

500 in the U.S. Change Sex In Six Years With Surgery

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Six years ago, it was disclosed that American doctors had been performing one of the most radical forms of surgery — the operations that change one's sex. Since then, an estimated 500 persons have undergone surgical sex change in this country, and hundreds more have applied for such surgery.

Now several university medical centers, where about one-third of the cases were handled, are in the midst of assessing the result of their work. Preliminary findings indicate that generally the surgical programs have been successful in achieving their goals: relative contentment and peace of mind for persons whose lives before surgery were marked by depression, isolation, despair and often attempted suicide.

Before surgery, the patients had been diagnosed as transsexuals — persons with the seemingly normal physical makeup of one sex but, for as far back as they can remember, the psyche of the other. Such persons are said to have a crossgender identity.

Unlike transvestites, who derive emotional satisfaction from occasionally dressing like the opposite sex, and homosexuals, who, regardless of how effeminate or masculine they may be, still think of themselves as belonging to the sex into which they were born, the transsexual — male or female — repudiates his or her biological sex and often tries to pass as a member of the opposite sex.

As adults, such patients have proved unresponsive to any form of psychiatric or drug therapy. Doctors specializing in the problem, unable to make the mind match the body, decided to make the patient's body match the mind.

For the male transsexual who is changed to a female—the more common direction of sex-change surgery—the procedure usually involves removal of the penis and testicles, construction of an artificial vagina lined with the sensitive skin of the penis, and in some cases breast enlargement.

In the change of a female transsexual to a male, the breasts are removed, a hysterectomy performed, a penis is constructed using the sexually responsive clitoris and other tissue and testicles are made by implanting prostheses under the skin. The penis, however, is incapable of erection.

In addition to surgery, the males—testosterone for the new males and estrogen for the females—that stimulate such secondary sex characteristics as beard growth, distribution of body hair and body fat and breast development.

The surgery is expensive—hospital costs can exceed \$10,000—and the results sometimes fall short of the physical ideal.

Still researchers maintain that in properly selected cases, there are no regrets. They concede, however, that a patient who has willingly undergone such radical, irrevocable surgery would be unlikely to say he or she was sorry the step had been taken.

Results Satisfying

In sentiments typically expressed by sex-changed persons, a former female who was operated on two years ago said:

"For more than 20 years, I lived in a continual state of confusion and loneliness. I thought of myself as a boy, but the world reacted to me according to what they saw—a girl. Now, for the first time in my life, I can live as a complete and normal human being. I am a man, the world sees me as a man and treats me like a man."

Despite such testimonials, even the most committed physicians regard surgical sex reassignment as a less-than-perfect solution to the problem of transsexualism.

In an effort to avoid surgery, a few medical centers are trying to identify children who may be "pretranssexuals," and are treating them with the hopeful goal of reversing their gender misidentification before it is too late.

Other researchers are seeking possible psychological and biological causes of transsexualism, which may one day lead to methods of preventing distortions of gender identity.

Although the successful transformation of George Jorgensen to Christine in Denmark 20 years ago received much publicity, it was not until 1966 that an American medical center—

Johns Hopkins University—announced its willingness to perform transsexual surgery. Johns Hopkins has since done 32 sex-change operations, nine of them changing women to men.

A Turn for the Better

In the next several years, similar surgical programs were established by a number of private surgeons and at nearly a dozen American medical centers—including the University of Minnesota, Stanford University, the University of Michigan, the University of Washington in Seattle and the University of Virginia.

In reviewing the results of their efforts, the centers are finding that life has taken a decided turn for the better for most patients. Many married for the first time after surgery; some are raising children obtained through marriage, adoption or artificial insemination.

In most cases, the partners of sex-reassigned transsexuals appear to be normal heterosexuals. The typical couple reports that sexual relations—however they are achieved—are satisfying physically and emotionally, and most patients say that they are capable of reaching orgasm.

A number of patients whose presurgical emotional difficulties interfered with their academic pursuits, have returned to school, one receiving a Ph.D., another becoming a medical doctor, others completing high school, college or vocational training. Most of those who were working before surgery are still working, a number of them today in better jobs than they had before.

A relative handful of patients have capitalized on their unusual condition, performing in nightclubs as "sex-changed Sally," or publicizing their history on talk shows, in interviews and lectures. But most patients, anxious to make new and private lives for themselves, have quietly blended into the mainstream of society, their past unknown to friends, neighbors and relatives by marriage.

Pierre (all patients' names have been changed to protect their privacy, operated on at the beginning of Johns Hopkins's program, is typical. As Patricia, she was depressed, out of a job, and suicidal. Then she learned of the Baltimore program. After surgery, Pierre married a young woman who was despondent following the birth of an illegitimate child.

Happy Harbinger

Now, six years later, Pierre's son adores his father, who recently became manager of an importing concern. His wife,

who feels that Pierre rescued her from hell, says her marriage is very happy and satisfying, emotionally and sexually.

Even the "spectacular failures" have had some measure of success, reports Dr. Donald Hastings, psychiatrist in charge of the University of Minnesota program.

Dr. Hastings' group knowingly included three sociopaths in the surgical program. One, now an attractive female, has since been married and divorced and has been constantly in trouble with neighbors and friends, drinking too much and abusing drugs.

"She's no worse than before, but also no better," Dr. Hastings said. "However, her sexual adjustment has been excellent."

On the basis of cases like this one, many doctors now realize that transsexual surgery is not a cure-all for social deviance or personal psychiatric difficulties not directly related to the patient's gender identity problems.

Most institutions now refuse to operate on patients who have been in trouble with the law (other than arrests for cross-dressing) or who have obvious neurotic difficulties.

Extremely careful selection of patients appears to be crucial to a successful program. Most centers require prospective patients to dress, live and work in their desired gender for six months or longer, aided by hormones, before they are accepted for surgery.

In general, the centers have moved very cautiously, performing only a few operations a year, even though they were swamped with hundreds—and sometimes thousands—of applications. It is not known how many true transsexuals there are in this country. Estimates range from 2,000 to 10,000.

In retrospect, the centers are pleased with their conservatism, for they see now how easy it is to misdiagnose transsexualism and consequently perform irrevocable surgery on the wrong persons.

"We have to be especially careful now," said Dr. Jon Meyer, who heads the Johns Hopkins program, "because the word is out on how to talk to the doctors to perform the surgery."

Doctors and patients alike said if a person is not 100 per cent certain that sex-change surgery is what he or she wants, the patient may find it difficult to withstand the discomforts and complications of surgery, the continued need for hormone treatments and a host of other difficulties not always possible to anticipate.

*Transsexual
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FILE - How Code (Sex)*

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Claire, a former male and now a slender woman in her late 30's, with a face and figure that attracts whistles, was operated on at the University of Minnesota nearly four years ago. Since surgery, she has continued her successful career as a hair stylist, encountering mostly encouragement from clients who knew her as a man.

But in an interview in Minneapolis, she was frank about her dissatisfactions in the following remarks:

"I have no bosom worth mentioning, and I've spent over \$6,000 to have hair removed from my face—and still it comes back. I can't get a normal medical policy because the insurance companies consider me a 'high risk.'

'An Awful Hurt'

"But the worst thing of all is the eyes of men who find out about my surgery. The warm admiration disappears, and the eyes get a vacant-searching look. It's an awful hurt, one I didn't expect."

Yet Claire said, "I got everything from the surgery I expected and more. Before surgery I was at loose ends constantly. My horizons were short. I could see only to here," she said, touching the end of her extended arm, "and I didn't like what I saw. Now I'm glad to be me."

The difficulties in financing these operations has, in fact, brought several of the transsexual programs virtually to a halt.

The University of Minnesota, which did the first two dozen operations under a research program almost entirely at the expense of the state, has decided that the taxpayers should no longer have to support the expensive surgery. But insurance companies have refused to contribute, contending either that the surgery is "cosmetic" or that the patient's condition pre-existed his medical policy.

The problem is researchers have found, that the patients who most need the surgery are also least likely to have the money. Dr. James Jones, who heads the Downstate program, at Downstate Medical Center in Brooklyn, explained:

"Typically, transsexuals before surgery are poor employment risks. They are often school dropouts. They drift about, looking for themselves, and frequently wind up on the fringes of society."

Many persons, including some rejected by the medical center, have been operated on by private surgeons here and abroad.

Although most of the private doctors are regarded as competent, researchers pointed out, some will perform the requested surgery on anyone who can lay cash on the line. Diagnostic workup may be inadequate,

and there is little, if any, followup on the results.

The Erickson Educational Foundation, with offices in Baton Rouge, La., and New York, maintains a list of American medical centers and private doctors capable of diagnosing transsexualism and willing to treat it. The foundation supports research and offers guidance to anyone with a transsexual problem.

Early Tendencies

Since adult transsexuals universally report that their gender problems date back to early childhood, some researchers are trying to identify young children who may be on the road to transsexualism and, through psychotherapy, change the direction in which they are heading.

At the University of California in Los Angeles, Dr. Richard Green and his colleagues, Dr. Robert Stoller and Dr. Lawrence E. Newman, have evaluated 40 extremely effeminate boys, aged 3 to 10, and their families.

Typically, by age four or earlier these children show a strong interest in dressing as girls, insist on playing with girls, avoid boys and boys' games, take the role of a female when play-acting and often state that they want to be girls.

The parents tend to view their son's feminine interests as "a passing phase" and are rarely alarmed about it, Dr. Green said. "They usually come here because teachers, relatives, friends or child guidance clinics urged them to."

U.C.L.A. is testing several different therapeutic approaches. Some youngsters are treated, in a group in which they play boys' games, associate with other boys, roughhouse and the like. Their parents also receive therapy in groups.

Fixed Gender Identity

Others are treated in individual behavioristic psychotherapy in which a male therapist, who serves as a role model, encourages the boy to pursue masculine activities and mannerisms and actively discourages feminine ones.

Johns Hopkins is now trying to do pretty much the same thing with pretranssexual adolescents, although most researchers believe that after puberty gender identity is permanently fixed.

The psychiatrists at U.C.L.A. have identified a number of factors that they believe contribute significantly to the development of gender mix-up in boys: an extremely close and binding relationship between the mother and her infant son; a father who is not really there, who abdicates to his wife and takes little interest in his son;

discouragement of normal aggressive behavior and subtle encouragement of feminine behavior.

Dr. John Money at Johns Hopkins is gathering evidence indicating that the predisposition to gender problems may actually be established in prenatal life, through improper programming of the fetal brain.

This theory, supported by animal studies, holds that initially the brains of all unborn children have the potential of developing either as male or female brains. What determines which direction the brain goes is the influence of male sex hormones—androgens in boys or their absence in girls—on special brain pathways at a critical time before birth.

Dr. Money cited studies in rats and monkeys showing that the administration of large doses of androgen to the mother during pregnancy results in behavioral masculinization of her genetically female babies.

But if at the same time, the mother is given a drug that competes with androgen for receptor sites in the brain, no masculinization occurs. The effect of androgen on the female babies is blocked.

Among the drugs that can block androgen are certain sleeping pills, an antibiotic called actinomycin D and some psychoactive drugs, Dr. Money said. Thus, the theory suggests, if a mother pregnant with a male fetus takes such drugs, the normal programming of the baby's brain by androgen may fail to occur, predisposing the child to distortions in his gender identity.

Severe stress of the mother during pregnancy might have a similar effect since, under stress, the mother produces steroids that compete with androgen. Experiments in rats showed that mothers subjected to a highly stressful environment during pregnancy produced male babies who acted like females.

Whatever the mechanism, Dr. Money emphasized, "a child's gender identification is never 100 per cent determined at birth. His prenatal environment may make him a vulnerable creature, but what happens next is a result of environment outside the womb."