Male Transsexualism: Uneasiness

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The author discusses sex reassignment in men. He points out that since 1953, when the procedures were first publicized, attitudes toward granting "sex change" have become increasingly liberal, resulting in a dearth of knowledge about the number of men who have received hormonal or surgical treatment; the frequency of surgical and postoperative complications and of morbidity and mortality; the nature and frequency of psychiatric complications; and the percentage of those treated who have benefited. Believing that sex reassignment should be restricted to the most feminine men, the author urges more scrupulous follow-up studies and more careful consideration of requests for change.

THE CARNIVAL ATMOSPHERE PREVAILING in the management of male transsexualism may have been unavoidable considering what a spectacular aberration this condition is. At any rate it is too late to back up. By now probably a thousand or so males have been "sexually transformed." (We shall never know exactly how many because of the clandestine arrangements used by some surgeons.) Should time prove that the rate of untoward results is acceptable in terms of the severity of the condition, then we shall rest comfortably, and such procedures will become an unremarkable part of medical practice. But while we await these follow-up studies, there is reason for uneasiness.

First, let me express the opinion, which is in disagreement with those who feel that "sex transformation" is never indicated, that there are extremely feminine males who can effortlessly pass undetected in society as females and for whom no known treatment exists that would render them masculine in behavior and appearance. In the absence of any such treatment we have three choices: 1) insist, nonetheless, that they be treated by some method which does not work (e.g., psychoanalysis); 2) do nothing, with or without moral exhortation; or 3) provide them with "sex transformation." I favor the third option for these patients.

COMPLICATIONS

The issue is complicated, however—more so than is usually acknowledged. Some years ago positions were polarized: A small number of physicians favored helping patients change sex roles, while a majority of people (of particular importance the medical profession, including psychiatrists) were opposed (1). Now, publicity and showmanship have reversed opinion, with a large part of the public and the medical profession comfortably, and unthinkingly, accepting the treatment.

Here the first complication arises: The patients themselves announce the diagnosis of transsexualism and expect physicians simply to perform the mechanics necessary for altering their bodies. This is odd, but more distressing are the referrals from medical colleagues who fail in their responsibility to diagnose the patient themselves but, rather, accept him as a transsexual simply because he has requested sex transformation. These physicians then want psychiatrists to arrange for the treatment; imagine: a diagnosis based on the treatment the patient recommends. This is terrible medical practice, mitigated for me only by the hope that it makes no difference who is "transformed" *if* all have happier lives. But we do not *know* that yet; we can *suspect* that some patients are not doing well postoperatively.

Following is a hypothesis that can be tested if proper follow-up studies are done: The more masculine a patient's appearance and behavior as an adult and the more masculine episodes he has had from earliest childhood on, the more likely he will have a psychic disorder after "sex change."

A second complication results from issues of diagnosis. Some believe transsexualism is fictitious, invented to permit homosexuals to escape their responsibility for being homosexual (2) or to prevent the unmasking of a psychosis hiding behind a clever delusion (3, 4). These positions grow from the inadequate criteria used to define transsexualism. There must be a more admirable way to diagnose this condition than to say a person is a transsexual because he requests sex reassignment. I would rather attempt to diagnose by assessing the degree of femininity and its length of existence. To put this differently, how firm is the patient's conviction that he really is a woman trapped in a male body?[1] Since it has already been done elsewhere, I shall not describe the clinical, psychodynamic, and etiological features that help me make the diagnosis of transsexualism (5, 6). A sketch may suffice if the reader keeps in mind that a more complete ar-

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[1] Of course, those of us faced with the task of diagnosing transsexualism have an additional burden these days, for most patients who request sex reassignment are in complete command of the literature and know the answers before the questions are asked.

gumcnt is to be found in these longer reports.

I have found the greatest femininity in males among those who have been feminine since earliest childhood and in whom no stage of masculinity has ever been observed. In such cases the mother has had a lifelong sense of worthlessness about being a woman that has driven her to want to be a male so intensely that during preadolescence she may almost have seemed a female transsexual. Following the changes of puberty, such a woman gives up hope and in time marries. Her husband is a distant, passive man and is never around the house to serve as a masculine presence. If this mother gives birth to a son who she feels is beautiful and graceful, she establishes an excessively close symbiosis with the child that excludes the father and persists for years. As signs of femininity appear in her son in the first year or so, she encourages them while snuffing out the slightest behavior she interprets as masculine. And so a genuine femininity is encouraged to appear from the first. It may not surprise us then if the son of such a person requests that his anatomy be changed to conform with his sense of himself as feminine.

To summarize my position regarding male transsexualism, if there is a group of people who more or less have the same clinical picture, dynamics, and etiology, one can properly consider them to belong to a clear-cut diagnostic category. Issues in treatment and in the search for etiology are only confused, however, if one throws many different clinical types into the same pot simply because all share one striking feature in common, i.e., the request for a sex reassignment, when they fail to share other features (6).

The following examples may illustrate my point.

CASE REPORTS

Case 1. This patient is the divorced father of two children, in his 30s, and in a profession that is practiced only by men and in which signs of femininity would lead to professional disaster. His appearance is masculine, not only because he is 6 feet 5 inches tall and weighs 250 pounds, but also because he is unable to carry himself in a feminine way. Nonetheless, since early adolescence he has secretly dressed for an hour or so at a time in women's clothes, becoming sexually excited and then masturbating. Despite his masculinity, he has recognized a wish to be a girl since mid-childhood. Beginning in adolescence, when he first started dressing in his sisters' or mother's clothes, he has told himself that he has two aspects, a girl's and a boy's. He has experienced the greater part of his life as a masculine-appearing man, inhabiting a male body; however, when he puts on women's clothes, he feels that he is a woman (although not a female) and that he has a woman's name. He does not believe that "sex change" will remove that part of his identity which is a man. Nonetheless, he demands this treatment since he believes his feminine aspect is enslaved inside his male body.

For years the patient could manage with intermittent cross-dressing; however, even though this was sexually gratifying, he began to yearn to reveal his femininity. Frustration of his desire made him severely anxious, and at times he slipped into a paranoid state with persecutory delusions. His next attempt at a "cure" was to try to find a masculine homosexual woman who would want to be transformed into a man and to marry her; then, each would trade roles. When he could not arrange this, he began thinking of sex reassignment. Not yet motivated to go through with the operation, however, he married, hoping either for a cure via heterosexuality or by spending more time in traditionally feminine activities, such as his wife's household chores. Although he could get erections and fathered children by fantasizing he had a vagina, this attempt—marriage—failed also.

With his marriage, the patient stopped seeing me. A few years later, he wrote to request an interview. A few minutes before the appointment he appeared, looking ashen and in shock. He had just incised the base of his penis in the bathroom across the hall. When the emergency was resolved, he told me how he had planned this exploit for weeks, having studied the anatomy of his genitals so he would not bleed to death inadvertently. He had hoped to force me, and thus the medical center, to give him an operation, although we do not have a program for such surgery.

Since the patient and I had always had a good relationship, I felt comfortable telling him that I would not be blackmailed in this matter. He apologized for having placed me in such a position but added that without the operation he would, regretfully, either blow up an airplane or poison the water supply of Los Angeles; he may have been technically equipped to do both of these. In addition he could barely resist running girls down with his car as they crossed the street to school.

Not forgetting his paranoid tendencies, I told him that on further consideration I could be blackmailed. This consisted of my condoning his dressing more frequently in women's clothes, prescribing a progesterone derivative (that has minimal feminizing effects), and standing aside as he worked to save money for the operation. Recently he arranged with a private surgeon for genital surgery. He calmed down, and the two years he has spent in this manner have been the happiest of his life. He bought a wig and women's clothes and for the first time began wearing them publicly during the day. He looks grotesque, but he is thrilled. Despite his mass, the blonde wig that does not fit, the bizarre makeup, the bulky walk, and his inability to carry himself in a feminine manner, he acts convinced that people think he is a normal female. He never appears at work as a female and has raised no suspicions there. In fact, the happy calmness that has overtaken him has led to the first professionally successful period in his life.

He says that after the operation he will continue to work and to spend his days as a man but that he can survive only if he has occasions to live as his womanly self. Let us hope he is right; this will be a better solution than another paranoid psychosis.[2]

Why call this patient a transsexual?

Case 2. This patient, who is in "her" 30s, divorced, and the father of two children, lived exclusively as a man until a few years ago. Having sensed a feminine quality since mid-childhood, he intermittently dressed in women's clothes throughout his teens, always becoming sexually excited. He lived for a few years with another man in an avowedly homosexual relationship in which he played both the masculine and feminine roles but preferred the feminine role. During his years in the military service, he had several homosexual affairs. In addition, he created and built a full-sized artificial man, which he kept hidden in an apartment. He made love to this man when-

[2] Beyond what I have said here, one may wish to contemplate further the morality of condoning a procedure with this patient because he threatened murder.

ever he could, placing the man's arms around him in an embrace and putting the man's penis in his anus. The patient also obtained pleasure from heterosexual affairs, and eventually he married.

In his late 20s, the patient spent several years as an armed robber whose spectacular feats were headline stories. This attempt to be manly ended when he was finally arrested; he spent many years in prison, during which time he decided that when freed he would live as a woman. I first saw him shortly after his release.

In time, he arranged for "sex change" and returned thrilled with the anatomical and psychological results. Although over six feet tall, he is sufficiently graceful to pass successfully as a woman, has been steadily employed, and has had boyfriends.

Should this patient be called a transsexual? Socarides reported the case of a similar patient whom he represented as the prototypical transsexual (2).

Case 3. This patient in his late 30s is married, the father of three children, and successfully employed in a typically masculine profession. He has never cross-dressed in his life, has never become sexually excited by handling women's clothes, and has never had homosexual relations. However, in recent years he has decided that he must have his genitals removed. During this time, he occasionally took estrogens, but whenever his breasts enlarged and his potency decreased, he became depressed thinking how he was hurting his wife. He finally decided to have the operation and to divorce his wife but still to support his family. He says he has no intentions of living as a woman.

Is this patient also a transsexual?

Case 4. This married man has never held a steady job because he has suffered from a schizophrenic thinking disorder since he was a teen-ager. When he was in his 20s, he decided he was a female. Nonetheless, he married a woman older than he was, because she felt she needed a husband. They had intercourse for a few months but ended this by mutual consent.

For ten years the patient wished for sex reassignment, insisting that he was a female. Unable to arrange for this, he moved away from Los Angeles; I have not seen him again. However, I did receive a letter from him in which he described how he had meticulously surgically removed both his testes in his bathroom. (The patient had had practical nurse's training.)

DISCUSSION

The list is endless. Anyone doing research on this subject has seen numbers of such people with the most varied personalities, having in common only their belief that a part of them is so feminine that it can be fulfilled only by "sex change." Some of these patients are primarily fetishistic cross-dressers; some, primarily effeminate homosexuals; some, primarily psychotic. The possibilities are endless. But if by inexorable logic they are all called transsexual and if that label is currently the only permit needed to grant sex reassignment, we have failed those patients for whom the operation is dangerous.

This detour into diagnosis promotes my argument: Until careful follow-up studies provide more adequate answers concerning who can safely be subjected to this massive surgical and psychological procedure, the most conservative and humane way to proceed, I believe, is to restrict "sex change" to the most feminine males. I believe that other workers can confirm my experience that all such patients pass silently, completely, and permanently into society as women.

Even if my proposition regarding etiology is wrong, perhaps this rule would still be the proper one to use. For instance, should it be proven that there is a specific biological cause for transsexualism, the wisest choice might still be to restrict the operation to the most feminine of males. They certainly give one the feeling that their femininity is firmly fixed and that their maleness can have no value to them.

Among those requesting help then, on whom should we not operate? I think that for the present time (although clinical judgment may force such rare exceptions as in case 1), we should exclude those who are psychotic, who have had psychotic episodes in the past, who are sorely depressed, who have had severe depressions in the past, who are currently married and have families, who have been married and were able to engage in intercourse with erections and orgasm, who appear to be masculine (by this I do not mean body build so much as manner of dress and behavior), or who for extended periods have appeared to be unremarkably masculine. We should also exclude the large group whose members, despite an ability to intermittently appear as feminine, have revealed throughout maturity that their genitals give them pleasure (e.g., fetishistic cross-dressers and effeminate homosexuals).

The rationale underlying the inclusion of this latter group of subjects (by far the largest number of people requesting "sex change") is that these men have significant, demonstrable masculinity and sense the value of their genitals, however much they also abhor them. In other words, these men have a history of valuing what they now propose to give up. One need not be a psychoanalyst to have seen people with ambivalence, one part of which is hidden until the other part is removed. Since it can be difficult to determine how highly a person prizes a given aspect of himself at a time when he denies it at the top of his lungs, we run risks in presuming that there is nothing of value to be lost. Until we can replace an amputated penis, we must be careful. Some physicians are familiar with the patient who has convinced a surgeon that "sex change" is indicated, indeed crucial; and yet the patient discovers postoperatively that he has made a mistake from which he cannot retreat. It is under these circumstances that we see the onset of psychosis, depression, suicidal intent, hopelessness, male homosexual prostitution, and even medico-legal complications.

Undoubtedly, however, there are many males, like those in my case reports, who would do better if granted "sex change." The problem is that we do not yet know how many will improve and how many will be harmed. We ought not be indiscriminant but, rather, we should establish criteria for accurate prognosis, not relying on anecdotes of good results and not minimizing those of bad results.

Now that I have rigorously restricted the diagnosis of transsexualism and suggested that we only operate on those who fit this diagnosis, how will we ever know what happens to the rest? With a bit of effort, we can probably obtain our answers from among the thousand or so such people already in society. Or we might set up an experiment to be carried out only by those medical centers in various countries which would be medically and scientifically responsible. In this experiment we could match categories reflecting the different clinical pictures, e.g., the transsexual, the transvestite, the effeminate homosexual, the mixed type. If only those who seem the most highly motivated were treated, we could then determine, with proper follow-up, whether those in one category did better than those in another or whether these concerns with diagnosis were not significant in the end results.

Can one argue that even without follow-up studies we can proceed without hesitation? This is how the medical profession has acted despite the example of such scrupulous teams as that at Johns Hopkins. At the least, changing a person's sex is no minor, benign surgical procedure, but rather one with significant surgical risks and with frequent postoperative complications. Any other new and potentially dangerous surgical procedure would have been tested more thoroughly. But there is something about the person who requests sex reassignment that brings out or attracts a lower level of medical performance in all areas of evaluation and treatment.

"Sex change" has profound implications that touch on everyone's vulnerability to magic; and in the management of would-be transsexuals the magic and mystery of the condition seem to act as an excuse for relaxing normal medical prudence. Worse, the treatment attracts some who are not medically prudent to start with. We all know of surgeons who are willing to operate as long as the price is right; they seem scarcely concerned even when they are inexperienced. We know of psychiatrists as well as other physicians who put themselves in the position of psychiatrists whose only criterion for recommending surgery is the shrillness of the patient's request. They are unconcerned about and unequipped to properly evaluate the patient's personality; they are equally uninterested in doing the follow-ups we so badly need. So far, there has been almost no protest about this state of affairs from those of us who know these patients best.

CONCLUSIONS

Since 1953, when procedures for "sex change" were first publicized (7), an unknown number of males have received hormonal and surgical treatment on request. That we have no notion how many have been treated when the procedures are experimental and potentially dangerous is astonishing. That we do not know, almost 20 years later, how the patients fared is scandalous. Only two workers have reported careful follow-up studies of more than single cases.[1] In 1969, Randell published results on 29 males and six females (9), which he extended in 1971 to 44 males and eight females (10). The Johns Hopkins team, the first to set up a well-planned program for sex reassignment, has published one report on 17 male and seven female patients. Originally done in German in 1970, Money later summarized this study in English (11). We do not know the frequency of surgical complications, postoperative complications, morbidity, or mortality. We know little of the nature and nothing of the frequency of psychiatric complications. We do not know what percentage of patients benefit from the procedures nor has anyone even published a competent rating scale to assess benefit. Except for anecdotes, we do not yet know what the passage of years does to these patients.

This is too primitive.

Can we not devise ways to control this runaway process? I believe that setting up programs for treatment ought to be the responsibility of the university medical centers—I think these experimental procedures should be restricted to the universities—not only to practice the finest medicine and to develop proper instruments to measure pre- and postoperative results, but also to exert effort to prevent incompetent and uncaring practitioners from treating these patients.

Finally, a closing thought: the conclusions in this paper hold for females as well as males.

[1] Benjamin also has reported his impressions, but he did not try to establish precise criteria for rating the results (8).

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