, already described in a previous section. Thus, the net impact of autogynephilia on erotic interest in other persons may be rather small. This was confirmed by Blanchard,[27] who found a near-zero correlation between the CAS and an Alloeroticism Scale, which was developed in that study to measure sexual interest in other persons irrespective of their sex.

Anatomic Autogynephilia, Transvestism, and Fetishism

I have already stated the opinion that anatomic autogynephilia is usually found in association with transvestism rather than alone. There is no previously published research to support this assertion, however. In preparing the present article, I therefore carried out a small study to demonstrate this overlap. I also tried to estimate the proportion of autogynephiles with some evidence of fetishistic traits.

This investigation used the same resources as my other studies of autogynephilia.[27,28,31] The on-line database of the Clarke Institute of Psychiatry's Research Section of Behavioural Sexology includes questionnaire data on 3,500 male patients who have presented either at that department or at the Institute's Gender Identity Clinic since September 1980—the date when the last questionnaire items used in this study were added to the test battery. These cases were searched for all subjects who satisfied both of the following criteria: 1) The subject obtained a score less than 10 on the Modified Androphilia-Gynephilia Index,[29] thus indicating a nonhomosexual partner preference; and 2) he obtained a score of 3 or higher on the CAS, clearly acknowledging some history of autogynephilic arousal.

A total of 210 cases was retrieved for this study. The mean age of the sample was 33.4 years (range = 18–67 years). The mean, median, and modal educational level were all Grade 12.

The selected subjects were then dichotomously classified as transvestic or not-transvestic, fetishistic or not-fetishistic. A subject was classified as transvestic if he endorsed any item on the CGFS. A subject was classified as fetishistic if he responded positively to the individual questionnaire item, *Do you think that certain inanimate objects (velvet, silk, leather, rubber, shoes, female underwear, etc.) have a stronger sexual attraction for you than for most other people?*

The results showed that 90% of these autogynephilic men acknowledged some history of transvestism: 35% acknowledged transvestism alone, and 55% acknowledged fetishism as well as transvestism. The remaining 10% denied both. It should be noted that this last group did not necessarily deny cross-dressing; they merely denied being sexually aroused by cross-dressing.

The above percentages should be regarded as "ball park" estimates rather than precise figures. The item used to diagnose fetishism does not distinguish as clearly as one would like between transvestism and fetishism (although its connotations seem clear enough, particularly for gender

patients, who rarely are very naive about such matters). We do not, moreover, know whether subjects are equally willing to acknowledge autogynephilia, transvestism, and fetishism; or how a greater reluctance to report one of these paraphilias might affect our results. I believe, however, that the above study is adequate to indicate the general trend: The majority of men who acknowledge anatomic autogynephilia also report some history of transvestism, and a substantial proportion also report some history of attraction to specific garments or materials.

Autogynephilia and Gender Dysphoria

The different types of autogynephilia, alone or in various combinations, tend to occur in association with another phenomenon of equal clinical significance, namely, gender dysphoria. Analyzing the relationship between autogynephilia and gender dysphoria is likely to prove a long-term undertaking, requiring multiple studies. A reasonable place to start on this task is determining which types of autogynephilia are most closely associated with gender dysphoria. One would think, on clinical or even commonsense grounds, that different types of autogynephilia are likely to differ in the strength of such associations. It would seem, in particular, that the man whose principal sexual fantasy is that of having a woman's body would be closer to requesting vaginoplasty than the man whose principal fantasy is that of wearing women's clothes. This logic leads to the general prediction that anatomic autogynephiles should be more gender dysphoric than transvestites.

The above prediction was tested in the fourth quantitative study.[31] The subjects were 238 nonhomosexual male outpatients with some history of autogynephilic behavior. These were divided into three groups: those most aroused sexually by images of themselves as nude women; those most aroused by images of themselves as women in underwear; and those most aroused by images of themselves as fully clothed women. Thus, in the terminology used in the present article, the first, or Nude, group were primarily anatomic autogynephiles; the Underwear and Clothed groups were primarily transvestic autogynephiles (or simply, transvestites).

These subjects were then compared on questionnaire measures of gender dysphoria as well as other psychosexual variables. As predicted, the Nude group was significantly more gender dysphoric than either the Clothed or the Underwear group.

The above finding suggests the following, rudimentary theory relating an individual's type of autogynephilia to the presence or absence of transsexual wishes: 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. I will return to this idea in a later discussion.

An unanticipated result of this study was the pattern of differences between the Clothed and Underwear groups. The Underwear group was reliably less gender dysphoric, reliably more sadistic and masochistic. This suggests that an adequate taxonomy of autogynephilia may require more than a breakdown into anatomic, physiologic, behavioral, and transvestic types. One may also find clinically significant distinctions by subdividing (primarily) transvestic cases according to their preferred articles of women's apparel.

Another secondary finding was that the Nude group was the same age as the Underwear group and significantly younger than the Clothed group. This outcome makes it unlikely that erotic fantasies of having a woman's body are the end result of some progression that necessarily begins with erotic fantasies of wearing women's clothes. This finding, therefore, reinforces the point made in introducing the clinical vignette of "Philip," namely, that it is questionable whether anatomic autogynephilia should be regarded as an outgrowth or extension of transvestism.

ETIOLOGICAL CONJECTURES

This section discusses hypotheses of autogynephilia and autogynephilic gender dysphoria suggested by the objective data reviewed above. These are intended as working hypotheses for future studies rather than final conclusions on the research completed to date.

Etiology of Autogynephilia

The finding that anatomic autogynephilia tends to be accompanied by transvestism and fetishism is another example of the well-known tendency for multiple paraphilias to occur in the same individual.[5,32-37] Specific clusters previously described include one comprising voyeurism, exhibitionism, toucheurism-frotteurism, and preferential rape[38-40] and another comprising shoe or foot fetishism and masochism.[22,41]

Bancroft[42] observed that the tendency of paraphilias to occur together suggests that the conditions necessary for the development of one type of paraphilia may facilitate the development of others. He conjectured that this potential might stem from some characteristic of the individual's nervous system that underlies sexual learning. Bancroft's notion may be extended a bit further: The fact that there is more than one type of paraphilic cluster suggests that there may be more than one type of paraphilic diathesis.

What kind of defect in a male's capacity for sexual learning could produce anatomic autogynephilia, transvestism, and fetishism, singly and in various combinations? Common to all these phenomena is a kind of error in locating heterosexual targets in the environment. In fetishism,

the individual orients toward a particular garment (e.g., panties, brassieres) rather than those parts of the female body the garment usually covers. In transvestism, the individual is aroused by the appearance of an attractively clad woman, but he locates this image on himself rather than another person. In anatomic autogynephilia, the individual is oriented toward the characteristic features of the feminine physique (e.g., breasts), but he attempts, in some way, to locate these features on his own body.

The above analysis suggests the failure of some developmental process that, in normal males, keeps heterosexual learning "on track," perhaps by biasing erotic response toward external rather than internal stimuli, and inherent rather than variable features of the female appearance. This putative defect allows the development of various misdirected—but still recognizably heterosexual—behaviors, and makes it possible, if not probable, that more than one misplaced interest will appear in the same individual.

This etiological hypothesis explains the tendency for anatomic autogynephilia to be accompanied by transvestism and fetishism without asserting that any one of these paraphilias is a direct consequence of another. This is critical because, although these paraphilias do tend to cluster, each of them can and does also occur alone. There are, on the other hand, some types of autogynephilic behavior and fantasy that might be explained as secondary elaborations of more basic forms.

Autogynephilic fantasies of vaginal intercourse with men, with the subject imagining himself in the female role, are a case in point. I have already presented my view that the effective erotic stimulus in such interactions is not the male physique of the partner, as it is in true homosexual attraction, but rather the thought of being a woman, which is incorporated in the fantasy of being penetrated by a man. This analysis prompts the question: Why should the autogynephile fantasize vaginal intercourse when he could simply fantasize himself with a vagina? The answer may lie with a general characteristic of heterosexual men. The most common activity in pornographic videotapes made for this population is heterosexual intercourse (including fellatio and cunnilingus); scenes of solitary women masturbating themselves are considerably less frequent. This suggests that heterosexual observers are more aroused by a man and woman together than by a woman alone, even though the male actor may have no value as a sexual object in his own right. In autogynephilic men "observing" their own fantasies, this same propensity may make images of vaginal intercourse more exciting than simple images of themselves with vaginas. This hypothesis illustrates that the relatively complex and active fantasies of behavioral autogynephilia may be the result of anatomic autogynephilia interacting with certain components of normal heterosexual behavior.

In summary, the quantitative data[27] together with the qualitative analyses presented in this section support Ellis's contention that autogynephilia is "really a modification of normal hetero-sexuality." The nature of this

"modification" is, at least initially, one of direction, with behaviors suggesting heterosexual intent directed at objects other than real-life females.

Etiology of Transsexualism in Nonhomosexual Men

The last quantitative study clarified one aspect of the relationship between autogynephilia and transsexualism: Within the population of adult nonhomosexual men with recurrent cross-dressing or cross-gender ideation, the desire to be female is more closely associated with anatomic autogynephilia than with transvestism.[31] Neither this nor any other available study, however, elucidates the developmental interrelationships of autogynephilia and transsexualism.

Any viable theory relating the etiologies of autogynephilia and transsexualism must explain the following well-established observation: Gender dysphoria, in young nonhomosexual males, usually appears along with, or subsequent to, autogynephilia; in later years, however, autogynephilic sexual arousal may diminish or disappear, while the transsexual wish remains or grows even stronger.[12,15,33,43–45] Such histories are often produced by gender-dysphoric patients, but one does not have to rely on self-report to accept that the transsexual motive may attain, or inherently possess, some independence from autogynephilia. The same conclusion is suggested by the fact that surgical castration and estrogen treatment—which decrease libido in gender dysphorics as in other men—usually have no effect on the desire to live as a female or the resolve to remain in that role.

One may speculate that the above developmental sequence reflects the operation, in autogynephilic men, of certain normal heterosexual behaviors. Many men, after years of marriage, are less excited by their wives than they were initially but continue to be deeply attached to them; in other words, pair-bonding, once established, is not necessarily dependent on the continuation of high levels of sexual attraction. It is therefore feasible that the continuing desire to have a female body, after the disappearance of sexual response to that thought, has some analog in the permanent love-bond that may remain between two people after their initial strong sexual attraction has largely disappeared.

It must be emphasized that the foregoing discussion pertains entirely to transsexualism in nonhomosexual males. I have previously argued, on the basis of both formal research and clinical evidence, that the type of transsexualism that develops in this population is qualitatively different from the type that develops in homosexual males[1,13,27,46] and from the type that develops in nonhomosexual females.[1,47]

CONCLUSIONS

The concept of autogynephilia—or something very like it—is needed to fill a gap in our current battery of concepts and categories for thinking about gender identity disorders. There is no other term for designating

erotic arousal in men associated with the thought or image of themselves as women; there is no other conceptual basis for classifying erotic fantasies as diverse in form—but similar in meaning—as menstruating, breast-feeding, making love to a lesbian as a gay woman, making love to a man as a straight woman, sitting in a girls' class at school, knitting, and possessing shaved legs. The concept of transvestism does not meet this need. Transvestism is now "officially" and quite narrowly defined in the DSM-III-R as "recurrent intense sexual urges and sexually arousing fantasies involving cross-dressing"[48] (p. 289). Broadening the definition of transvestism to capture behaviors and fantasies like those mentioned above would, at this point, create more confusion than simply adding another term to the nomenclature; moreover, the term *transvestism* would be a very poor descriptor of the behavioral class in question.

The notion of autogynephilia points toward an unexplored, multiform array of cross-gender behaviors that must eventually be explained by any comprehensive theory of gender identity disorders. The process of generating and testing such theories might even force refinements, if not substantial revisions, in current explanations of the familiar form of autogynephilia, transvestism. Not only the etiological theory of gender identity disorders but also the clinical management of these conditions could profit from adding the notion of autogynephilia to our conceptual armamentarium. The research completed to date on nonhomosexual male gender patients indicates that anatomic autogynephilia rather than transvestism is the main correlate of transsexual tendencies and also of diminished capacities for heterosexual relations and pair-bond formation. These findings suggest that clinicians' prognostic judgments might improve if they question their patients about the less visible forms of autogynephilia as well as the outward forms such as transvestism.

I have, at a few places in this article, speculated that some aspect of autogynephilia might be understood in relation to characteristic features of heterosexual behavior. If I am correct, then progress in explaining autogynephilia is linked to progress in explaining normal heterosexual development. It is conceivable that concepts and theories might flow in both directions, with research on autogynephilic behavior elucidating aspects of ordinary heterosexuality. It is, on the other hand, certain that a full account of normal psychosexual development is essential to any comprehensive theory of autogynephilia, and that we cannot, in the final analysis, understand how one man comes to love himself as a woman until we understand how another man comes to love a woman.

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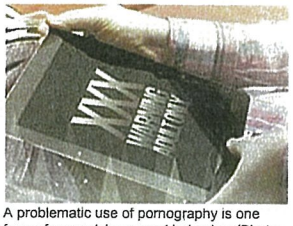
Study yields insight on sexual disorder and its effects on Vets

June 7, 2017

By Mike Richman
VA Research Communications

Compulsive sexual behavior (CSB), also known as hypersexual disorder, is of emerging interest in the psychiatric research community. But data are shallow in terms of fully understanding CSB—often defined as difficulties in controlling inappropriate or excessive sexual fantasies, urges, or behaviors that interfere with key areas of daily life—as well as its relation to other mental health problems.



A problematic use of pornography is one form of compulsive sexual behavior. *(Photo: ©iStock/milindri)*

Researchers believe that CSB may be tied in some cases to PTSD, suicide risk, and other psychiatric concerns in the Veteran population. But not enough is known about the relationship. Even explaining why CSB is more prevalent among Veterans compared with non-Veterans, or diagnosing Vets with the disorder and figuring out how best to treat them, has been a challenge.

As Dr. Shane Kraus, a clinical psychologist at the Edith Nourse Rogers Memorial Veterans Hospital in Bedford, Massachusetts, puts it: "We're just scratching the surface" in researching CSB.

"Our Veterans have so many complex problems that sometimes...we're not always thinking right away about these other behaviors."

To learn more, Kraus led a team of researchers that conducted the most thorough Veteran study on compulsive sexual behavior to date. In the study, almost 14 percent of men and more than 4 percent of women acknowledged CSB-related symptoms. The study, published in March 2017 in *Military Psychology*, also indicates that gambling, suicidality, and sexually transmitted infections were associated with male CSB. (Due to the small percentage of women reporting the disorder, further analyses focused only on men.)

The results suggest "CSB may be prevalent among U.S. military Veterans post-deployment and associated with significant negative health indices in men," the researchers write. "Some Veterans may be having difficulty managing their sexual behavior, raising concerns about possible unmet treatment needs for soldiers after they transition back to civilian life. CSB warrants attention regarding screening and intervention."

At the Bedford VA, Kraus sees Veterans suffering from behavioral addictions such as compulsive sexual behavior, excessive gambling, and binge eating. He says a lack of research and training has led to uncertainty in the medical community about how to best treat Veterans with CSB.

ESMIRNA L CARABALLO
Notary Public – State of Florida
Commission # GG 134903
My Comm. Expires Aug 15, 2021

This is Exibit "J" referred to in the Affidavit of Jamie Shupe sworn before me this 25th day of June 2019.

"It even took me a while to learn," he says. "Our Veterans have so many complex problems that sometimes when we see them we're not always thinking right away about these other behaviors. We might be thinking about someone who's having difficulty with alcohol use or PTSD or something else. So you're more focused on that. These other areas kind of get ignored or pushed to the side, not intentionally. It just happens when you're working with someone who has a lot going on."

New research sparked by smaller earlier study

The Kraus-led study piggybacks on a 2014 VA study led by Dr. Philip Smith, an epidemiologist at Yale University (he's now at the City College of New York), that consisted of 258 male Veterans who had recently returned from Iraq and Afghanistan. Nearly 17 percent of the participants reported CSB symptoms, with researchers linking the disorder to PTSD and childhood trauma.

The conclusions in Smith's study sparked a more comprehensive look at the issue. Kraus' study included 820 Veterans—both male and female—who had combat exposure in Iraq and Afghanistan. The names were randomly drawn from the Survey of the Experiences of Returning Veterans (SERV), a VA-funded study that is looking at gender differences in coping behaviors of those returning from military service. Dr. Rani Hoff, director of VA's Northeast Program Evaluation Center, which is responsible for evaluating programs in VA Mental Health, and the lead investigator on the SERV study, co-authored the research led by Kraus and Smith.

The average age in Kraus' sample was 35, and nearly 80 percent of the participants were white. The researchers conducted phone interviews with the Veterans, who were guaranteed their names wouldn't be used in the study. The Vets screened positive for CSB by responding "yes" to either of two items in the Minnesota Compulsive Disorders Interview, which includes questions on compulsive gambling and sexual behavior:

- "Do you or others that you know think that you have a problem with being overly preoccupied with some aspect of your sexuality or being overly sexually active?"
- "Do you have frequent sexual fantasies, urges, or repetitive behaviors which you feel are out of your control or cause you distress?"

Sixty-eight of the 493 male Veterans (13.8 percent) reported CSB symptoms, compared with 14 of the 327 women (4.3 percent).

Kraus is unsure whether the percentage was much smaller for the women because they were perhaps more reluctant to speak out on a very sensitive subject.

"That's a really good question," he says. "It's kind of hard to know because there's a lot of shame. Any person would be naturally uncomfortable sharing any difficulties they're having, but we know when you're having problems with sexual behavior or substance abuse or other things, it's very difficult to talk about it. Women Veterans have lots of complex needs and are dealing with lots of things already, so this may be even more difficult for them to talk about."

He says he finds it interesting, though, that 4.3 percent of the women screened positive for CSB, compared with 1.2 percent of women in a 2013 non-VA survey of college-age people. The rate was 3 percent for men in the same survey.

"The college sample had "pretty young, pretty active men and women," he says. "Those college samples don't have the mental health problems that some of our returning Veterans are having, so it's not the same kind of population. But our rate is much higher than we would have expected."

Data suggest that CSB rates range from 3 percent to 6 percent in the general population. Kraus explains that the rates in his study may have been much higher, particularly among men, because of its low-threshold, two-question system for screening positive. He cautions that the study was intended only for screening purposes and didn't include more lengthy CSB assessment measures. He's now working on a paper that consists of data from a 19-item inventory that reliably assesses compulsive sexual behavior. Such data are needed to provide "more comprehensive, more robust ways to measure these problems among Veterans," he says.

In his latest study, many of the male Veterans who screened positive for CSB also provided information that identified possible risk factors for the disorder. Kraus wasn't surprised that gambling, suicidality, and sexually transmitted

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infections were "significantly associated" with male CSB. He says those findings were consistent with past literature. He says there was no breakdown on the types of gambling involved and notes that suicidality referred only to suicide ideation, or thoughts of taking one's own life.

Anonymous sex, pornography major forms of CSB

Engaging in anonymous or casual sex multiple times per month, whether or not one is married, and a "problematic" use of pornography were the most common forms of compulsive sexual behavior, Kraus says. The study did not assess whether participants engaged in heterosexual or homosexual acts, or if they showed forms of aggression such as rape, he says.

Last year, Kraus co-authored a paper that said young Veterans—36 percent of men and 9 percent of women—are using digital social media platforms to meet someone for casual sex. The paper also found ties between such behavior and PTSD, insomnia, depression, hypersexuality, suicide ideation, and sexually transmitted diseases.

But in a sign of the ambiguous nature of CSB, his latest study said PTSD symptom severity, anxiety disorder, impulse-control disorder, and mental health functioning were not "significantly associated" with the disorder. "I'm not 100 percent sure why," Kraus says. "I think it's hard to say. It's one of those things where we know they're highly comorbid, but why we didn't find them is unclear. We did see a basic association, but when we put the findings in a model we didn't see them come through. So it doesn't mean they're not associated with CSB. It just means that when you're looking at a whole group of factors, they're not coming out the strongest of the group."

In light of his group's findings, Kraus advocates more precise psychiatric evaluations to screen, for instance, for gambling, suicidality, and the possibility of acquiring sexually transmitted infections.

"Sometimes we're missing stuff," he says. "One of the things I'm curious about is [that] we're seeing a strong relationship between PTSD and sexual behavior. Some people use alcohol and other things to cope with PTSD and other problems. What if people are engaging in certain sexual behaviors to cope or to deal with PTSD or other mental health problems? It's kind of an avoidance behavior. We just don't know."

Kraus thinks his study and future research could help guide VA care.

"We want our research to have clinical outcomes, and we want those clinical outcomes to improve education, training, and implementation," he says. "We plan to roll out a clinical training plan sometime in the next two years. Some of that will be part of policy implementation. I'm working with the VA Central Office to say, `Here are some things that we're finding. How do we disseminate this more broadly?'

"But you've got to show it's a problem first," he says. "That's what we're doing."

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2/08/2019

I, Ashok Srihari, MD, State of Florida Medical license ME 133002, DEA registration number FS7060318, am the physician of Jamie Shupe (DOB 8/10/1963), with whom I have a doctor/patient relationship and whom I have treated. Jamie Shupe has undergone treatment for gender identity concerns, and is requesting that identity documents revert to the male sex originally assigned at birth.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

Thank you in advance for treating my patient with dignity and respect.

Signature of Physician

Ashok Srihari MD

Notary Public State of Florida
Johanna G Conner
My Commission GG 189236
Expires 02/22/2022

Johanna Conner
2/08/2019

ESMIRNA L CARABALLO
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This is Exibit "K" referred to in the Affidavit of Jamie Shupe sworne before me this 25th day of June 209.