Few of us, even in our most introspective moments, question our sexual identity. What we see when we look at our genitals confirms our sex. But for a small minority—the transsexuals—the reality of their anatomy is in direct conflict with their feelings. Medicine is trying various methods of resolving this conflict—including the surgical removal of the "offending" organs.

THE SEX CHANGERS

by Bobbie Jacobson

In 1954 an American doctor, Harry Benjamin (described as the "pioneer of transsexual research"), first introduced the term "gender rôle disorientation" to label biological males or females who were convinced they were really members of the opposite sex, but had been endowed with the "wrong" set of genitals.

It's difficult to estimate the extent of transsexualism because only a small percentage of transsexuals seek medical help. The ratio of male to female is about three or four to one. Reasons for this ratio are unclear but it might be that a woman dressed as a man is less conspicuous and more acceptable than a man in a skirt. Despite the lack of accurate statistics, it is safe to say that transsexualism affects only a minute proportion of the population. (A 1968 estimate for the USA suggested there was only one male transsexual to every 100,000 people.) But transsexualism does raise two potentially hazardous problems for the doctor, patient, and society: how should the condition be defined and how can transsexuals be helped?

Since Benjamin's work, wider clinical experience has confused rather than elucidated these problems. Definitions of transsexualism still vary widely. Some doctors claim the

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Della Aleksander was a male transsexual until June 1970 when she underwent surgery in Casablanca. She originally attended the Gender Identity Clinic at Charing Cross Hospital where she received a course of oestrogen therapy. As well as its physically feminizing effects, the oestrogen produced marked changes in mental outlook leading to the adoption of feminine interests and even visions of having babies. She now feels completely at home in the female rôle.

condition is non-existent, others believe it to be an obsessional neurosis or even psychosis manifested in a patient who has fantasies about being the opposite sex. The latest (American) variation on the theme is that the root of the transsexual problem is constitutional. This hypothesis involves the introduction of the concept of "psychological sex" which could be constitutionally different from the anatomical or genetic sex. Proponents of this theory claim a male transsexual's brain failed to be androgenized at birth. There is little evidence to support this theory apart from a few animal experiments which show that testosterone given to chicks before birth causes all the progeny to behave in a stereotyped male way irrespective of their genotype. This can hardly be extrapolated to explain transsexualism in terms of the human hypothalamus being insensitive to androgens.

Dr Joseph Adler, formerly clinical assistant at the endocrine clinic at Charing Cross Hospital, London, has been treating transvestites and transsexuals for many years. He sees no essential difference between the two groups.

"They both desire to remove the external criteria used for sexual recognition by the outside world," he says. The only difference is in degree. "In the transvestite the stress is on clothes and cross-dressing, whereas in the transsexual the stress is on removing the external genitalia."

As an endocrinologist, Dr Adler is convinced the transsexual's problem is not an organic one; research has shown that male transsexuals have normal testosterone and other ketosteroid levels and female transsexuals have normal oestrogen levels. The only exceptions are sufferers from rare chromosome anomalies such as the Klinefelter syndrome with its XXY chromosome configuration.

Dr John Randell, consultant psychiatrist at Charing Cross Hospital, does see a definite distinction between transvestites and transsexuals. In the course of his work as head of the Gender Identity Clinic at Charing Cross Hospital, he has seen 700 male and 140 female transvestites and transsexuals. Both Dr Randell and Dr Adler agree that cross-dressing and envy of the opposite sex occurs early in childhood. But this, says Dr Randell, is where the overlap

Georgina Somerset, née George Turtle, was always aware of a certain degree of intersexuality. She underwent surgery in 1957, married a few years later, and is now working as a dentist in Hove. Despite the happy outcome of

her own experience, she still thinks that surgery is probably not the right answer for the transsexual. Many of those who go ahead with it will be as unsuccessful in the female's rôle as they were in that of the male.

between transvestites and transsexuals ends. The transsexual reaches sexual awareness at the age of three or four and begins to feel that "Nature has made a mistake". But cross-dressing in transvestites starts much later—at the age of eight or nine years.

The motives for cross-dressing are different too. "The transsexual has no emotional response to clothes," says Dr Randell. "Cross-dressing for them is merely part of the whole female rôle. The transvestite is a person who derives pleasure from a compulsion to dress in female clothes. This always occurs in a state of heightened emotional tone (which can be sexual excitement)."

Jokingly perhaps, Dr Randell suggested I was a female transvestite (I was wearing trousers) because I must have felt "compelled" to wear them. It must be difficult to distinguish between a transvestite who feels the compulsion all the time and a "true" transsexual, yet this distinction is important for anyone deciding what methods of treatment will help.

Is it likely that a child of three can distinguish between the sexes in an adult genital sense? Dr Adler says no. "A child's concept of the other sex is not genital. It merely gathers experience of the other sex by how they appear externally (i.e. by dress) and how they play."

He thinks the clue to the origin of transvestism/transsexualism comes from the child's positive or negative identifications with either parent. All children experiment in playing different rôles and often an element of a child's frustration is "if only I were someone else". So if, for example, a young boy hates his father he may identify with him negatively and want to become "something different". Or he may positively identify with his mother and consequently dress and play like a girl. Dr Adler believes the transvestist act is a gender identification with the sex that is in a more advantageous position, and the transvestite will want to change rôle when it gives him greater advantages.

Using Jungian psychoanalytical terms, Dr Adler says the male transvestite/transsexual will want to change his persona to *appear* as much like a woman as possible but not to

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be a woman. Just as the child who misbehaves may submit to his parents' wrath by presenting a more favourable persona, so the transvestite extends this infantile concept of gender rôle into adulthood.

Dr Randell agrees there is little evidence to suggest a person's inherent constitution has any influence on whether they become transsexual or not. "Children respond to the instructions they are given. On the basis of conditioning you can produce a male or female." This sort of conditioning occurs in the rare cases where a child's external genitalia belie the true internal or genetic sex and the child is reared as the "wrong sex".

If transsexualism is a form of obsessional neurosis can psychoanalysis and psychotherapy help? Dr Randell says: "All analysts agree that psychoanalysis makes no impression at all. Aversion therapy will work if anything does, but the patient must be highly motivated for this unpleasant treatment to be of any use." And presenting transsexuals never want to be "cured", they merely seek the means by which they can "change their sex".

But in Dr Adler's Jungian argument, the key to successful treatment is to "make the transsexual believe that his 'persona' is acceptable as a male and not as a female". He admits this is a long uphill process which needs years of concentrated analysis and psychotherapy but the psychiatrist must be willing to devote his time to doing this. Disagreeing with psychiatric opinion and methods at the Charing Cross, he decided to start his own group therapy sessions for 30 of his transvestite/transsexual patients. He used a combination of dream analysis, group, individual, and paint therapy and says 20 of the 30 patients are now "well" insomuch as they now no longer want to be rid of their "offensive" genitals.

Says Dr Adler: "We are all bored by the outdated Freudian thinking that the root of all neurotic problems is sexual. It is obvious that the transsexual's problems are much more complex than Oedipus would have it."

People who believe psychotherapy cannot help transsexuals have used a combination of long-term oestrogen therapy with or without subsequent surgery. What effects do oestrogens have on the healthy male? Dr Randell says: "By reducing the sex drive it is hoped they (oestrogens) channel the desires away from the transsexual direction." But where does this leave the impotent and chemically castrated patient? Oestrogen will cause testicular atrophy, possibly by direct action on the testes, and it also has a hypothalmic affect. People working at contraceptive pill factories and on hen farms also know that oestrogen stimulates the growth of breast tissue. Surely the transsexual who sees his breasts developing will be even more convinced of his femaleness.

Della Aleksander was a male transsexual who has had both oestrogen therapy and surgery. She had the surgery in Casablanca in June 1970 and now feels totally stabilized in her new female rôle. She originally attended the Gender Identity Clinic at Charing Cross where she was prescribed oestrogen treatment on her first visit. "I was not examined or given any tests until I had a buccal smear taken and an EEG six weeks later," says Della. "Subsequently I had a 10-15 minute interview once a month at the clinic where I got another prescription for stilboestrol."

"Oestrogens do not only have physically feminizing effects; they have marked mental effects too. After I started taking them I became rabidly homosexual. I had visions of having babies and adopted feminine interests, including an interest in men. What is so amusing and tragic is that female hormones are given to quieten the male libido, but something much more insidious happens. The patient *feels* more female. Oestrogens essentially convert a transvestite into a transsexual. If I hadn't been on hormone therapy I would never have dreamt of changing my sex."

Mrs Georgina Somerset was born George Turtle. In her case she says there was a "certain degree of intersexuality". In 1957 she was operated on and has now been married 11 years and is a practising dental surgeon in Hove, Sussex. Although intersexuality is not the problem of the transsexual, says Mrs Somerset, she is acquainted with over 300 cases of transsexualism and feels she can comment because she has gone through the very operation that they seek. She says: "Oestrogen therapy brings on the actual thing you're trying to stop. There is no doubt oestrogens produce feminine feelings. They are only justified and indicated in the male transsexual who has clinically abnormal levels of testosterone." (This is not generally the case in male transsexuals.)

But long-term oestrogen therapy has other serious drawbacks. The original high oestrogen-containing contraceptive pill was withdrawn from the market because of the danger of thromboembolism. A transsexual may take stilboestrol for many years before surgery, and will probably continue afterwards. Is not such a person in danger of thrombosis? Della Aleksander has been lucky and only suffered gastritis and headaches. But her friend Jan, also a transsexual, has not been so fortunate. Shortly after "conversion" surgery she developed a serious thrombosis and was re-admitted to hospital. After successful anticoagulant therapy she was put back on a low dose of oestrogen, but the clot began to reform—and so the vicious circle went on.

Mary Jane (born David) was also prescribed oestrogens for several months. She has now been taken off the hormones because she developed signs of thrombosis. Mary has not been recommended for surgery yet and is in the "halfway house" state—an impotent chemically neutered male. Any amount of plastic surgery is unlikely to produce a satisfactory external female appearance because Mary is 6 feet 5 inches tall. She was given aversion therapy and ECT—but to no avail. Presumably the aversion therapy was an attempt to cure Mary, but in a letter from her psychiatrist *before* the treatment she was told: "If the treatment fails . . . you would have to convince me and society that you can live and pass as a lady." Further letters suggested Mary would "do better to work up to a complete life as a female by easy stages and become adept at female impersonation". In June 1973 the psychiatrist wrote to Mary's mother saying, "I do not think that we are going to be able to alter Mary very quickly and am afraid that he/she will have to put in more time as a female before I can take any action." Throughout the correspondence there are under-

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Dr Joseph Adler. Has been treating transvestites and transsexuals for many years, and sees no essential difference between the two groups. The problem, he believes, is not an organic one, and its solution lies in convincing the patient that his "persona" is acceptable as a male rather than a female. The means of achieving this outlook —analysis and psychotherapy.

lying hints that Mary will receive the surgery "in time".

Mr Grant Williams, consultant urologist at Charing Cross Hospital who has performed surgery on a number of transsexuals, is not happy about the dangers involved in oestrogen therapy. He says all patients recommended for surgery are taken off oestrogens a month before the operation. He points out that the death rate for patients on oestrogen therapy for carcinoma of the prostate "is often higher due to oestrogen-induced thromboembolism than due to the disease itself". He agrees that early oestrogen therapy may encourage the desire to "change sex" but points out again that patients with prostatic carcinoma who receive oestrogens "do not *behave* like females although they become physically feminized". Mr Williams says he is not responsible for prescribing oestrogens. "That is within the realm of the psychiatrist."

Dr Randell is not worried about the possibility of thrombosis. "I have been prescribing oestrogens to male transsexuals for 20 years and there have been very few cases of deep vein thrombosis. None of my patients has developed carcinoma either."

The oestrogen controversy does not end here. Professor William Symmers, professor of histopathology in the University of London reported in the *BMJ* (April 13, 1968) two cases of male transsexuals who died of mammary carcinoma. Both patients had had mammoplasty and had been on oestrogen therapy. Professor Symmers concluded, "There is no reason to suspect that mammoplasty played a part in predisposing to the development of carcinoma . . . There were two exceptional cases of breast cancer in men whose hormonal balance had been massively upset by castration and administration of oestrogens."

It is easy to regard these reports as isolated anomalies of no statistical importance. But in view of the very small numbers of transsexuals who take oestrogens or have surgery (a rough estimate for this country is 200 operations to date) these "anomalies" may be alarmingly significant.

Improvements in surgical techniques (particularly plastic surgery) now allow the male transsexual to have a "conversion" operation which involves castration, penectomy, vaginoplasty, and mammoplasty. The operation has been euphemistically termed "gender-reassignment surgery" and is usually referred to in the Press as a "sex change operation". Mr Williams agrees these terms are misnomers. "We make a point of telling our patients that they can never change their sex or birth certificate."

Mr Williams operates on 10 per cent. of the patients from the Gender Identity Clinic. "I rarely operate on patients coming to me without prior psychiatric recommendations. I have operated on only one patient who came from abroad without recommendation." What was the justification for the operation? "It was obvious from his voice, behaviour, and dress that surgery was indicated. He even deceived my secretary."

About 90 per cent. of the operations are performed on the NHS. But for an operation that takes three hours, the waiting is bound to be long. Obviously operations for conditions like bladder cancer must take priority on Mr Williams's list. But he stresses, "It is imperative to perform

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Dr John Randell runs the Gender Identity Clinic at Charing Cross Hospital, and believes that oestrogen therapy can help by channelling the sex drive away from a transsexual direction. Surgery, he feels, "is well justified in the light of subjective and objective improvement in life adjustment."

this surgery on the NHS or it could turn into a money-making racket reminiscent of the back-street abortionists." Unfortunately many transsexuals are not willing to wait for several months to have the surgery and may pay up to £500 to have it privately.

The sort of "racket" Mr Williams refers to thrives in Casablanca where the operation is performed in unsalubrious surroundings and with no questions asked—as long as the patient can afford to pay anything up to £1,000. Dr Bourou at the Casablanca clinic has become renowned as "the expert" in plastic vaginas. Della Aleksander, April Ashley, Wally Stott, and Jan Morris are among the many satisfied ex-Casablanca customers.

But what are the medical criteria upon which the psychiatrist decides whether to recommend surgery or not? Dr Randell says, "I always assess them for at least six months to a year to see if I can help them psychiatrically. They must show me that they can pass and live as females before I will recommend surgery. The period of screening can be shortened if it has been established that the patient has lived as a female for several years."

Dr Randell stresses that the operation consists of plastic surgery on a neutered male and there is no question that the patient has changed his sex. If the transsexual's problem is psychological how does the removal of his genitals help him to cope with his neurosis? "You could say that we are helping people to be neurotic more efficiently. But we are aiming for a better adjustment to life in the converse gender rôle," says Dr Randell.

Dr William Kennedy, a psychotherapist, has very different views. "To recommend surgery for the transsexual is to collude with the patient's fantasies about himself. It is in the same category as the psychiatrist who would collude with his patient's fantasies about committing suicide—and then provide him with a method to do so. If all psychiatrists 'complied' with their patients' fantasies, what possible use could psychiatry be?"

Dr Kennedy claims that in the light of present knowledge, it is unlikely that people who are chromosomally male can be regarded as inherently female in any way. The psychiatrist's job is to "see the total person" and not to become fixated by the sexual aspect of the problem. Many transsexuals have sado-masochistic tendencies; they may attempt self-castration and suicide. In order to understand such acts "we must go back to *before* the sexual identification in the emotional life of the transsexual, to find out what fears, anger, and hatred he has in relation to his mother," he says.

Mrs Somerset, perhaps surprisingly, thinks that surgery for the transsexual is probably not the answer. "There is no doubt that surgery produces a mutilated individual. The transsexual is merely swapping one set of difficulties for another." Very few transsexuals are aware of the tremendous problems and agony that lie ahead after the operation. They think the surgeon will magically transform them (often from large hirsute men) into devastatingly beautiful women. Says Mrs Somerset, "Many of those who go ahead with surgery will be as unsuccessful as females as they were as males."

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Although Della Aleksander advocates transsexual surgery, she thinks the criteria used for selection of patients are totally unacceptable. "To prove that you can pass an obstacle test and work and impersonate a woman for a few months has nothing to do with being a viable female. It merely shows that you can be a female workhorse. We don't live in clinics, we live in a human society and the only way to assess our true ability to exist as females is to study our background and the relationships we form."

For the USA the "philosophy" used to decide who is to be castrated and who isn't is similar to ours. As a result of Benjamin's "revolutionary" work, a gender identity clinic was set up at the Johns Hopkins Hospital, Baltimore. Writing in the book *Transsexualism and Sex Reassignment,* Dr John Money, a psychologist at Johns Hopkins, describes the main criterion for selection for surgery: "The patient must have lived in the desired sex vocationally and socially for a long enough period of time (up to two years) to prove his (or her) ability to function in society in the changed sex." The patient must also be "authentically motivated" and "non-psychotic". Questions to be asked include: "Will he undergo a sociocultural crisis? Is the patient a candidate for psychotherapy?"

Dr Adler had practical experience of the use of these criteria when he was invited to the Johns Hopkins Clinic. He was told a panel of "experts" assessed all cases for at least a year before recommending surgery. Yet when he examined a patient who had been recommended for surgery after three months' "assessment" he was astonished by what he found: a team consisting of a psychiatrist, an endocrinologist, a neurologist, and a gynaecologist established the patient's psychiatric status, but not one person on this impressive list considered it necessary to actually examine the patient. The patient, although male, was referred to as "she" and the team concluded "she" had been having "heterosexual" intercourse with another male. "These people are completely confused," says Dr Adler. "They are so anxious to become the world's leading sex-changers, they have created a social phenomenon which may reach addiction levels."

If we assume for a moment that surgery is justified in a few cases, how successful is it in producing a sexually active "female"? Dr Randell and Mr Williams both say post-operative follow-up is difficult (Mr Williams says "or even undesirable") because patients rarely come back to the clinic. This is hardly surprising because the transsexual has (apparently) got what he wants. When, in *Transsexualism and Sex Reassignment,* Dr Randell reported the results of transsexual surgery in a series of 29 male patients, he concluded: "The overall post-operative appearance was good in only a third.

Despite this two thirds were satisfied with the end result. Vaginoplasty was only carried out in a third of the cases but seldom proved satisfactory. This means that most transsexuals will not be able to enjoy any kind of sex life at all. Yet Dr Randell

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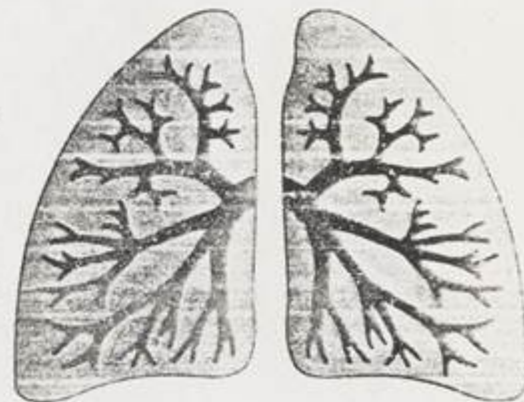

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says the results suggest "The operation is well justified in the light of subjective and objective improvement in life adjustment."

But can the transsexual who has taken an irreversible step afford to have any regrets? "Many do have regrets," says Della, "but to admit them would be tantamount to throwing themselves off the bridge."

Transsexual surgery cannot be considered only in a medical context. What is the socio-legal status of the transsexual? The law (and medicine for that matter) says that any person bearing XY chromosomes is a male and the "converted" transsexual is disappointed and confused to find "he" cannot legally change his birth certificate.

Transsexuals often want to get married after surgery. Since 1971 marriage between a surgically treated male transsexual and another man is "lawful but not legal". April Ashley found out when her marriage was annulled that she was legally labelled as a "male homosexual transsexual". If "gender reassignment surgery" is to become an acceptable form of treatment should we revise our laws accordingly? Mrs Somerset says "The medical profession has no right to take the *law* into their own hands. For the law has not yet caught up with medical advances."

Surgeons and psychiatrists may argue that there is no such thing as a "change of sex", but by performing the surgery they are inadvertently causing a legal paradox. "We mustn't change the laws too quickly and make it too easy for the transsexuals to change their legal sex indiscriminately," says Mrs Somerset. "But medical progress and legal reform must be linked."

Equally relevant is the question whether it is now *medically* too easy to obtain transsexual surgery?

The existence of transsexualism and other sexual variations has prompted us to start rethinking our definitions of sexuality. But most of us are perhaps not emancipated enough to accept these variations as part of a real sexual spectrum. Paradoxically, even the transsexual who would consider us narrow-minded in our strict definitions of sex and gender, strives himself to conform to being either male or female.

The only thing that emerges clearly from this whole controversy is that there is little agreement within the medical profession. Dr Randell says there is virtually no liaison between his and the other two gender identity clinics in this country. (Professor Sir Martin Roth runs one at the Newcastle General Hospital and Dr Sydney Brandon runs the other in Manchester). Dr Kennedy feels there is no sense in pointing the finger at a particular person or method used. "The proper authorities should be made aware of what is happening and some form of committee should be set up through the GMC/NHS to examine the evidence collectively. At present we understand very little about the elusive 'transsexual phenomenon'.

"The case for multilating an individual by chemical or surgical castration needs much more justification." ■