AN OUTLINE OF

MEDICAL MANAGEMENT OF THE TRANSEXUAL

Erickson Educational Foundation
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The purpose of this booklet is to provide physicians, general and specialists, who are inexperienced in working with transexuals with basic procedures of medical management. The information presented is based on material compiled from the medical literature and from interviews with medical specialists who have had considerable and successful experience in treating transexual patients.

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AN OUTLINE OF MEDICAL MANAGEMENT OF THE TRANSEXUAL: ENDOCRINOLOGY, SURGERY, PSYCHIATRY
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INTRODUCTION

Since the first publicized sex reassignment operation was performed upon an American in Denmark nearly two decades ago, members of the medical profession and the general public have learned a good deal about the condition known as transexualism. The notoriety attending upon this case, and the questionable nervous jokes in the popular press, did not perhaps provide the best climate for illumination. But it did serve the purpose of bringing the problem to general and medical attention.

Psychiatrists and physicians tended, until very recently, to diagnose transexualism as a more flagrant (and perhaps more stubborn) variety of homosexuality, and to claim either that it would or would not respond to psychotherapeutic treatment. More careful and extensive study and research finally revealed that nothing less than surgical alteration would provide effective therapy for the transexual. The credit for the clinical study of this condition and the establishment of new and successful therapeutic techniques belongs largely to the multidisciplinary staffs of the gender identity clinics, here and abroad.

Gender identity clinics are generally associated with a university hospital and are funded to treat a limited number of patients as part of a strictly defined clinical investigative project. This orientation demands that the patient be seen repeatedly by a team of specialists in physical and psychological medicine over an extensive period of time, generally one to two years, before a decision to perform sex reassignment surgery is finally implemented.

Psychological evaluation will include intensive interviews and testing, interviews with the patient's family where possible, and perhaps a course of supportive therapy. Physical testing includes: General examinations, 17 ketosteroids, other endocrinological studies, chromosome analysis and, in some instances, semen analysis. The patient is treated with heterotypic sex hormones and is required to live, dress and become rehabilitated in the cross-gender role. When sufficient documentation has been compiled, the medical team confers to make the decision whether or not to proceed with surgery. Since extensive clinical observation has now established that gender identity is well set by the age of four, no attempt is made to effect a psychological

'cure' or to dissuade the patient from his[1] desire for surgery once he has been diagnosed as a transexual.

The thoroughness of the medical procedures of the gender identity clinics provides an invaluable contribution to scientific knowledge. But, according to the growing number of internists, endocrinologists, family physicians and surgeons who treat transexuals, this exhaustive process of testing and observation is not strictly necessary. Since test results conclusively show that the great majority of transexuals are physiologically unremarkable specimens of their genetic sex, such extensive testing, these doctors say, is not essential except in the interests of research. From the patient's point of view, the time and money consumed during this period presents a severe burden, if not a prohibitive one.

Gender identity clinics are dependent for funding on foundation grants and private donors. This presents a dual handicap. First, they must proceed with exceptional care or risk a cutting-off of funds if unsuccessful treatment or mistaken diagnosis produces adverse publicity. Second, they may treat only a strictly limited number of patients from the increasing numbers who apply for help. One of the most prestigious of these clinics is currently accepting only ten to twelve patients a year, and has a waiting list of some 600. At this rate, it would be fifty years before all those now waiting could be accommodated!

There is a pressing need, therefore, not only for the establishment of gender identity clinics in all teaching hospitals and medical schools, but for more endocrinologists, internists, and surgeons to equip themselves to treat transexuals, through study of the extensive medical literature now available and through clinical observation of numbers of transexuals. This is the theme repeatedly sounded by the endocrinologists and surgeons interviewed for the preparation of this booklet. In their dedication to the interests of their transexual patients, they too maintain exacting standards of diagnosis and treatment (which we shall elaborate below), but find that they rely most heavily,

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1. It has been estimated that the male outnumbers the female transexual by a ratio of four to one. Except where the female transexual is specifically discussed, masculine pronouns will be used throughout for purposes of clarity.

and that results justify them in this, on clinical impressions which become more refined with experience. These doctors strongly confirm the conclusion of gender identity researchers that sex reassignment therapy provides for the transexual the only alternative to a life of misery or suicide.

They also confirm the data compiled by the gender identity clinics, which indicates that the great majority of transexuals shows marked social and emotional improvement in life adjustment following surgery. One surgeon remarked, "People say that transexuals are poor risks, potential suicides. But it is only the transexual who does not achieve surgery who is a poor risk. Of the sixty patients I have seen through surgery, only one committed suicide. In his case it was a calculated risk: he was likely to have done so in any case. But the percentage of suicides among treated transexuals is no greater than average for any group of disturbed people. Most of my patients adjust very well, and not one regretted his surgery. On the other hand, I'm convinced that 10-15% of them would have attempted suicide if they had been denied surgery. If a person has problems, surgery won't solve them all; but it will solve the problem of transexualism."

DIFFERENTIAL DIAGNOSIS

There are gender identity disorders which have a superficial or profound resemblance to transexualism, but which are nevertheless not to be confused with this condition. Prior to surgery great care must be taken in diagnosis, since the radical physical alteration which has proved to be the one effective therapy for the transexual might represent an irreparable and tragic mistake for the individual with a related but different disorder. Although there is a sort of family resemblance between homosexuality, transvestism and transexualism, observable common areas of concern, essential distinctions become apparent to the trained clinical eye, with experience. The ambiguities which may, at first, cloud the picture, will not be elaborated in the discussion that follows, so that these basic differences may be emphasized.

The male transvestite cross-dresses, or employs the imagery of cross-dressing, in order to achieve satisfaction in heterosexual relations. The effeminate homosexual occasionally may cross-dress, but he does not share the transvestite's compulsion to do so. Although he plays the feminine role with his male partner, he has no compelling

desire to be a woman, and may derive considerable pleasure from genital sensation.

The male transvestite-transexual begins to cross-dress usually before puberty. Later, he may experience great conflict about this, and apply himself vigorously to the masculine role, perhaps even going so far as to marry. Eventually, however, his gender identity reveals itself as so overpoweringly female that nothing less than the alteration of his masculine body traits, as well as abandonment of the masculine clothes and role, can afford him relief. Homosexual relations are usually repugnant to him, as he envisions himself freed from his male genitalia, in an unequivocally feminine role with a heterosexual male partner.

The effeminate-homosexual transexual has a history, going back to early childhood, of avoidance of masculine competition and activities, and a preference for the friendship and interests, as well as the clothing, of little girls. His mannerisms, as well, were and are typically feminine, and he may have been drawn quite early to homosexual relationships. He experiences the same intense dissonance between mind and body as the transvestitic male transexual eventually acknowledges, and the same compelling conviction that only sex reassignment can resolve his dilemma.

Transvestism without transexualism apparently does not occur in the female. The distinction must then be made between masculine-role lesbianism and female transexualism. In the former, there is an acceptance of homophile relations and a degree of reconciliation with the feminine physique, especially in the physical satisfaction it affords.

The female transexual, like the masculine-role lesbian, rejects the feminine and aspires toward the masculine role from early childhood; and she, too, is aroused by other girls, and often has relations with them. But, unlike the masculine lesbian, at the onset of puberty she totally repudiates the feminine physique and functions that are so strikingly out of harmony with her uncompromisingly masculine gender identity. As with the male transexual, sex reassignment presents the one means toward a fulfilling life, in her case often as a husband and father, supporting her family by means of one of the masculine occupations. Physicians and psychiatrists who have worked with female transexuals commonly remark upon the impressively stable lives these patients often achieve.

Care also should be taken to distinguish borderline schizophrenia, with temporary illusions and obsessions of transexualism, from true transexualism.

It should be noted that rarely does any one individual present as clear a clinical picture as outlined in the idealized examples above. Thus, it is not unusual for a patient to be refused sex reassignment surgery by one gender identity clinic and be accepted by another. It has happened, too, that the refusing clinic, upon seeing the patient after surgery, agrees with the reversed decision. The criteria for diagnosis are by no means absolute, and research is proceeding with the purpose of further refining the distinctions between the various gender identity disorders. To date, it is generally agreed that the common requirement of a preoperative period of six to twenty-four months of living and working in the gender role of choice provides the best index of judgment for eliminating non-transexuals.

ETIOLOGY OF TRANSEXUALISM

Most, if not all, specialists in gender identity are agreed that the transexual condition establishes itself very early, before the child is capable of elective choice in the matter, probably in the first two years of life; some say even earlier, before birth during the fetal period. These findings indicate that the transexual has not made a choice to be as he is, but rather that the "choice" has been made for him through many causes preceding and beyond his control. Consequently, it has been found that attempts to treat the true transexual psychotherapeutically have consistently met with failure.

Yet, some sort of treatment is urgently indicated, for in many instances his suffering is so intense that suicide and self-multilation are not uncommon. So it is that a distinguished doctor, joined by many others in this view, compassionately decided: "If the mind cannot be changed to fit the body, then perhaps we should consider changing the body to fit the mind."

Although the causes of the transexual condition are not yet understood, extensive research in recent years has indicated some possible biological and psychological factors which might render one individual more vulnerable than another to develop in this way. The following brief summary will cover some of these factors.

Experiments with animals suggest that the altering of hormone

balances, during certain limited, critical prenatal periods, will affect those areas of the brain that regulate masculine and feminine behavior. Other medications administered to the pregnant mother (barbiturates for example) may also have an effect on the development of the unborn child, as may certain intrauterine viral infections.

Transexual symptoms need not develop under such circumstances, and of course, usually do not. Predetermining circumstances may simply make the individual more susceptible to the development of transexualism. The postnatal determinants of gender identity—the child's relationships with those who form his early social environment—may then supply the deciding factor, if these relationships are seriously disturbed during the critical postnatal period of gender identity formation.

Highly qualified doctors of physical and psychological medicine all over the world, working singly or in teams, are concerning themselves increasingly with investigations into the causes and treatment of transexualism. Evidence as to causes, and data as to effects of treatment, are accumulating, encouraging the hope that earlier diagnosis and more effective preventive and ameliorative procedures, as well as education of the general public, will successfully reduce this source of human suffering.

THERAPEUTIC ATTITUDES

Doctors of psychology and physical medicine almost without exception report an initial negative reaction, not substantially different from that of the average layman, in their first encounters with transexuals. In particular, male doctors confess to an almost reflexive resistance to the male transexual who presents himself in the consulting room with a request for castration.

Yet, as they gain experience in helping these patients to a resolution of their deep psychological conflicts, they express considerable satisfaction in observing the positive changes brought about through therapy. Indeed, more than one physician has found himself gradually phasing out the rest of his practice in order to devote himself exclusively to this absorbing and professionally challenging work. Dr. Harry Benjamin, the New York endocrinologist who is considered a pioneer in this field, is one such doctor. To date, he has treated about 800 transexuals, with notable success.

Thus the initial obstacle to successful treatment of the transexual, and one which must be overcome if the physician is to establish a viable therapeutic relationship with his patient, consists of the physician's own attitude of resistance. Once he is convinced, as a result of study, consultation with colleagues, and, if possible, direct observation of transexuals who have been manifestly benefitted by sex reassignment, that this is indeed the only effective therapy, some of his resistance will fade. His own direct experience, as treating physician, will do the rest.

One endocrinologist who now works exclusively with transexuals acknowledges that his own first reaction was much as expressed above. The following is a paraphrase of his advice to doctors new to this work: Try to avoid judging the patient by your own reaction to the presenting complaint. Realize that something that might be wrong for you personally may be not only right but essential for him. Learn to listen with detachment, but with sympathy. When the patient discovers that he is not being treated as a psychotic, he will begin to open up and to reveal a convincing and detailed clinical picture, which he may never before have found the confidence to do. You will find that as treatment progresses and the patient shows unmistakable signs of improvement, becoming progressively more feminine, your identification with him will dissolve: you will no longer be treating a projected image of yourself, but the patient himself.[2]

FOSTERING REALISTIC EXPECTATIONS

Ignorance about the limitations of present medical procedures, or wishful-thinking about what they may accomplish by way of physical changes, is prevalent among transexuals. It is essential that the patient be thoroughly informed at the outset of treatment, so that he may adjust his expectations toward a realistic basis.

He should be advised that there is a wide variation in the cosmetic and functional results of surgery. There is at present no technique for the transplant of reproductive organs. Therefore, following surgery, both male and female transexuals will be sterile. The degree of possible sexual pleasure cannot accurately be predicted. In some

2. These remarks reflect the point of view of a male doctor treating a male patient with feminine gender identification. But they may be translated to apply to similar difficulties encountered by the physician of either sex in treating a female or male transexual. For example, similar resistance may be recognized by the male or female doctor who hears a well developed genetic female's appeal for mastectomy.

cases, the capacity for orgasm may be lost. (However, in others it is "found.")

The male transexual must prepare himself for the possibility of postoperative vaginal stricture and a prolonged healing period. The female transexual should understand that techniques for construction of the penis have not yet been perfected. Even after the several operations required, the appearance and functional capacity of the penis will not approximate that of a natural organ. It will not erect and it will be numb and totally without feeling.

Estrogens rarely raise the voice pitch of the male transexual and they do not promote perfect feminine body proportions. Nor will they accomplish removal of facial hair: electrolysis is necessary for this. Testosterone will lower voice pitch and suppress menstruation in the female transexual. However, it will not appreciably diminish the size of the breasts. Mastectomy is then required. The clitoris will be augmented, but will not assume phallic proportions. Estrogens will diminish and androgens increase the libido.

The information above covers some of the more common questions and misconceptions you may encounter. More detailed data will be given below.

The transexual may present himself for treatment directly to a surgeon, an endocrinologist, an internist, or, more rarely, to a psychiatrist. In the following summaries of medical management, digested from the latest medical literature and from conversations with specialists in these fields, there will necessarily be some duplications of procedure.

MEDICAL PROCEDURES

Endocrinology (Preoperative)

1. The Initial Interview

Elicit information which will provide an impression of the atmosphere in which the patient was reared. This will include a family history and the relationships of the patient with his parents and siblings. Try to determine at what age the gender identity disturbance first manifested. At what age did he first cross-dress? What were his family's reactions? Ask for his earliest memory of cross-gender identification: When did you first feel like a girl/boy?

Gather details of personal history: interpersonal relations and sexual experience. Does he relate well to other people? Has he had any heterosexual relations? Homosexual relations? How did he feel about these?

Typically, there might be some evidence of social maladjustment between the ages of three and five. Often the child is at that time unaware of the physical distinctions between the sexes, but he is aware, for example, of being more like his sisters than like other boys. It is exceedingly rare that the child feels he fits in with others of his own sex.

Since the patient is often unusually wary and suspicious, several interviews may be required before a full history emerges. It is advisable, in any case, that he be seen for several meetings, perhaps during hormone therapy, in which he is encouraged to talk freely. As his confidence is gradually gained in this atmosphere of acceptance, he will express, perhaps for the first time to anyone, the full intensity of his cross-gender identification.

The diagnosis is based on the history and clinical impression obtained.

2. Physical Examination and Testing

Transexuals are almost invariably physically and endocrinologically normal. Hormone analyses are usually unnecessary in determining the optimum dosages to be administered. This may be ascertained through clinical observation. Only in rare instances of gonad abnormalities are chromosome and endocrine tests indicated.

3. Psychiatric Consultation

Refer the patient to a psychiatrist who is open-minded, preferably one who has had some experience with transexuals, for diagnosis and evaluation. A frequent patient reaction is, "All right, I'll see him. But he's not going to change my mind." Impress upon him that the psychiatric consultation is only for the purpose of obtaining another opinion to confirm and amplify your own, and that no attempt will be made to pressure him.

4. Supplementary Interviews and Permissions

The treating doctor should be aware of the other lives which will be affected by his decision to initiate therapy. The parents of

a minor have a right to know about their son's or daughter's plans. And certainly the doctor has an obligation to inform the patient's spouse about circumstances which will profoundly alter his marriage.

It is also important to protect yourself from the possibility of a malpractice suit. If the patient is under twenty-one (eighteen in some states), secure the signed, notarized consent of his parents to treat him. If he is married, an interview with the spouse should include the request for a signed and notarized statement of acknowledgment that he or she has been informed of and agrees to the course of treatment you have planned. The legal right of a spouse to contest a husband or wife's treatment for transexualism is currently being tested in the courts. However this case is decided, it may benefit all concerned to include the spouse in a discussion of the transexual's plans.

5. **Hormone Therapy**

Hormone therapy proceeds simultaneously with or after the preliminary interviews. It may be initiated immediately, if the clinical picture is unequivocal. The physical changes affected by administration of hormones are helpful in the psychological and social preparation for surgery, laying the foundation for the final change in role. Another common benefit of hormone therapy is its calmative effect. For these reasons, it is important that this treatment be followed for at least six months preoperatively.

Physical changes are largely reversible, especially for the male transexual. The skin will take on a softer texture, there will be some decrease in body hair and possibly an increase in hair growth on the scalp. After some time there will be a diminution of muscular strength and a more feminine distribution of subcutaneous fat. The breasts will gradually be augmented to a size comparable to that of a girl in the late teens. These proportions may be satisfactory or breast implants may later be desired. Voice pitch usually will not be altered; this may be achieved to some degree by practice in voice modulation. Beard growth is not greatly suppressed, and a course of electrolysis should be pursued simultaneously with hormone therapy.

A sufficiently intense dosage of hormones, where this is advisable, usually in injections administered every week or two, will temporarily suppress menstruation in the female. Deepening of the voice, through a gradual thickening of the vocal cords, is irreversible. There will be beard growth, masculine growth and distribution of body hair, and the clitoris will increase in size. Breast size may be appreciably

diminished only in the very young. Where there is no diminution mastectomy is required. Acne and edema are possible side effects of hormone therapy for the female transexual. If acne is marked, a course of tetracycline will usually prove effective; if edema occurs, a diuretic may be prescribed or, alternatively, the hormone dosage may be decreased.

6. **Counseling**

During the preoperative period, it is important to discuss with the patient his social and economic plans, to help him to gain a practical basis for the new life he is preparing. Most gender identity clinics, as well as physicians in private practice, insist upon a considerable period, varying from six months to two years, of living, working, dressing in the cross-gender role, before they will recommend the patient for surgery. It is not enough for the male transexual, for example, to hold the conviction that he is a woman. He must develop and express the habit patterns that will cause other people to respond to him as they normally would to a woman (if they do not already do so), so that his inner feelings are reinforced and his feminine behavior becomes habitual and unremarkable. This testing period is of prime importance in revealing to the patient whether or not his decision is the right one.

You may also wish to refer him to experienced legal counsel for assistance in the alteration of his civil status. It is essential that divorce proceedings be concluded prior to surgery.

Endocrinology (Postoperative)

The transexual must continue to take hormones throughout his life. Suppression of phenotypic sexual characteristics is achieved through castration and hysterectomy with bi-lateral oophorectomy. The primary goal of post-surgical hormone administration is the stimulation and maintenance of development of the characteristics of the opposite gender. Its other functions are to maintain skin tone, adequate calcium in the bones, and to prevent arteriosclerosis. Therefore it is desirable to see the patient postoperatively every six months, where this is possible, for physical examination and to check on hormone dosage, though this is seldom varied. Occasionally conversations may indicate the advisability of recommending sympathetic counseling or psychotherapy to assist him in his adjustment.

Remarks

Since hormones are used throughout life, a moderate oral dosage is recommended for genetic males and monthly injections for genetic females. High potency injections should be confined to the early stages of treatment of the male transexual, if used at all. Larger dosages are usually necessary to effect initial virilization in the female.

The endocrinologist who has had the most extensive experience with transexuals, Dr. Harry Benjamin, suggests interruption of endocrine administration for two to three weeks every two to three months as a precaution against dangerous or undesirable side effects. The postoperative dosage most commonly recommended is generally about half or less than half of the preoperative (precastration) dosage. In some cases, where further changes in the secondary sex characteristics are desired, the more potent dosage administered by injection may be given temporarily.

Hormone therapy is contraindicated for patients with a history of pulmonary embolism, thrombophlebitis, malignancy, or liver dysfunction.

MEDICAL PROCEDURES

Surgery (Preoperative)

1. **Initial Interview**

Obtain a detailed family and personal history. Carefully observe the patient's facial and physical appearance, the way he talks, his affect. Make an interim decision on the basis of the history, and relying heavily upon the clinical impression.

Patients should be informed at the outset of the cosmetic and functional limitations of constructed genitalia. Since male transexuals, in particular, often have a low threshold of pain, patients should be prepared to expect considerable discomfort in the period immediately following surgery. It is also well to advise them that they will have to refrain from sexual intercourse for at least two to three months after surgery.

Where important systemic problems, such as diabetes or hypertension, exist, surgery is not necessarily contraindicated, but special care must, of course, be taken.

2. **Psychiatric Consultation**

Many transexuals have seen psychiatrists, but usually in child-

hood or early youth. Because of the gap in time, and because it is not uncommon that the psychiatrist consulted may have been uninformed about transexualism, any documents available are generally inadequate for present purposes and should be viewed with reservations.

Since transexualism is a disorder which, unlike some types of homosexuality, is basically inaccessible to psychiatric treatment, the purpose of the consultation is to gather material which will amplify and possibly confirm the surgeon's clinical impression. It is important to choose a psychiatrist who has had adequate clinical experience with transexuals. He will then submit a written summary of the interview to the surgeon.

3. Hormone Therapy

The patient is then referred to an endocrinologist or an internist. If his evaluation is a positive one, and in accord with that of the surgeon and the psychiatrist, hormone therapy is initiated. The surgeon should require that male transexuals follow a program of hormone therapy preoperatively until there is some evidence of breast formation; and females until there is noticeable beard growth and suppression of menses. These changes serve to lessen anxiety and provide a positive psychological preparation for surgery.

4. Electrolysis

It is imperative that the male transexual complete at least half of a course of electrolysis of the beard (usually requiring a total of one to two years) before undertaking surgery. There are several cogent reasons for this. Since the process involves considerable expenditure of time and money, as well as a good deal of discomfort, the patient's persistence in following through on this treatment is one good index of the seriousness of his committment to sex reassignment.

More important still, if, after surgery, when he is now anatomically a female in all other respects, there is noticeable evidence of beard growth, it is possible, and even likely, that he will suffer serious confusion as to his postoperative gender identity. In the experience of more than one surgeon, these are the patients who undergo deep psychological conflict, caused directly by this physical contradiction, and may even be liable to suicide.

5. Cross-Gender Experience

Another essential requirement is that the patient gain the experience of constant, not intermittent, cross-dressing for a considerable

period prior to surgery, where this is feasible. The only exception that may be made is in instances where there is no alternative to financing surgery and other therapy except through a job in which cross-dressing is not permissible.

Operative Procedures (The Male Transexual)

Some surgeons prefer to perform surgery in two stages: castration is done in the doctor's office, and penectomy and vaginal construction in the hospital four to five weeks later. Those who follow this procedure claim that the patient will experience less pain and have a shorter recovery time after the second stage. However, many surgeons complete the work in a single process.

1. **Castration** (Postoperative)

The patient will sustain some pain and swelling postoperatively, but usually he will feel well within a week. Prescribe antibiotics to combat possible infection and an analgesic and warm baths (100-104 degrees) to ease discomfort.

2. **Genital Reconstruction** (Preoperative)

Antibiotics are prescribed for a week preceding surgery. Bowel prep: sulfa preparation and an enema daily for four to five days.

3. **Surgical Procedures**

There are several alternative techniques for genital reconstruction now in use, and these are undergoing constant modification and improvement. A paper published by a surgeon as recently as a year or two ago may describe methods which he himself no longer uses. Since no written statement may be relied upon to represent the latest innovations and revisions in technique, any surgeon planning to undertake transexual surgery should observe the process at first-hand at a gender identity center.

4. **Genital Reconstruction** (Postoperative)

A. Hospital Care

(1) Feeding—Intravenous feeding is employed for three or four days postoperatively, since there is the danger that bowel elimination might strain and tear the common wall shared by the vagina with the rectum. After four days clear liquids may be taken and more solid food is allowed after seven to eight days.

(2) Medication—Heavy dosages of antibiotics are administered during the hospital stay and for ten days after the patient leaves the hospital. Additional protection against infection is provided by frequent warm sitz baths and gentle washing with a mild soap or Phisohex. Infection is rare, but if it should occur the wound should be opened and drained.

B. Home Care

(1) The Prosthesis—During surgery the vagina is packed with gauze. When healing is well advanced, the patient is instructed in the use of a vaginal form. These are of various compositions: rubber, lucite, silastic, or balsa wood with a foam rubber sheath. For the first few days of use, this should not be removed for more than a few minutes at a time, in order to counteract the tendency of the vaginal cavity to contract.

For at least six months following surgery, the form should be inserted four or five times daily for one or two hours at a time. This may most easily be done while reclining in a warm bath, so that the musculature will be relaxed to facilitate insertion.

(2) Dilation—Using a sheathed finger or a surgical dilator, with generous amounts of lubrication, the vagina should be dilated at least twice daily. Oil or a silicone type cream should be used internally each day.

(3) Hygiene—Warm baths are recommended for twenty minutes twice a day to cleanse the wound and reduce postoperative swelling. The vaginal area should be cleansed frequently.

(4) Medical Observation—The patient should be advised to see the physician if there is fever, or if the surgical area becomes hot or swollen: signs of infection. Difficulty in urination may indicate stenosis of the new urethra, for which mechanical dilation by the physician, or by the patient under his instruction, may be required.

Impress upon the patient that anyone taking hormones must be checked periodically for such possible side effects as water retention and blood clots in the legs.

(5) Other Surgery—If other surgery, such as rhinoplasty and breast implants, should be desired, it is strongly recommended that

this be postponed until the first surgical area is completely healed and functional.

(6) General Health Care

a. Rest—Returning to work prematurely may prove more costly than allowing an adequate recovery period after surgery. Prolonged standing will cause fluid to collect in the surgical area, so it is inadvisable for the patient to stand for long at any one time. Prolonged sitting will at first prove uncomfortable.

b. Diet—Inform the patient that a balanced diet, including generous amounts of protein daily, will promote healing. This should be supplemented with a multiple vitamin and 100 mg. daily of Vitamin C.

Salt and salty foods should be avoided or taken in moderation to avoid excessive water retention. Adequate water and roughage will ensure against constipation, which can strain the wall of the new vagina.

It is important to keep the weight stable, and especially to avoid any weight gain, in order to keep from burdening the surgical area.

(7) Sexual Activity

Because of the danger of infection and rupturing of the sutures, it is important to impress upon the patient that sexual intercourse should not be attempted for at least two to three months following surgery.

It will be necessary to experiment to find the optimum position for intercourse, since the bones of the pelvis or the direction of the vaginal passage may at first interfere. Large amounts of lubrication should be used, and the patient should urinate and empty the bowels prior to intercourse to provide maximum room in the vaginal passage.

Operative Procedures (The Female Transexual)

There are alternative techniques for the construction of the penis, but at present the results are far from satisfactory, cosmetically and functionally. One method produces a simulacrum of a copulatory organ with implants of cartilage or bone, but a prosthesis is still generally required to provide adequate stiffness for intercourse. A penis functional for urination is achieved by extending the urethra

with an artificial tube, but since the tube is, of course, not self-cleansing, the danger of infection is always present. To date, no created organ has been made functional both for intercourse and for urination, and in either case the organ is devoid of sensation.

No matter which method is chosen, a multistage procedure requires as many as a dozen or more hospital admissions. The cost in pain and expense is so great, and the organ itself is so far from satisfactory, that the patient should be discouraged from this undertaking unless he is unshakably convinced that to forego it would deprive him of a psychological and social sense of security he may obtain in no other way. Even so, if he persists, he may well be deeply disappointed in the results.

A far better alternative would be to instruct the patient in the use of a prosthetic device (a so-called dildo) and to explain other modes of satisfying a sexual partner, perhaps recommending selected sex manuals if this is indicated.

Hysterectomy with bilateral oopherectomy is usually required, and breast removal, mastectomy, is usually necessary for post-teenage patients.

MEDICAL PROCEDURES

Psychiatry

Although there are some common areas of difficulty shared by the homosexual, the transvestite and the transexual, there is an essential distinction in gender identity conflict which is peculiar to the transexual alone. His psychosexual identity is absolutely inconsistent with his physical sex characteristics, towards which he feels a deep aversion. It is his conviction, with which gender identity specialists would agree, that this contradiction may be resolved only by the surgical alteration of his anatomy, with the consequent opportunity to live his life in the chosen gender role.

The need for an objective attitude on the part of the psychiatrist towards the transexual's ultimate goal of sex reassignment is axiomatic. If he takes the position that all those who request surgery should be granted it, or that no one, under any circumstances, may benefit therefrom, it is obvious that this dogmatism will stand in the way of a helpful evaluation of the transexual's difficulties. It is essential, then, that he maintain, in this as in all professional situations,

an attitude of open-minded impartiality, allowing the facts of each individual case to speak for themselves as they unfold before him.

While few patients presenting transexual symptoms and desiring surgery will change their mind, a period of hormone therapy and of living in the desired gender role is strongly indicated, so that those whose motives are confused or weak may discover this for themselves through direct experience. With these few, the psychiatrist's function will be to assist the patient to explore and clarify his motivation, and to find another resolution of his conflicts.

A similar exploration will, of course, be helpful for the transexual for whom surgery is indicated. In addition, he will require support in making necessary adjustments to his new social role, and in coping with his family's reactions to his decision. Information or referrals may be given to assist the transexual in establishing a new identity through legal procedures and documents.[3]

Frequently, male transexuals, in particular, go through a brief period of quasi-adolescence, similar to adolescence in the genetic female. That is, in testing the new feminine role, they tend to experiment with dress and make-up that is sometimes exaggerated or inappropriate. Some counseling will be useful in this regard.

Many transexuals harbor magical expectations of what life will be like following surgery, and psychiatrists find that they must devote much of their efforts to fostering more realistic expectations. Similar misconceptions are often entertained regarding what may be achieved by way of physical changes, and these too must be dispelled.

Dr. Richard Green, Assistant Professor of Psychiatry and Director of the Gender Identity and Research and Treatment Clinic, U.C.L.A. School of Medicine in Los Angeles, describes the special rewards of working with transexual patients: ". . . An interest in the development and manifestations of masculinity and femininity, plus a desire to assist another human being toward the resolution of profound emotional conflict, can make the management of patients seeking sex reassignment a professionally enlightening experience."[4]

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3. See "Legal Aspects of Transexualism and Information on Administrative Procedures," available from the Erickson Education Foundation, 4047 Hundred Oaks Avenue, Baton Rouge, La. 70808.
4. See 6, *Suggested Reading*, p. 20.

SUGGESTED READING

1. Should Surgery Be Performed on Transexuals?," Harry Benjamin, *American Journal of Psychotherapy*, January 1971.

2. *The Transsexual Phenomenon*, by Harry Benjamin, M.D., New York, Julian Press. 1966.

3. *Transsexualism and Sex Reassignment*, edited by Richard Green and John Money. 1969. Johns Hopkins Press.

4. *Sex Errors of the Body: Dilemmas, Education, and Counseling*, by John Money, Johns Hopkins Press. 1968.

5. *Sex Reassignment*, by John Money and Ronald J. Gaskin, reprint from International Journal of Psychiatry, 9:249-282, 1970-1971. A copy of this 34 page reprint is available from Erickson Educational Foundation on request plus $1.00 to cover postage and handling.

6. "Guidelines to the Management of the Transexual Patient," *The Roche Report: Frontiers of Phychiatry*, Vol. 1, No. 8, pages 5-8 (April 15, 1971).

Additional Information Available

at the

Erickson Educational Foundation