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Crossing Over Sex-Change Clinics Provide New Identities For Troubled Patients Surgery, Hormone Therapy Are Principal Treatments For Perplexing Disorder A GM Executive Starts Over

By JANICE C. SIMPSON

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PALO ALTO, Calif.—About 20 times a week, Marti Norberg answers the phone on her desk to hear what has become, for her, a familiar but still pathetic plea. "I am a woman," the caller will say, "I have the body of a man but I am a woman. Can you help me?"

The caller is a transsexual, one of an estimated 10,000 people in the U.S. who, though born with the physical anatomy of one sex, identifies psychologically and emotionally with the other.

Mrs. Norberg is the coordinator of the Gender Dysphoria Clinic at Stanford University, one of 40 medical centers and teams in the U.S. that try to help transsexuals with hormone therapy and surgery that changes their physical appearance to conform with the image they have of themselves.

The number of such operations in the U.S. is growing dramatically, giving medical scientists new insight into the problems of sexual adaptation and also, because of widespread publicity about sex-change surgery, focusing public attention on the broader problems of those suffering from sexual abnormalities.

Numbers on the Rise

According to the Erickson Educational Foundation, a Baton Rouge, La., group that serves as a clearinghouse for such information, there are over 3,500 postoperative transsexuals in the U.S. In 1975 alone, at least 300 operations were done in this country, says Dr. Roberto Granato, a New York urologist. That's twice the number performed five years ago, he adds. Dr. Granato has performed 250 such operations himself in the last eight years, including one on Dr. Renee Richards, the ophthalmologist turned tennis player.

Follow-up studies indicate that most people who have had the operations are able to lead normal lives as a result. Jason, a 29-year-old Stanford patient, recalls struggling to act feminine before surgery changed him from female to male. "I'm happier," he says. "I no longer have to worry about what I do or what I say. I can just be myself." Neither the church—he had considered becoming a nun before he had the operation—nor lesbianism, nor drinking solved Jason's problems. Now, he talks easily about his future plans, which include marriage to a woman who knows about his past.

Transsexualism isn't simply another form of homosexuality (attraction to a member of one's own sex) or transvestism (an attraction to the dress and behavior of the opposite sex). Rather, it is a more deeply rooted identity conflict in which a person with a male body views himself as a woman or a person with a female body views herself as a man.

A Cure Is Elusive

Experts don't agree on the cause of transsexualism. Some suggest that it may result from prenatal hormonal imbalances in the mother. Others contend that it is a matter of conditioning during the early stages of childhood. Most, however, say there is no cure short of surgery.

"Classical psychotherapy, behavior therapy and psychopharmacological therapy have met no success so far as getting such an individual—male or female—to change his orientation to one consistent with his anatomic sex," says Dr. John Money, a psychologist who helped start the sexual-behavior consultation unit at Johns Hopkins Hospital in Maryland.

One who disagrees with this view is Dr. Charles W. Socarides, a New York psychoanalyst who says analysis enabled two of his transsexual patients to function heterosexually. Dr. Socarides considers sex-change operations harmful. "Transsexuals suffer from psychological problems that people are attempting to ameliorate through drastic, mutilating means," he says.

Changing Behavior

Since 1971, George Reekers, a child psychologist who teaches at the University of California at Los Angeles, has been working with boys ages four to 10 who exhibit extreme gender confusion (for example, refusing to dress in boys' clothing). Using behavior-modification techniques, Mr. Reekers' team has been able to change the overtly feminine mannerisms of the 25 boys in the project. But, Mr. Reekers says, "we'll have to wait 10, 15 years from now to see if this really works."

The first sex reassignment clinics in the U.S. opened in 1966 at Johns Hopkins Hospital and the University of Minnesota. (European doctors began performing the operations in 1930. Their work was brought to the American public's attention in 1952, after the highly publicized—and sensationalized—conversion of the GI George Jorgensen into Christine Jorgensen.) Over the last decade, the 40 American centers involved in this work (only 20 actually perform the operations) have designed comprehensive programs aimed at smoothing their patients' adjustment to their new sexual identities. These include family workshops, legal counseling and vocational training for those who may have to change their occupations.

The clinic at Stanford is typical of these programs. Since it began in 1968, it has performed 160 operations, 74% of them male-to-female. In the last year, however, the number of applications from women has increased dramatically, so that now the ratio of operations performed is about equal. "Women were more reluctant to come forward until it was more legitimized," says Dr. Norman Fisk, a gynecologist and psychiatrist who is co-director of the program.

Stanford's patients have ranged in age from a 16-year-old boy (who, although he is on hormone therapy, won't be allowed to receive the operation until he is older) to a 65-year-old woman. They come from all racial

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and ethnic groups and all social and economic levels. One patient, a General Motors Corp. executive, waited until his children were grown, divorced his wife, took an early retirement and then moved to a small Midwestern town to live the rest of his life as a woman.

Once a potential patient contacts the Stanford center, an elaborate screening process begins. "We won't be a surgery-on-demand center," Dr. Fisk says, referring to the increasing number of private doctors who perform these operations without providing any preliminary evaluation or follow-up counseling. Stanford patients must fill out a lengthy questionnaire on their family, sexual experiences and social problems. (Many have attempted suicide, or, in an effort to cope with their condition, have developed drinking or drug habits.)

During interviews, patients are told what they can reasonably expect from the operation. They are also questioned to make certain that transsexualism is really the problem. (Families are urged to participate in later meetings.) During one recent interview, a woman discovered that she wasn't a transsexual, but rather a homosexual suffering from intense guilt.

To discourage the merely curious, there is a \$210 charge for the interviews. This begins what ultimately becomes a very expensive procedure. Hospital and surgery costs run \$4,000, paid in advance. Electrolysis to remove hair from men's bodies is about \$20 a visit and requires about 200 sessions. And in California it costs \$35 to get a legal name change.

Insurance Payments

Most insurance companies and Medicaid agencies refuse to pay for the operations, asserting that such surgery is elective. Prudential Insurance Co. of America, however, picks up the tab for the operation and the hormone therapy. It doesn't pay for electrolysis or breast implants, calling these the cosmetic aspects of gender reassignment.

The company has handled a dozen cases since 1971. "Our policies are based on the medical necessity of the operation," a Prudential spokesman says. "It's not the type of operation that anyone would undergo just on a whim. Anyone who's willing to go through the process has to have something deeply wrong."

After the initial interviews, Dr. Fisk, Mrs. Norberg and Dr. Donald R. Laub, a plastic surgeon and co-director of the team, evaluate the patients. They refer those with serious emotional problems to psychiatrists or psychologists, and they refuse to operate on people for whom surgery of any kind might be dangerous. They try to discourage those who, because of their particular body build, will have a difficult time passing as a member of the opposite sex. And they require married patients to obtain a divorce. But few patients are rejected.

"The Last Hope"

"For a lot of people, this is the last hope," Dr. Fisk says. "If we tell them, 'No, you're not suitable,' that might be enough to tip the scales." He says that many of the patients who receive operations aren't truly transsexual but instead suffer from "gender dysphoria," an intense dislike of their own sex that causes them to reject it. Such people, Dr. Fisk says, suffer just as much as transsexuals do. Most centers agree, and have relaxed their standards.

Dr. Harry Benjamin, a retired New York endocrinologist and pioneer in the field, worries about this trend. "There may be patients who are operated on who in later years may regret it because they are not true transsexuals," he says.

According to Mrs. Norberg, three of the 160 Stanford patients—all men prior to the operations—changed their minds after the operation. One said he had had a religious revelation that directed him to return to his old life. Another found that his social life suffered after the operation. And the last had difficulty, as a woman, finding work that paid as well as the job he had held before the operation. Because the operation is irreversible, these men must keep their feminized bodies and content themselves with simply dressing and acting as men. They must also take testosterone, because castration reduces the normal levels of this male hormone in their systems.

Once admitted to the program, a patient begins hormone therapy that continues for the rest of his life. Men are given estrogen, which softens their skin and redistributes the fat on their bodies into a more womanly shape. It also makes them impotent. The women receive androgen, which causes their voices to deepen, produces heavier and darker hair on their bodies and faces and causes menstruation to stop.

When the hormones have begun to work, usually after two or three months, patients are required to begin dressing and living in the gender role they desire for at least 18 months, often longer. "No amount of daydreaming or verbal exploration can substitute for this direct experience," an Erickson Foundation publication explains.

During this period, some patients decide that they don't want the operation—that cross-dressing and hormone therapy adequately assuage their problems. Others, who can't come up with the operation fee, drop out or go to private doctors who charge less. According to Mrs. Norberg, about 25% of those who begin the program at Stanford receive the operation.

For men, the operation involves removing the male organs and constructing female genitalia. The women's operation is more complicated, and is usually done in several stages. A double mastectomy is performed during the cross-dressing period to make passing as a man easier. Later, the doctors perform a hysterectomy, and then, in still another operation, they construct artificial male organs.

Having the operation doesn't complete

the reassignment process. "Just because they've had the operation doesn't mean they don't have the gender problem anymore," says Claire Brader Caper of the Center for Special Problems, a San Francisco group that counsels transsexuals.

Experts say it is more difficult for post-operative women to adjust to their new lives than it is for postoperative men. Many of them wear too much makeup and go through a promiscuous stage in an attempt to prove that they are now truly women. Stanford tries to make the transition easier by bringing in experts to give makeup and poise lessons, to discuss the changing image of women and to teach voice inflection and phrasing. The Center for Special Problems holds group therapy sessions, and some transsexuals have even set up self-help groups. Stanford also maintains a halfway house staffed by a former patient.

There are other problems, too. Nine states won't allow name or gender changes on their birth certificates, a severe handicap for someone who is trying to start a new life. The legal rights of transsexuals who marry after the operation is ambiguous. Last year, however, the New Jersey Superior Court set a precedent when it ordered a husband to pay support when he left his transsexual wife.

Job discrimination may be the biggest hurdle. Most transsexuals simply accept the fact that they must look for another, sometimes lower-paying, job after the operation. But some have begun to resist this notion. Paula Grossman, a postoperative woman, fought to the U.S. Supreme Court her case asserting the right to go back to the teaching job she had held as a man. The court ruled against her. Last fall, Steve Dain, a school teacher in Emeryville, Calif., and a Stanford patient, began his fight to continue working at the school where, as Doris Richards, he had taught girls' physical education. Mr. Dain has gained the support of many local parents and students, and says he is determined to pursue his case.

Earlier this week, Mr. Dain won a round when a state hearing board overturned his dismissal by the local school board. It is expected, however, that the board will appeal the decision.