"SHE" - MAY 1978

how a man becomes a woman

CHANGE FOR THE BETTER

by JAMES O STALLINGS, MD with TERRY MORRIS

TRANSSEXUALS in our society are predominantly (95%) males who feel that they are psychologically women, but are biologically trapped in a man's body. Such individuals have been recognised since antiquity, but only in the past two and a half decades, since the celebrated sex change surgery in the case of Christine Jorgensen in 1953, have intensive studies been made of the psychiatric and surgical needs of transsexuals.

Advances in plastic surgery techniques and hormone replacement now make it possible for a biological male to be transformed into an anatomical female, except for a functioning uterus and ovaries. And, to a lesser degree, a biological female can be transformed into an anatomical male.

Needless to say, no reputable surgeon would remotely consider performing such operations without requiring a complete psychological and psychiatric check-up of the patient. Certain criteria have evolved in recent years to help identify and define who is and who is not a true transsexual, and I think that a brief review may be generally helpful towards a better understanding of these people.

According to leading psychiatrists in the field, a true transsexual has "an intense, insistent and overriding wish for sexual transformation into a person of the opposite sex by direct surgical alteration of the external and internal sex apparatus and secondary sex characteristics, and indirectly through hormone preparations".

The transsexual man is convinced that he is basically a person of the opposite sex and from the earliest years of life has been unable to achieve a definitive identity as male in accordance with his anatomy. His behaviour is imitative of the opposite sex in dress, activities, attitudes and choice of sex partners. The search for transformation is so obsessive, in some instances, that it is sought through self-mutilation.

Yet, even when these characteristics are abundantly evident, agreeing to the transsexual's desire for surgical sex change poses a thorny dilemma to the psychiatrist and surgeon evaluating the case. The surgery involved is not undertaken lightly. Clearly, transsexuals have psychological problems which surgery can improve only to a certain extent, and extreme care must be taken in the selection of such patients.

Sex change surgery (sometimes called sex reassignment) was first performed in Germany in 1931. Then, as European physicians became convinced that in many cases it was useless to treat the adult transsexual only with psychotherapy, operations were reported from Switzerland and Scandinavian countries as well. But many physicians have maintained a rather negative attitude towards sex change operations, often out of much the same religious and moral scruples as those which make them reluctant to perform abortions.

Recently, however, certain developments indicate a change in these conservative attitudes. A court decision in Maryland ruled that a transsexual could be operated on, thereby offering physicians and hospitals protection against some of the legal consequences. As a direct result, a Gender Identity Committee was formed at Johns Hopkins Hospital, where a team of specialists (psychologist, psychiatrist, urologist, gynaecologist, plastic surgeon and endocrinologist) evaluate transsexual patients and select suitable candidates for more thorough investigation and possible surgical treatment. Later on, the University of Minnesota and UCLA medical schools also established research projects to study and evaluate the transsexual and to treat other problems of gender identity.

The incidence of transsexuality in the United States can only be roughly approximated, based only on those individuals who are under sufficient stress to seek medical attention: about one in 100,000 for males, and about one in 400,000 for females in the general population. But a few years back, the Gender Identity Centre at Johns Hopkins reported that requests for help continue to arrive at a rate 20 times greater than its capacity for treatment. Also, surgeons from medical centres around the country are displaying an extensive interest in the surgical treatment of transsexuals.

The transsexual should be clearly distinguished from the transvestite and homosexual. For one thing, when the transsexual (and let's consider only males since they far outnumber females) dresses in women's clothing, it is because he feels more "normal" and more "natural" in such attire, but when the transvestite does so, it is for sexual excitement and arousal. As to choice of sex partners, the transsexual, who perceives his gender as female, prefers normal, heterosexual men, since to have sex with a woman or homosexual male would be "unnatural". Also, the transsexual, totally unlike the homosexual, despises his genitalia and desperately wishes for their removal. And last, the true transsexual showed signs of gender reversal long before he was old enough to know anything about homosexuality or sexual intercourse.

mother fixation

The precise causes of transsexuality are still uncertain, but various common characteristics show up in significant numbers of cases. The male transsexual generally has a very pronounced mother fixation; she is the ideal person and an excessively close mother-son relationship develops. The father is usually pictured as aloof, rejecting, and failing to provide an effective role model for his son. Preference for the female role is markedly present even when the child is a toddler, and by the age of five, he is convinced that he is really a "she".

Long before puberty, such boys wear dresses occasionally, play exclusively with girls, are drawn to activities usually thought of as female, and are embarrassed by undressing in front of boys. As a result, such behaviour leads to their being rejected by their male peers.

As adolescents, intense disgust with their developing male anatomy grows, along with the conviction that they really belong to the female sex and the desire to be accepted as females. As already noted, the craving for sex change surgery may become so obsessive that, for example, in a review of 100 male transsexuals, 18% had committed acts of genital self-mutilation.

Therapy in its various forms is generally not helpful in bringing the adult transsexual to accept a gender identity which is in accord with his genital anatomy. Medical literature reports that intensive psychoanalysis, hypnosis, aversion reconditioning, chemotheraphy and behaviour therapy have all been tried and proved unsuccessful. Apparently, once the core gender identity as a member of the opposite sex has been firmly established, attempts to change it are not only fruitless but may be harmful in the long run.

Some transsexuals may decide to "pass" as females before deciding to have sex change surgery and most are so convincing in their roles that they are accepted without question. But the true transsexual will be satisfied with nothing less than anatomical transformation by surgery, and the surgeon must be prepared to go all the way, for it is extremely unlikely that the patient will call a halt before the conversion is complete.

A most memorable experience in my practice began when a young man, Mitchell R aged 29, consulted me about having his eyelids repaired. Quite prematurely he had wrinkled and puffy eyelids, adding years to his age and detracting from his otherwise handsome appearance.

"It's a family thing," he said, "and I can see no good reason for living with it when plastic surgery can do the trick."

I performed the necessary procedures and the patient was well satisfied with the result. And that was all until, a few months later, Mitchell asked to see me again, but would not tell my receptionist why.

We were standing beside my desk while I checked up on his eyes, which were by then thoroughly healed, when Mitchell, his tone quite casual, asked, "Doctor, would you be willing to remove my testicles?"

Now, I don't believe that I'm easily thrown, but Mitchell certainly succeeded. I sat down, hard, and when I got my voice back, I shook my head and said, "Well no, I would not."

Among the difficulties in dealing with a transsexual is that his request is for an irreversible procedure.

"Let's talk about it," I said. "Why do you want me to remove your testicles?"

"You see," Mitchell replied, "I want to be all-female, because that's the way I really feel and think and act. It's outrageous to have organs which don't really belong with the rest of me."

He went on, then, to tell me about how he had arrived at his decision to have sex change surgery. "I knew I was feminine from a very early age. My baby pictures looked just like a little girl, and when I went out to play, it was with girls. I enjoyed games like hopscotch and skipping and I had no desire to play baseball or football. Besides, I was just not strong enough. The boys didn't tease me much. I was very precocious at school, so they labelled me 'The Brain' and didn't expect me to be like them.

"My father was away on business a lot of the time, and when he was around, he didn't make any effort to masculinise me. Neither of my parents felt that I had any gender disorder. I didn't think so either. The fact that I had a girl's way of thinking and writing – I wrote a romantic novel when I was in the sixth grade – didn't bother me because it felt perfectly normal to me.

"As I reached puberty, my skin remained soft and my waist was narrow, but I was wide in the pelvic region. When I grew to full height at 1·75m (5′ 9″), I weighed 61 kg (135 lbs), in other words, like a fairly slender girl. My voice wasn't typically masculine either. It sounded a bit throaty, like a 'sexy' girl's voice.

"My genitals were unusually small, and although I never wore dresses, I did wear girls' panties because my penis didn't fit into a man's pouch. Buying clothes was a problem, because I had to go to the boys' section to get fitted at all properly. My shoe size, for instance, was only a size 7, and my entire frame simply didn't fill out to a grown man's dimensions.

"When other boys my age were obsessed with sex, I had no sexual feelings at all. Girls appealed to me as friends, but not sexually, and having relations with males was abhorrent to me. So I was in a sort of limbo as far as sex was concerned and I've stayed there ever since."

At college, Mitchell remained the good student he had been right from the start. He made the grade easily and had plenty of time to see films and attend concerts, usually alone.

"One day," Mitchell recalled, "I saw a picture about Christine Jorgensen, the transsexual. I thought the actor looked fantastic as a man, but so ridiculous as a woman that I just laughed at the idea that she

was a real female. I thought, so that's what a transsexual is like. And I didn't make even the faintest connection to my own situation."

Meanwhile, Mitchell was able to function normally in his chosen profession as a public accountant, but felt out of his depth when confronted by male competition.

"I looked younger than my years and, as a man, I felt and looked insignificant. One incident in particular brought home to me that I was the wrong sex. Nowadays, when clothes are so unisex, simply wearing trousers doesn't denote masculinity. I went into a men's room at a restaurant and one of the men in there called out 'Say, girlie, aren't you in the wrong place?'

"It began to dawn on me that I didn't want to be male. When I stripped in front of my bathroom mirror, I saw that if I had breasts and got rid of my beard, which was light and sparse anyway, I could make a fairly good-looking girl. As for my genitals, the penis was so small that I thought of it as an enlarged clitoris and my testicles were also negligible. I was impotent even when I tried to masturbate, so these organs had no value for me. Why should their mere presence arbitrarily classify me as masculine when, in my own inner reality, I'm feminine?

"I want to be completely feminised. Simply wearing women's clothes and using make-up are repugnant to me. I don't want to look like a homosexual in 'drag' and for a very good reason – I'm *not* a homosexual, but a transsexual with some kind of genetic disorder or hormone imbalance or whatever.

"I've been reading up on the subject and I know that the whys and wherefores of my condition are still a medical mystery. OK. But I am what I am, and I've got to find a way to live comfortably in my own skin, according to my own nature, and to be accepted by society. One psychiatrist I came across put it just right: I want to 'pass silently, completely, and permanently into society as a woman' ."

As a first tentative step, Mitchell had decided to go for electrolysis treatment to remove his beard, which was so light that he could go for several days without shaving. He had no hair on his chest, and only about as much as his legs as many women do. "I'm not going to settle for anything else but getting so far into the role that nobody will question that I am a woman," Mitchell drew a long breath and looked at me pleadingly. "Can you help me? I've got to have help."

help available

"Look, Mitchell," I said, "I think we're getting in over my head at this point. I'm not a psychiatrist, and as an indispensable first step you must have a thorough psychiatric evaluation, both in your best interest and my own. Help is available to you, but not solely on your terms."

Mitchell had not had any psychotherapy, but he readily consented to go to the University of Minnesota Gender Identity Clinic where a full assessment of whether or not he was an acceptable candidate for sex change surgery would be made. There, a plastic surgeon, psychiatrist, and clinical psychologist put Mitchell through an intensive three days of tests and interviews. Their judgment was that he was a true transsexual who probably would benefit from the surgery.

I consented to perform it – eventually – but not before Mitchell had lived for at least a year as a woman to find out how well he adjusted to it. Further, we decided first to feminise his face and body before doing the genitalia change.

"That's OK with me," Mitchell said. "Right now I'm not so much concerned with the genitals as with looking like a woman so convincingly that I'll be treated like one."

Mitchell left his job and moved to another community to begin life as a woman, and I was startled at how easily and naturally he assumed a feminine role, in dress, mannerisms, and behaviour. He changed his name to May and, it appeared, simply sloughed off his former identity. Accordingly, I shall refer to my patient from now on as May and use only female pronouns.

I put May on oestrogen, one of the female hormones which, in males, causes enlargement of the breasts and deposits body fat in accordance with female contours. Also, May continued the electrolysis treatments.

I started the feminising process with reduction of a rather prominent Adam's apple (thyroid cartilage over the voice box) which is essentially a masculine characteristic. I discovered that each change in appearance delighted May, and she anticipated each new procedure eagerly with no sign of regret.

We discussed a rhinoplasty, and since her nose was fairly small I opted for a slightly uptilted shape which conformed to her facial contours. At another stage I pared down her jaw and did a chin implant. When the healing period was over, May looked like a pretty young woman who, she told me with great glee, got whistled at and loved it!

"Within a few months of taking oestrogen," May says, "my breasts budded out and I began wearing size 36C bras and a size 12 or 14 dress, depending on the style. I let my hair grow, and had it dyed auburn, which made a striking combination with my hazel-coloured eyes.

"What I enjoyed most and felt entitled to was to be accepted as an appealing woman".

"I knew I had made the grade as an attractive young woman the day I went shopping for a special dress to wear to a party. I was waited on by an elderly lady. 'Honey,' she said, 'I can still remember that men love redheads in jade green dresses and I've got just the one for you.' She helped me into the dress which did look terrific. 'With a figure like yours', she commented, 'what wouldn't look good?'

"My measurements were 91-63-96 cm (36"-25"-38") and I could and did wear a bikini without anyone noticing my other equipment.

"I was living a nice interim life until the transformation was finally completed. My family was standing by me, not only in accepting the choice I had made but also by helping to support me until I went back to work. I kept my hand in by doing tax returns and so on for a few people in town. One day I had to see a bank official who had known me in the old days. I phoned him in advance and told him that I was now living as a woman. But when I showed up in person, he was so shook up that if he had been wearing false teeth, they would have been on the desk!

"I made friends and had them over for dinner and found that I enjoyed cooking gourmet meals from scratch. I dated sometimes, but the dates ended outside my apartment door. What I enjoyed most and felt entitled to, after all the surgery and so on, was to be accepted as an appealing woman and to be able to feel natural and happy in that role."

The last steps in May's transformation will be to remove the male genitalia and provide her with a vagina and clitoris.

Early on in genital surgery on male transsexuals a simple amputation of the phallus was performed, leaving a stump which was uncomfortable and sometimes painful. No attempt was made to construct a vagina or labia, yet even so crude an operation, as reported back in 1959, gave "great psychological improvement to many patients". Later on, plastic surgeons developed a method of creating a vagina by applying split-thickness skin grafts over a plastic form which was inserted into a surgically created pocket between the anus and the scrotum. Once amputation of the penis and castration were performed, the patient had a functional vagina but one lacking in sensitivity.

Now techniques have been further refined, and in operating on May I shall use the skin of the shaft of the penis to invert in a tunnel just in front of the rectum, creating a vagina which is responsive to erotic stimulus. The labia will be made from the scrotum at a second-stage procedure.

I shall also resort to an innovative technique I have developed for building a clitoris in the male-to-female transformation. Basically, this involves taking part of the *glans penis* or tip, which is embryologically similar to the clitoris, and trimming it down to size. The new clitoris gets its blood and nerve supply from the neuro-vascular bundle consisting of the dorsal artery, vein, and nerve of the penis, producing a clitoris capable of sexual arousal to orgasm.

May is representative of a few carefully selected cases for whom sex change surgery may provide a humane alleviation of a tragic disorder for which we do not now have a satisfactory alternative treatment. What May will do with the options which will become open to her is difficult to predict, although she does not rule out marriage and, in that case, perhaps she will adopt children. It is just too soon to tell.

new feelings

"Right now," May says, "I'm really glorying in all the new feelings and awareness I never experienced before. Even sunlight has a new dimension, and all my senses are so much more alive. Sensually, I feel an awakening. Colours and scents and textures have fresh meaning for me, and for the first time in my life I can contemplate the joys of sex and believe that one day I'll be able to share in them."

What we badly need with reference to transsexuals are far more intensive studies of these individuals, before, during, and after they have been feminised. I have been consulted by eight other men who were ready to go ahead with sex change surgery, but I rejected them as bad risks. Possibly, they will tirelessly make the rounds of other surgeons and eventually persuade one to operate. I do not know. But for the true male transsexual, as nearly as we can diagnose and evaluate him today, a compassionate response to his intense emotional suffering is in the best traditions of modern plastic surgery.

PREDICTIONS

The possibilities for plastic surgery of the future are very nearly limitless and I believe I may safely predict that in the next 20 years startling advances will be made on all fronts. As people live longer, the quality of their lives will be enhanced through more effective preventive medicine and treatment of existing diseases along with greatly improved regimens of nutrition, diet and exercise. Plastic surgeons will work in closer harmony with all other specialists to perfect procedures on every part of the body, while medical research and experimentation will result in major breakthroughs with great significance for us all.

Further advances will be made in the replacement of joints in the hand and other areas of the body with various plastic and metallic materials.

Through a better understanding of nerve, muscle, and tendon physiology, I believe that in 20 years' time, we will be able to obtain much better movement, perhaps even normal movement, in any paralysed part of the body. In cases of paralysis of one side of the face, I have been thinking through a technique which involves running a wire beneath the skin over to the normal side so that when it begins to smile, an impulse is sent to the paralysed side, triggering a motor implanted in the face through a system of pulleys and producing reasonably normal facial animation.

We are verging on the ability to transplant tissues from one person to another, regardless of their tissue type, and it may even be possible to take tissues from another person who has died. Such transplants would also include almost all types of organs. As a result, immediate reconstruction of defects which now require multi-stage techniques will become fairly commonplace.

It will be routine to replace arms and legs amputated in accidents, with reasonably good function, within hours after the injury, and extremities will probably be transplanted from deceased persons to victims of accidents or disease.

Major tumours from almost anywhere in the body

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will be resected and this would be followed by immediate reconstruction, using the patient's own tissue or tissue from someone else.

Within 20 years, the entire hair-bearing scalp of a deceased person will be transplanted for male pattern baldness.

Eventually, I predict that breast cancer will be controlled by medicine or other treatment without surgery, as we develop a more profound understanding of its causes. In the meantime, the modified radical mastectomy will be the operation of choice throughout the United States in the next five years. Presently, of some 90,000 mastectomies performed annually, 50% are radical and 50% are modified radical. It will be standard procedure to reconstruct the breast primarily at the time of the mastectomy. In all probability, the reconstruction will involve taking a breast from someone who has recently died, and by the the use of microvascular techniques, to completely rebuild it so that feeling and lactation (the ability to breast feed) will be intact.

Further advances in techniques will permit taking apart the face and skull and putting it all back together the way it should be, almost no matter how badly the person is deformed. Conceivably, after the immune or rejection reaction is overcome, large portions of the face of a deceased person will be transferred to supplant a deformed one. And as facilities for reconstructive plastic surgery proliferate throughout the country, all such unfortunate people will have immediate treatment available to them.

camouflage

As research into the causes of congenital deformities continues and further genetic mysteries are solved, preventive measures may be taken to guard against such scourges as cleft lip and cleft palate and other accidents of birth.

Although techniques in plastic surgery for minimising scars have been greatly improved over the past two decades, further improvements are distinctly in the offing. Acne scars will be almost totally controlled by techniques such as the boring-out method, and it will be possible to remove stretch marks completely, if not prevent them entirely. In the future, tattooing, or the insertion of permanent colours in the skin through punctures, will be used to camouflage birthmarks. Methods will also be devised to minimise small superficial varicose veins, which are so difficult to get rid of at present. Along with a keener understanding of good hygiene and skin care, more effective cosmetics will be developed to cover up minor blemishes without causing an allergic reaction or other unfavourable results. We will learn how to control wound healing to a larger extent and prevent the formation of hypertrophic scars.

About five years ago, a new medical speciality called dolorology, the science of pain, came into being. I believe that pain will be completely

OPPOSITE

eliminated from surgery within the next two decades. New approaches to coping with pain, including a number of electronic devices which jam pain signals, are now being used by thousands of chronic pain sufferers. This fresh impetus given to pain research is bound to rub off on surgical procedures. Once pain is eliminated and we know how to speed up wound healing, recovery time after plastic surgery will be considerably lessened. Also, I expect, as newer drugs are developed to make such procedures safer, more and more plastic surgery will be done in the doctor's surgery.

Burn dressings will continue to be improved upon and will greatly alleviate the suffering and threat of infection faced by victims of severe or widespread burns. I predict that artificial skin will be developed which could conceivably replace lost or scarred tissue.

stigma

With respect to problems of impotence, I am convinced that, particularly with increasing longevity, the number of men seeking a penile implant will greatly increase, removing any stigma or embarrassment associated with the procedure. Also, better techniques will be developed in answer to the stepped-up demand.

Vaginoplasty or plastic surgery on the vagina to tighten it and provide more pleasurable sex both to the woman and her partner has been and is being done. But, here again, we have not yet adjusted to the fact that such a procedure is medically and emotionally justified where multiple pregnancies or advancing age cause sagging of the vaginal tissues and surrounding muscles. We shall shortly reach a stage in our society where improvement of our sexual apparatus by plastic surgery is no more remarkable than having dentures fitted in order to be able to chew.

When the sports page of a daily newspaper frankly discusses such questions as whether a male transsexual, who has had a sex change surgery, should be admitted to professional tournaments of the Women's Tennis Association and compete as a female, then it is reasonable to project a time in the not-so-distant future when more and more people will have the operation and be accepted by society.

Surgical techniques exist right now for transplanting a uterus and ovaries (the organs necessary to conceive and deliver a baby) to a male transsexual. All which remains to be overcome is the immune or rejection reaction, and strides are being taken toward this goal. ●

This is the second and final extract from *A New You – How Plastic Surgery Can Change Your Life* by Dr James O Stallings, written with Terry Morris and published in the USA by Mason/Charter.

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Please take note that his comments in the section subtitled *Predictions* are entirely his own opinions for which SHE can take no responsibility.