

The Surgical Approach to Problems of Sexual Identification*

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At the level of chromosomes recognized morphologically in every cell, two sexes are a basic biological phenomenon. At the level of the total organism, these sexual differences may be seen anatomically and endocrinologically and perhaps in a less precise way psychologically, especially as measured by behavior. In the human, various errors in the anatomical development of the sex organs due to genetic, environmental, or unknown causes have been recognized and described under the general heading of intersexuality. Poorly treated victims of these aberrations may experience confusion, or even crises, in sexual identification. For the most part, such psychological difficulties can be related to the anatomical ambiguity of the genital organs.

However, there are other individuals who, by ordinary anatomical, endocrinological, and chromosomal examination, are quite consonant with respect to one or the other sex but who, nonetheless, consider themselves to be of the other sex. In its full-blown clinical expression, such individuals manifest with consistent and persistent conviction the desire to live as a member of the opposite sex and progressively take steps to do so. Furthermore, psychological evaluation of such individuals reveals many characteristics of the sex opposite to their anatomical sex. Such individuals may be labeled as transsexual, and it is to the therapy of such patients that the role of surgery has been evaluated on a small number of patients at The Johns Hopkins Hospital over the last several years.

While transsexualism is a disorder which seems to affect both anatomical sexes, the gynecologist plays his principal role in the therapy of the

male transsexual, i.e., the anatomical male who considers the difficulty to be that of a female psyche trapped within a male body. It is only with these male patients with a female gender orientation that this discussion will deal.

Unfortunately for the therapist, the diagnosis of transsexualism is not easy and must be distinguished from other disorders which have, or seem to have, expressions of incongruent gender behavior. Among these are transvestism, homosexuality, psychotic individuals with confusion in sexual identification and gender role, neurotic sexual problems, and exhibitionism.

The gynecological surgeon should not, and indeed cannot, dispense with the wholehearted help of psychiatrists and psychologists in sorting out these sometimes overlapping entities. As with most behavioral disorders, there are no objective criteria, no specific physical findings, no laboratory test, no pathomonomic sign by which a specific diagnosis can be made. Nonetheless, it cannot be overemphasized that no pains must be spared to make an accurate diagnosis. Experience to date has made it abundantly clear that surgery is unlikely to be appropriate and may be devastating for those disorders which might be confused with true transsexualism but which, nevertheless, exhibit signs of deviant gender role.

Thus, the male transvestite is a "cross-dresser" at intervals for the relief of an insistent tension that builds up between cross-dressing. However, he is usually heterosexual in his relation with women and, if married, takes the position that his wife and children understand him and are not devastated by his actions and cross-dressing. It would obviously be an error to think of reconstructive surgery of the genitalia for the transvestite.

The effeminate male homosexual is erotically attracted exclusively to men. He may wear wo-

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men's clothes, but apparently the compulsion to do so is less than that of the male transvestite. He is not heterosexual, as is the transvestite. However, and most important, he seems to have no problem with his own sexual identification and has no desire for transsexual surgery, except in temporary situations such as the break up of homosexual partners.

The true male transsexual exhibits many phases of a female personality. This includes not only the desire to repudiate men's clothing and strictly male activities, but expresses itself to the surgeon as a desire to be rid of the male genitalia which serve as a constant reminder of a sexual symbol and status which are regarded with repulsion as inaccurate. Also, it is generally true that when a male transsexual is offered the option of having a vagina constructed, which is the only female organ which can be surgically offered, she will invariably elect to have that procedure carried out.

The undesirability of offering operations to psychotic individuals with confusion in sexual identification and gender role should be obvious. The other disorders which might be of some confusion, such as neurotic sexual problems and the like, are not only too trivial for surgical reconstruction but are amenable to psychiatric therapy.

One of the main reasons for evaluating surgery in the treatment of this disorder is the fact that transsexual individuals are very resistant to psychiatric help for their disturbance. While the gynecologist obviously cannot speak with great understanding and experience on the psychiatric approach to disease, it is perhaps not inaccurate to observe that psychiatric failure to offer help to the transsexual stems from the fact that the psychiatrist necessarily wishes to aid the transsexual by reorganizing the psyche to conform to the anatomical sex. This the transsexual resists and does not want. The psychiatrist, therefore, has no handle on the transsexual and does not have a sympathetic patient, for the patient regards with suspicion anyone who denies what the male transsexual believes to be the basic problem, that is, a female psyche trapped within a male body. It is because of this basic impasse in psychiatric therapy that endocrine and surgical manipulation might have a role in bringing the patient to terms with her basic conflict.

The Selection of Patients for Surgery. About five years ago at The Johns Hopkins Hospital, a gender identity clinic was established for the pur-

pose of studying the problem of transsexuality and the role of surgery in the therapy of patients with transsexualism. This clinic consists of several individuals from various disciplines. Psychiatry is very heavily represented, and a psychiatrist is chairman of the committee. Representatives of plastic surgery, endocrinology, urology, and gynecology and obstetrics regularly attend the clinic. Since the establishment of the gender identity clinic in 1966, there have been over 1200 inquiries by mail or individual application of individuals who considered themselves candidates for surgery. However, several of these applicants eliminated themselves from further consideration by failure to answer follow-up questionnaires about certain details of their disorder. In the third year of its existence, the clinic mailed additional questionnaires to all applicants and has a waiting list of approximately 500 individuals who might be candidates for further evaluation. It has never been the primary object of the clinic to service all comers, but rather it has been hoped that its principal objective would be a mature and careful consideration of the problem, especially of the relation of surgery to therapy.

Suitable patients are interviewed by a psychiatrist in a preliminary interview and if, on this occasion, the various confusing disorders mentioned above can be tentatively eliminated, the patient is then admitted for what is termed a full-scale evaluation. By this is meant an examination by each of the various members of the gender identity clinic during which time the patient is given not only a physical examination but an extensive psychiatric and psychological work-up. Patients to be considered candidates for reconstructive surgery must have fulfilled as a minimum the following requirements:

1. Insofar as can be determined by the various psychiatric and psychological tests, the patient must be a true transsexual and not suffering from any of the allied disorders mentioned above which have deviant sexual identification as part of the syndrome.
2. The patient must be at least 21 years of age.
3. The patient must have no police record of a serious crime or misdemeanor.
4. The patient must have lived in the female sex role for a minimum period of twelve months. During this time she must have proved her ability to be gainfully employed

as a female and to function satisfactorily in society as a female.

5. The patient must be unmarried.
6. The patient must be available for follow-up.
7. A responsible member of the family, the parents if possible, must be completely aware of the situation and enthusiastically support the possibility of surgical sex reassignment.
8. The patient must receive estrogen for a minimum of twelve months prior to the operative procedure.

It is obviously wrong, therefore, to think of surgical sex reassignment as changing the sex of the individual. The operation cannot be looked upon as a sex change operation. It is simply one step in the total rehabilitation of the patient. Since it is an irreversible step, it is of the greatest importance that no error be made in the diagnosis. Furthermore, it is highly desirable, but difficult of achievement, that the period of surgical sex reassignment not be the final contact of the patient with the clinic, so that the members of the clinic can be as useful as possible in aiding the further rehabilitation of the patient in her continuing female sex role.

Results of Surgery. The postoperative behavior and adjustment of transsexual patients is the key to an evaluation of the role of surgery in the treatment of transsexualism.

The postoperative course of 17 male transsexuals who have had endocrine and surgical sex reassignment has been the subject of a study by Money and Ehrhardt of our clinic (Money and Ehrhardt, 1970). These 17 patients were followed from one to thirteen years. As a group, they expressed a willingness to undergo surgery again and all of them considered that they had achieved improved status. Eight of the patients had an employment status which was essentially the same as that before operation, but nine of the patients had an improved employment and economic status. Six of the patients, prior to the adoption of a policy which would exclude such individuals at the present

time, had a police record. Two of these continued to have difficulties with the police after surgery, and it is for this reason that such patients are no longer considered for surgery. The marriage status of the individuals was as follows: two were married preoperatively only as males, seven were married postoperatively only as females, two were married preoperatively as males and postoperatively as females, and six were never married.

It seems clear that surgical reassignment does not harm carefully selected patients, does offer considerable improvement but, by the same token, does not automatically result in the cure of various problems not directly related to the problem of gender identification.

Postoperative male transsexuals living as women do not lose the capacity for erotic genital sensation. Orgasm is not unusual. There seems to be a particularly erotic area in the region of the prostate.

In general, follow-up of transsexual patients who have been successfully operated on is difficult because the more successful the treatment of the patient, the less they wish to maintain contact with the clinic and the more they wish to disappear into the new society they have found and created.

Our experience would lead us to believe that endocrine and surgical therapy of carefully selected male transsexuals has a role in the contemporary management of such individuals. However, it cannot be overemphasized that the proper diagnosis is not simple, requiring the dedicated cooperation of psychiatrists and psychologists who are knowledgeable in the field and who are willing to devote the necessary time and energy to add their skills to those of the endocrinologists and surgeon; all of whom as a team can make the only reasonable approach to this problem.

REFERENCE

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